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A Growing Fiscal Concern: Medicaid Spending in Maryland

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In a special session in late 2007, Maryland's General Assembly expanded the state's Medicaid program. Given that this special session was convened to deal with the state's deficit, expanding a program that has caused financial challenges for the state seems an odd decision. Over the past 15 years, this program has strained state budgets, especially during times of economic recession. A different approach is needed.

Maryland contends with a long-term budget deficit and faces the possibility of a slowing economy. In this economic and fiscal climate, state policymakers should seek alternatives to Medicaid expansion. Steps to make health insurance more affordable for Marylanders and fundamental reform of the structure of Medicaid would benefit Marylanders more than expanding an expensive program.

Anyone considering Medicaid expansion should keep in mind the state's recent experience with Medicaid and the Maryland Children's Health Program (MCHP). Looking at spending patterns in the years since 1992 gives a good snapshot of how Medicaid and MCHP work in both good economic times and bad. Medicaid occupies a significant share of the state budget and squeezes out spending on other programs during economic hard times. Although Medicaid is known as a program that is needed to help people who are in difficult economic circumstances, only during 1998 did spending actually decrease despite many years of high economic growth.

The portion of Maryland's general fund taken by Medicaid has remained relatively constant over time. However, earlier this decade the rise in enrollment and the drop in revenue caused the program to grow from 13 percent of general fund revenues in 2000 to 17 percent in 2003. That type of pattern does not bode well for the state's fiscal health during the next economic downturn, especially given current projections of state deficits over the coming years.

CURRENT SYSTEM

Around 11 percent of Marylanders are enrolled in either Medicaid or MCHP. The total cost of the program in FY 2006 was $4,449,957,000. Of that, $2,085,217,000 was from Maryland's General Fund. The rest came from special funds or the federal government.[1]

Seventy-eight percent of those on Medicaid or MCHP are enrolled with managed care organizations (MCOs). These MCOs receive a fee from the state and in return enroll beneficiaries in programs to provide them with Medicaid-eligible services.

1. All information regarding spending, enrollment, and the structure of Medicaid and MCHP comes from the yearly Department of Legislative Services Operating Budget analyses.

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Medicaid

Eligibility: There are a variety of ways to qualify for Medicaid in Maryland. Those deemed "categorically needy" are Marylanders who are eligible for Temporary Cash Assistance or Supplementary Security Income. "Medically needy" Marylanders have incomes too high to be deemed "categorically needy" but still qualify by having income below the state's income limits.

Services: There are two types of services covered by Medicaid. One type is "mandatory" services, which the federal government says must be covered if states are participating in the Medicaid program. These are:

- Nursing facility services
- Inpatient and outpatient services at hospitals
- X-ray and laboratory services
- Early and periodic screening, diagnosis, and treatment services for children
- Family-planning services
- Transportation
- Physician care
- Health care and rural clinic services
- Nurse practitioner services

States can also elect to cover other services and the federal government will help fund them. These are labeled as "optional," and include the following in Maryland:

- Vision care
- Podiatry care
- Pharmacy services
- Medical day care
- Medical supplies and equipment
- Intermediate care facilities for people with mental disabilities
- Institutional care for elderly Marylanders who have mental diseases

Maryland Children's Health Program (MCHP)

The MCHP program is more generous in its eligibility than the state's Medicaid program. It covers pregnant women who have incomes up to 250 percent of the Federal Poverty Level (FPL) and children up to 300 percent of the FPL.

Premiums and Co-payments

Only MCHP charges premiums. Families with an income between 200 percent and 250 percent of FPL pay a premium of $44 a month to participate in the program. Those with incomes between 250 percent and 300 percent pay a premium of $55. In FY 2004, families between 185 percent and 200 percent of FPL were also required to pay premiums, but this requirement was dropped in 2005. Maryland also has few co-payments. Certain Medicaid recipients must pay $3 for non-preferred drugs and $1 for preferred drugs. These drugs cannot be denied to the recipient for failure to pay, however. Beyond these limited measures, there are no other cost-sharing requirements in either program.

PROPOSALS TO EXPAND MEDICAID

2007 Regular Session of the General Assembly

In the 2007 legislative session, some Maryland lawmakers pushed legislation to expand the program. Newly-elected Governor Martin O'Malley also supported a plan to include more Marylanders within the program's eligibility requirements.

Legislation to expand Medicaid and MCHP, sponsored by Delegate Peter Hammen, passed the House of Delegates but died in the Senate. Delegate Hammen's bill, which was mainly supported by Democrats but picked up the votes of a few Republicans, would have expanded Medicaid eligibility for adults up to 116 percent of FPL and expanded MCHP eligibility to children in families with incomes up to 400 percent of FPL. According to the Department of Legislative Services, this bill would cost $79.3 million in the first year. Spending would rise dramatically in FY 2009 (costing the state almost $200 million) and continue an upward climb in future years.

The primary method of funding these expansions would be a doubling of the state's tobacco tax, from $1.00 a pack to $2.00 a pack. As the fiscal note on the bill showed, however, this tax would not cover the full cost of the expansion in 2009 and later years, only bringing in $160 million in that year and then continually decreasing in the years thereafter.[2]

The House of Delegates passed this legislation, with a few minor modifications. Senate President Mike Miller, however, prevented the bill from

2. The fiscal note for this bill can be found here: http://mlis.state.md.us/2007RS/fnotes/bil_0004/hb0754.pdf

advancing in the Senate. Senator Miller expressed concern about raising cigarette taxes to pay for new government spending when the state faced a $1.5 billion structural deficit in FY 2009. Miller contended that any tax increase should specifically address that deficit and not pay for new spending.

2007 Special Session of the General Assembly

In late 2007, Governor Martin O'Malley convened a special session of the General Assembly to raise revenue to deal with the state's structural deficit. As part of that special session, legislation to expand Medicaid was also signed into law.

SB 6, the Working Families and Small Business Health Coverage Act, expanded Medicaid eligibility for adults. On July 1, 2008, adults making up to 116% of the Federal Poverty Level will be eligible for Medicaid services (currently only adults who have incomes below 46% of the FPL are eligible for Medicaid). Parents and adults who are taking care of children to whom they are related will receive full Medicaid benefits. In an attempt to contain costs, childless adults will see their benefits phased in over time. In 2010, they will begin receiving specialty medical care and hospital emergency services. In 2011, they will begin to receive outpatient hospital services. In 2012, they can receive inpatient hospital services with some limitations. Childless adults will receive full Medicaid benefits in 2013. In another attempt to contain costs, the legislation allows a cap on the number of childless adults who can receive Medicaid.

Unlike the legislation passed by the House of Delegates during the regular legislative session, this benefit expansion does not include MCHP and is not reliant on a specific funding source. The revenue to pay for SB 6 comes from the general fund. With the expansion projected to cost Maryland taxpayers an additional $265 million in 2013, the financial impact is significant. As mentioned above, the phase-in of benefits is designed to help address fiscal concerns about such an expansion. The stated intent of the legislation is that if general fund revenue is not sufficient to pay for the expansion, the phase-in for childless adults will not take place.[3]

Table 1: Fifteen-year History of the Program

Year	Spending	Percent Increase	State Share	Federal Share	Percent of Gen. Fund	Medicaid Enrollment	Percent Increase
1992	$1,853,532,000	N/A	$968,416,000	$874,755,000	15.5 %	442,017	N/A
1993	$1,853,913,000	0.04 %	$960,770,000	4875,982,000	15.0 %	426,233*	-3.6 %
1994	$1,933,966,000	4.30 %	$997,146,000	$926,644,000	15.1 %	443,376	4.0 %
1995	$2,067,889,000	6.90 %	$1,035,068,000	$1,017,971,000	14.8 %	462,503	4.3 %
1996	$2,121,914,000	2.60 %	$1,061,828,000	$1,048,869,000	14.4 %	460,664	-0.4 %
1997	$2,200,720,000	3.70 %	$1,096,386,000	$1,097,384,000	14.6 %	449,825	-2.6 %
1998	$2,041,132,000	-7.30 %	$1,009,687,000	$1,004,329,000	12.7 %	437,355	-2.8 %
1999	$2,221,401,000	8.80 %	$1,096.952.000	$1,098,789,000	13.4 %	413,400	-5.5 %
2000	$2,491,792,000	10.90 %	$1,140,265,000	$1,234,065,000	13.3 %	441,690	6.9 %
2001	$2,736,530,000	9.80 %	$1,342,836,000	$1,353,160,000	13.7 %	527,752	19.5 %
2002	$3,122,684,000	14.10 %	$1,567,639,000	$1,540,123,000	16.5 %	567,391	7.5 %
2003	$3,454,614,000	10.60 %	$1,583,431,000	$1,744,167,000	17.0 %	595,509	5.0 %
2004	$3,831,471,000	10.90 %	$1,647,633,000	$2,045,458,000	15.0 %	603,653	1.4 %
2005	$4,080,069,000	6.50 %	$1,935,043,000	$2,059,068,000	15.5 %	621,264	2.9 %
2006	$4,449,957,000	9.10 %	$2,085,217,000	$2,212,174,000	15.2 %	628,336	1.1 %

3. All information on this legislation comes from the bill's fiscal note: http://mlis.state.md.us/2007s1/fnotes/bil_0006/sb0006.pdf

Looking back at the history of the Medicaid and MCHP program, one thing is clear: These programs strain the state budget, especially during times of economic recession. Once a program that saw only minor growth in expenditure (less than half of one percent between 1992 and 1993), the current Medicaid program now grows at an astonishing rate (9 percent between 2005 and 2006; 14 percent between 2001 and 2002). These increases occur regardless of the economic climate. The state faces a budget deficit caused in part by increasing Medicaid spending. As a result, policymakers need to realize that further expansion of the program will only reduce funding for other programs, and/or necessitate an increased burden on taxpayers.

Logically one could assume that during good economic times, programs that ostensibly target people in poverty would see less growth than in bad economic times. This is not the case with Medicaid and MCHP. Instead, when the state saw relatively high economic growth and low unemployment during the late 1990s and in the past few years, the growth of the program rarely slowed.

Maryland did see relief to a certain extent between 1997 and 1998, when overall spending dropped. Enrollment also dropped between 1997 and 1999, although spending between 1998 and 1999 increased. This was a time of good economic growth in Maryland. In 1998, for example, economic growth was 4.3 percent. Unemployment was at 4.2 percent.

It would be a mistake to think, however, that robust economic growth always produces such a drop. In 2004, for instance, when the state experienced identical 4.3 percent economic growth and 4.2 percent unemployment, Medicaid spending was almost 11 percent higher than in 2003.

Medicaid Strains the State Budget in Bad Economic Times

As noted, Medicaid spending declined in only two of the 15 years examined. For the other thirteen years, spending increased. These increases put an especially severe strain on state budgets during times of economic recession, where tax and other revenues coming into the state were below expectation. This usually coincided with Medicaid spending being above budgeted amounts. This situation meant that the General Assembly faced spending constraints due to the Medicaid program.

For example, from 1992 to 1996, the state experienced relatively low economic growth and relatively high unemployment. Medicaid spending and enrollment, however, fluctuated.

Table 2

Year	Spending Increase	Percent General Fund	Enrollment Increase	Economic Growth	Unemployment
1992	N/A	15.5 %	N/A	N/A	6.6 %
1993	0.04 %	15.0 %	-3.6 %	1.6 %	5.5 %
1994	4.30 %	15.1 %	4.0 %	3.1 %	5.2 %
1995	6.90 %	14.8 %	4.3 %	1.3 %	5.1 %
1996	2.60 %	14.4 %	-0.4 %	2.1 %	5.0 %

Table 3

Year	Spending Increase	Percent General Fund	Percent Enroll Increase	Econ. Growth	Unemployment
2000	10.90 %	13.3 %	6.9 %	2.9 %	3.6 %
2001	9.80 %	13.7 %	19.5 %	3.4 %	4.1 %
2002	14.10 %	16.5 %	7.5 %	3.0 %	4.5 %
2003	10.60 %	17.0 %	5.0 %	2.3 %	4.5 %

The decrease in enrollment in between 1992 and 1993 occurred almost solely because 1993 was the year that Maryland ended a state-only Medicaid program. Even with low economic growth, spending growth remained fairly modest.

However, by the time of the next economic recession, Medicaid growth was much more explosive.

As can be seen, during this recession the share of the General Fund consumed by Medicaid reached as high as 17 percent. During the previous recession, it only consumed 15.5 percent of the General Fund.

What is striking is that during the previous recession, the state saw much lower economic growth and much higher unemployment. However, enrollment in Medicaid was much lower during the earlier recession than during the latest recession. This meant that spending increases were also much higher during the 2000-2003 recession.

This is important in terms of how it affects the Maryland budget because during times of economic recession, the state often sees General Fund revenue decrease. For example, in 2001 the state collected roughly $9.8 billion in General Fund revenue. That decreased to $9.3 billion by 2003. As the numbers above show, Medicaid spending those years increased 14 percent and 10 percent, respectively.

Medicaid Grows Even in Good Economic Times

While Medicaid clearly squeezes state budgets during economic downturns, what is often not discussed is how the program continues to grow in good economic times.

Table 4

Year	Total Spending	Percent Increase	Percent Increase in Enrollment	Economic Growth	Unemployment
1997	$2,200,720,000	3.70 %	-2.6 %	4.4 %	4.7 %
1998	$2,041,132,000	-7.30 %	-2.8 %	4.2 %	4.3 %
1999	$2,221,401,000	8.80 %	-5.5 %	3.8 %	3.6 %
2004	$3,831,471,000	10.90 %	1.4 %	4.2 %	4.3 %
2005	$4,080,069,000	6.50 %	2.9 %	3.6 %	4.2 %
2006	$4,449,957,000	9.10 %	1.1 %	2.9 %	3.9 %

Now, as these numbers show, both spending and enrollment have declined during certain years of good economic growth. Notably, although enrollment declined for three of these years, spending declined in only one. In fact, during the year when enrollment declined the most—1999—spending went up almost 9 percent.

In general, these spending numbers indicate that even in times of good economic growth and low unemployment, spending will increase. In addition, they indicate that spending will likely increase even in times of low growth in program enrollment.

LESSONS FOR POLICYMAKERS

Medicaid Spending and Enrollment Are Hard to Predict

As Table 5 demonstrates, it is difficult for policymakers to accurately forecast Medicaid spending.

Table 5

Year	Budget	Actual	Amount over/ under Budget
1992	$1,543,895,000	$1,853,532,000	$309,637,000
1993	$1,932,944,000	$1,853,913,000	-$79,031,000
1994	$1,981,308,000	$1,933,966,000	-$47,342,000
1995	$2,337,912,000	$2,067,889,000	-$270,023,000
1996	$2,197,105,000	$2,121,914,000	-$75,191,000
1997	$2,314,267,000	$2,200,720,000	-$113,547,000
1998	$2,097,743,000	$2,041,132,000	-$56,611,000
1999	$2,193,281,000	$2,221,401,000	$28,120,000
2000	$2,242,844,000	$2,491,792,000	$248,948,000
2001	$2,658,792,000	$2,736,530,000	$77,738,000
2002	$2,856,086,000	$3,122,684,000	$266,598,000
2003	$3,309,469,000	$3,454,614,000	$145,145,000
2004	$3,773,767,000	$3,831,471,000	$57,704,000
2005	$3,990,064,000	$4,080,069,000	$90,005,000
2006	$4,310,617,000	$4,449,957,000	$139,340,000

The reason for this is Medicaid is an entitlement program. Anyone who is eligible can sign up for it. And for those who are not in managed care and obtain coverage through the fee-for-service model (which includes many of the highest-cost Medicaid recipients), there is little way of controlling cost. If a person under the fee-for-service model wants a certain service covered by the program, that person gets the service, whether or not it is truly needed. That is a recipe for uncontrollable spending.

This type of spending uncertainty is especially troubling during times of economic recession. As can be seen in the chart above, the government underestimates Medicaid spending most of the time. During the last recession, it severely underestimated spending in most years. When policymakers do not set aside enough money to pay for Medicaid spending in one year, the following year's budget suffers. During a recession, with general fund revenue declining or only rising a little, the uncontrolled cost of Medicaid spending is especially noticeable.

Minor Efforts to Contain Spending Are Ineffective

During times of rising Medicaid spending, state policymakers have tried to limit the growth of the program by restricting eligibility to the program or limiting what type of services would be covered. Before 1993, Maryland had a state-only Medicaid-type program that paid for medical services for some individuals. In 1990 it began to phase that out. In 1993, the final year of the phase-out, Maryland saw a drop in the number of people covered. The Department of Legislative Services estimated that $27 million was saved by this. However, the next year the state saw a number of new enrollees in the Medicaid program. It attributed this, in part, to people who were eligible for the discontinued state-only program signing up for Medicaid.

Another eligibility restriction took place in 2004, when lawmakers attempted to slow the growth of the program in response to the economic slowdown. In that case, there was a one-year freeze on the enrollment of children in families whose income exceeded 200 percent of the federal poverty level.

There have also been attempts to reduce services or impose co-payments. In 1993, for instance, the state stopped paying for eyeglasses, dental services, and physical therapy. The Department of Legislative Services estimated this move only saved $600,000. In 2005 the state imposed a $10 co-pay-

ment on Medicaid recipients who used emergency rooms for non-emergency purposes.

As mentioned above, MCHP has premiums for users in families with incomes exceeding 200 percent of FPL. In 2004, it also charged premiums for users with incomes between 185 percent and 200 percent of FPL. These premiums have the effect of slowing enrollment growth.

As the Department of Legislative Services notes:

> Subsequent to the inception of premiums, enrollment dropped more than 20 percent. Robust growth in enrollment followed the elimination of the premium requirement in FY 2005. Data from other states (Oregon, Rhode Island, and Vermont) adopting premium requirements for existing programs demonstrate similar and in some cases even more pronounced enrollment declines.[4]

There has not been much support for expanding premiums, however, and it is unlikely that charging premiums for very low-income Medicaid or MCHP recipients would be practical or politically acceptable.

Any reductions in eligibility or the type of services covered is often temporary, and is usually more than offset in later years by legislative action to expand Medicaid and MCHP coverage. The trend is usually to enact small, temporary cutbacks in bad economic years and then expand in good economic years. Eligibility expansions for MCHP took effect in both 1998 and 2001 and were passed by the General Assembly at a time when the state saw rising revenue into the General Fund.

High-Cost Recipients Must be Included in Reform

In 1997 Maryland began to enroll Medicaid recipients with managed care organizations (MCOs). This was supposed to help control costs and give recipients better care. However, the most costly and most needy recipients were not included in this reform effort. The elderly and people who rely on Medicaid to pay for institutional care, for instance, are not included in the managed care program. That helps explain why, with 78 percent of Medicaid recipients enrolled in MCOs, managed care spending is only 40 percent of the state's Medicaid budget.

Maryland's managed care program is not ideal. The state would do better to follow the example of Florida, described below. Unfortunately, when policymakers did decide to enact this reform, they did not include a large number of people in the groups that largely drive Medicaid cost increases. In 2004, the elderly and disabled made up only 26 percent of Medicaid recipients but they accounted for 70 percent of the program's cost. Children, by contrast, made up 60 percent of the enrollees in Medicaid and MCHP but accounted for only 20 percent of the program's cost.

Until true reform efforts can be made that include the elderly and people with disabilities, Maryland cannot begin to control or even accurately predict the state's Medicaid spending.

SUGGESTIONS FOR POLICYMAKERS

Pursue Broad Reform

In Annapolis, the only reform to Medicaid in Maryland being considered is just how much to expand its reach. There is no discussion of fundamental changes to the program. As the recent history of Medicaid shows, spending has grown dramatically since 2000. Expanding the program will only cause this growth to accelerate.

Such growth is clearly unsustainable, especially in light of the state's other fiscal troubles. Furthermore, the care received by Medicaid recipients is often poor. Low reimbursement rates often discourage doctors from seeing Medicaid patients, forcing recipients to travel far to receive care or to experience long waits for service.

Instead of expanding eligibility for an expensive program that offers inferior care, Maryland policymakers should explore reform options that would fundamentally change the way Medicaid operates in the state.

These policymakers do not even need to generate original ideas. A handful of states are implementing reform plans that are promising to have the twin effects of both serving Medicaid recipients better as well as controlling long-term growth in the program. Here is a brief overview of some states' efforts.

4. Department of Legislative Services, "Analysis of the FY2008 Maryland Executive Budget: Department of Mental Health and Hygiene, Medical Care Programs Administration," pp. 49, 50.

- **Florida** has moved from a "defined benefits" system to a "defined contribution" system. Unlike the state's previous open-ended benefit system, Florida now caps the amount it spends on a Medicaid beneficiary (although children under 21 and pregnant women are exempt from this cap). It does this by moving towards a managed care model where the state would buy medical care for a recipient by paying a monthly premium to a private provider. A recipient can also choose to forgo Medicaid coverage and instead receive a subsidy to help purchase private insurance. There are also incentives for recipients who enroll in programs to help them improve their health by doing such things as quitting smoking and losing weight.
- **South Carolina** has applied for a waiver from the federal government to use personal health savings accounts to help Medicaid recipients purchase private coverage.
- **Idaho** has implemented a three-tiered Medicaid system that provides a different set of benefits for three groups: children, people with disabilities, and people eligible for both Medicare and Medicaid. A Medicaid recipient can also choose to remain in the state's traditional Medicaid program. Providing different sets of benefits to different groups will allow the state to focus resources on these groups' different needs as well as make it more efficient.
- **Kentucky** has undertaken an initiative similar to Idaho's and now has a six-tiered system tailored to meet the needs of various Medicaid recipient groups.

Maryland policymakers should evaluate these states' progress with Medicaid reform and see if similar programs would be good for our state. This would be a better course rather than wait for a recession and cut back services or imposing cost-sharing plans. These steps do little to actually save real money; they hurt people who depend on the program, and are often reversed within a year or two. Instead of doing minor tinkering around the edges of the Medicaid program, policymakers need to fundamentally reform it so that it delivers the necessary help for those who need it without placing an undue burden on the state's taxpayers.

Private Insurance—Not Medicaid—Is Best for Marylanders

The focus in Annapolis is about how to get more people on Medicaid and MCHP. That is exactly the wrong way to go on this issue. Policymakers should be trying to move people off these programs and onto private insurance. This approach will not only save the state money, but will also lead to better health care for the people who would have been on Medicaid.

Make Private Insurance More Affordable

One of the easiest ways to help more Marylanders receive private insurance coverage is to reduce state regulations that make insurance unaffordable. The relaxation of these regulations would also make insurance more attractive to those who can afford it but who do not see the value of plans offered in Maryland. This regulatory reform would also likely address the situation where two companies provide 92 percent of the health insurance policies in the individual and small group market in the state. This lack of real competition in the health insurance market also tends to drive up prices for health insurance.

The first step the General Assembly should consider is to scale back the number of mandated services that it has imposed on health insurance carriers. Maryland has 60 such mandates, higher than all but one state.[5] The Council for Affordable Health Insurance explains how such mandates drive up the cost of service:

> While mandates make health insurance more comprehensive, they also make it more expensive because mandates require insurers to pay for care consumers previously funded out of their own pockets. Based on our analysis…, mandated benefits currently increase the cost of basic health coverage from a little less than 20 percent to more than 50 percent, depending on the state. Mandating benefits is like saying to someone in the market for a new car, if you can't afford a Lexus loaded with

5. See "Health Insurance Mandates in the States: 2007" by the Council for Affordable Health Insurance, http://www.cahi.org/cahi_contents/resources/pdf/MandatesInTheStates2007.pdf

> options, you have to walk. Having that Lexus would be nice, as would having a health insurance policy that covers everything one might want. But drivers with less money can find many other affordable options; whereas when the price of health insurance soars, few other options exist.[6]

These mandates are ostensibly put in place to ensure that insurance covers necessary services. The problem, however, is that segments of the health care industry lobby legislators to make sure their service is covered, leading to a large number of services with dubious value for many people. For example, Maryland is one of two states to mandate coverage for Alzheimer's disease. For a young person with no history of Alzheimer's in his or her family, this mandate only increases the cost of insurance without providing any benefit.

The General Assembly is not the only body that places restrictions on health insurance in Maryland. The Maryland Health Care Commission regulates how much health insurance plans can charge for such things as co-payments, deductibles, outpatient lab fees, and a variety of other things.[7]

Reducing the number of mandates would bring down the cost of insurance in the state for those who buy their own plans or receive them through small businesses.

Use Medicaid Dollars to Pay for Private Insurance Premiums

Of course, even if the state of Maryland relaxed restrictions on health insurance policies and prices dropped, there would still be some people who could not afford such policies. How, then, should the state deal with them?

In some cases, especially regarding children's health insurance, it makes more sense to have the state help workers pay their premiums for private insurance rather than absorb all the cost by expanding MCHP. For example, many Marylanders choose to use MCHP for their children instead of obtaining health insurance that is provided by their jobs. This is a perfectly rational choice, since MCHP coverage is often cheaper than the coverage offered by employers.

The attractiveness of MCHP is, in large part, responsible for the issues surrounding Maryland's so-called "Fair Share" bill. Claiming in 2005 that Wal-Mart was shifting the cost of health care onto government programs instead of providing it itself, the Maryland General Assembly passed a law to essentially penalize Wal-Mart. The real issue, however, was not that Wal-Mart did not provide health care. According to one analysis, in 2005 over 80 percent of Wal-Mart workers were eligible for health coverage.[8] However, 27 percent of the workers had children on some form of state insurance. Thirty-six percent of employees of other retail companies also had children on state insurance.[9] These are national numbers, but they illustrate the fact that a significant number of retail employees choose government health programs over private insurance.

Instead of providing MCHP coverage to these families, the state should consider providing assistance to them to help them obtain private coverage. Since Maryland currently offers MCHP coverage up to 300 percent of the FPL, it would make sense for the state to have a sliding scale of assistance to workers. Those who make less money would receive more help than those at 300 percent of FPL, for instance.

CONCLUSION

As the history of the Medicaid program shows, spending for the program consumes a large share of General Fund revenue. The trend is for the program to grow, in both good economic times and bad. However, during economic slowdowns, state Medicaid spending has proven (especially during the last recession) to take an increasing share of General Fund revenue (which generally decreases during this time). That is troubling news for Maryland policymakers as the state faces a structural deficit while also looking at a looming economic slowdown.

6. *Ibid.*, p. 2
7. See http://mhcc.maryland.gov/smallgroup/cshbp_brochure.htm for more details on the type of restrictions placed by the Maryland Health Care Commission.
8. Jason Furman, "Wal Mart: A Progressive Success Story," p. 6, http://www.americanprogress.org/kf/walmart_progressive.pdf
9. *Ibid.,* p. 7

Instead of continuing to expand Medicaid as some legislators desire, a better idea is to take steps to make health insurance more affordable. This can be accomplished without placing burdens on the state's General Fund. Taking steps like reducing mandates and other restrictions on health insurance will allow more Marylanders to afford it. For those who are working and yet still have trouble buying health insurance, the state could consider helping them with premium payments. Doing these things would ensure that Medicaid is reserved for the state's truly needy. It would also reduce the rate of growth in the program, partially alleviating pressure on state revenue.

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