STATE EXPERIENCES WITH COST-SHARING MECHANISMS IN CHILDREN'S HEALTH INSURANCE EXPANSIONS

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Mary Jo O'Brien
Health Management Associates

and

Meghan Archdeacon
Midge Barrett
Sarah Crow
Sarah Janicki
David Rousseau
Claudia Williams
The Lewin Group

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EXECUTIVE SUMMARY

Cost-sharing—in the form of copayments and premiums—is a prominent feature of the State Child Health Insurance Program (CHIP) in many states. The rationale for cost-sharing in CHIP, as in other insurance programs, is to control use of health care services, foster the notion of personal ownership and responsibility for health care among beneficiaries, and generate revenue. CHIP policymakers and program designers instituted cost-sharing to accomplish two other objectives that other insurance programs do not share. First, by structuring CHIP more like commercial health insurance, they hoped to reduce the "welfare" stigma associated with publicly funded insurance programs. Second, they wanted to limit the substitution of public coverage for commercial or employer-sponsored insurance.

Twenty-five states chose to include some form of cost-sharing in their CHIP program designs. This paper examines early program experiences to gauge the effect of cost-sharing on program participation. We focus on several questions of concern to policymakers, advocates, and other leaders in children's services:

- Does cost-sharing create a barrier to enrollment—either financial or structural—for low-income families with children?

- What administrative concerns result from cost-sharing? Do administrative burdens or costs outweigh potential benefits?

- Does cost-sharing affect the public's perception of CHIP as a "welfare" program?

- Are there indications that premiums or other cost-sharing mechanisms help limit substitution of public coverage for private health insurance?

To answer these questions, the study conducted literature reviews, interviews with nationally recognized experts, and case studies of six states. The states chosen—California, Colorado, Florida, Massachusetts, New York, and Washington—represent a cross-section of CHIP designs, including Medicaid expansions, "stand alone" CHIP or state-only programs, and combinations of CHIP programs and Medicaid expansions. The research team spoke with state legislators, program administrators, advocacy and community group leaders, researchers, health plan representatives, physicians and other health care providers, and officials from local government agencies in each state.

Based on first-year experiences of states with newly implemented CHIP programs and experiences of states with a longer history of cost-sharing, both premiums and copayments introduce new complexity into program administration. Premium-sharing, in particular, may provide disincentives for enrollment—even at quite low levels. It can also create logistical difficulties for families in arranging monthly payments.

State programs have found that low-income families who do not have experience with the health insurance system often lack familiarity with basic insurance concepts, including prepayment for coverage regardless of the immediate need for care. As a result, premiums affect both the initial decision to enroll as well the decision to remain in the program. States have also found that low-income families without a checking account or credit card, or the ability to have premiums deducted from paychecks, face problems in arranging for payment of monthly premiums. Because states are unable or reluctant to accept cash payment, many families must use more costly money orders instead.

Copayments for services appear to be less of a barrier to program participation. When set low, copayments for some services (with full preventive care coverage) seem to create fewer burdens for program administrators. They do, however, add to the responsibilities of physicians, who are expected to collect copayments.

Cost-sharing implementation and monitoring introduce a range of new concerns for program administrators, insurance plans, and health care providers. These include:

- tracking participants' payment of premiums and copayments, either by the state or through third-party administrators;

- monitoring total family payments to determine whether a family has reached the maximum cost-sharing limit, set at 5 percent of yearly income;

- establishing procedures to ensure that families who have reached the 5 percent cap do not pay further premiums or copayments; and

- enforcing collection of copayments, which some physicians do not ask their patients to pay.

At the same time, program administrators and others noted that despite their cost-sharing features, CHIP programs appeal to new applicants because they are distinct from programs

linked to welfare. Some families with children who are eligible for Medicaid—which does not have premium costs and often has no copayments either—preferred to participate in a stand-alone CHIP program.

Although states have devised an array of approaches for simplifying premium payment arrangements for families and coping with administrative concerns, relatively little is known about their impact on CHIP participation. To inform program development and future incremental expansion efforts, states may need to learn more about why potentially eligible families do not enroll and the extent to which premiums and copayments affect their decision. We do know that family participation is influenced by enrollees' understanding of health insurance, the value they place on being insured, and the administrative difficulties they face. Analysis of how these factors influence enrollment would help administrators shape program strategies.

The case studies suggest a number of ways that insurance programs for low-income families could minimize premium- and cost-sharing obstacles to enrollment and services:

- establishing flexible health insurance premium payment options for enrollees;
- designing repayment programs for families who fall behind on their premiums, including lenient grace periods for late payments;
- mailing payment reminders to families;
- shortening the period for which families are excluded from programs (locked out) for nonpayment of premiums; and
- investigating the possibility of payroll deductions for premiums with employers who are willing to participate.

Regardless of what cost-sharing requirements are set, states need to ensure that program components are sustainable and free of undue administrative costs. Policies must be simple, practical, reinforced, and enforceable. The study demonstrates that if premiums or other forms of cost-sharing are to be incorporated into CHIP programs, policymakers will also need to take steps to help families not accustomed to insurance understand how health coverage works.

This study raises the central question of whether the hoped-for value of cost-sharing can be achieved while also assuring that all children get health insurance and keep it—plus have access to regular care. A CHIP system that makes insurance available but loses low-income families who are reluctant or unable to pay even modest monthly premiums, or who postpone care to avoid copayments, will ultimately undermine efforts to improve children's access to care.

STATE EXPERIENCES WITH COST-SHARING MECHANISMS IN CHILDREN'S HEALTH INSURANCE EXPANSIONS

I. INTRODUCTION

Nationally, policymakers, politicians, and the general public recognize that there is a high cost in dollars and human suffering when people do not have adequate access to health care because they lack health insurance. The federal State Child Health Insurance Program (CHIP) provides an opportunity for all 50 states to design publicly supported programs that can provide the basis for a comprehensive system of health insurance for all low-income families and individuals. The Commonwealth Fund engaged the Lewin Group to study the implementation of CHIP with a focus on cost-sharing in order to provide states with guidance gleaned from the early stages of program design and implementation. The study examines design and administrative issues and perceived effects on program participation with the goal of informing future program development and efforts to expand coverage to low-income families.

Purpose of This Paper

This paper reviews previous studies on use of cost-sharing in insurance programs for low-income families and analyzes the experiences of six study states with cost-sharing. For each state, the study describes:

- cost-sharing mechanisms employed;
- the processes underlying the selection of these strategies;
- implementation experiences; and,
- the perceived effect premium and patient cost-sharing mechanisms are having or are likely to have on enrollment.

The paper addresses two central questions: Does cost-sharing create a barrier to enrollment (either financial or structural) for near-poor families with children? Do administrative burdens imposed on the state through cost-sharing implementation and oversight outweigh potential benefits? Lessons from the early experiences of the six states under study are also explored.

Overview of Title XXI

More than 44 million Americans—16 percent of the population—are uninsured. Of that number, children account for one of every four. Roughly one-third of the uninsured have incomes of less

than 100 percent of poverty, and another third have incomes from 100 to 200 percent of poverty.[1] While the majority of the former group is Medicaid-eligible but unenrolled, the latter group has traditionally had few options for securing affordable health coverage. Therefore, federal and state policymakers are developing new ways to bridge the gap between those already covered by Medicaid and those able and willing to purchase private insurance.[2]

Congress passed the State Child Health Insurance Program (CHIP) as part of the Balanced Budget Act of 1997 in a specific attempt to provide insurance to children in families who earn too much to qualify for Medicaid but too little to afford private health insurance. Enacted as Title XXI of the Social Security Act, CHIP appropriated $24 billion over a five-year period to help states establish or expand children's health insurance programs for uninsured, low-income children from families with incomes that are beyond each state's existing Medicaid eligibility limits. Although plans vary from state to state, the insurance expansion is generally targeted at children living in families with incomes from 150 percent to 200 percent of the federal poverty level (FPL). CHIP gives participating states significant flexibility in the design and implementation of their insurance expansion programs. They may use their federal allotments to expand Medicaid, to develop a new health insurance program for children or expand an existing one, or to develop a combination of these approaches. The Congressional Budget Office has estimated that CHIP programs will cover roughly 2.8 million children who are not eligible for Medicaid, thereby extending coverage to 25 percent of the 10.7 million uninsured children in the United States.[3]

Overview of Cost-Sharing as an Issue for Public Programs

Private health insurers use cost-sharing as a way to discourage policyholders from overuse of services. Recently, some public insurance programs have begun to adopt this strategy—to date, 25 states and the District of Columbia have CHIP programs that include some form of cost-sharing.

While the CHIP legislation limits the extent to which states that opt for a Medicaid expansion can impose premiums or other cost-sharing arrangements, states that choose to use CHIP money to develop stand-alone or combination insurance expansion programs are given fairly wide latitude in the way they design the cost-sharing structure. Their decisions about this issue are expected to affect the number of uninsured who enroll in the new programs as well as

[1] Bureau of the Census (online). Available at: http://www.census.gov:80/hhes/hlthin97/hi97tl.html.

[2] Leighton Ku and Teresa Coughlin, *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*, March 1997 (online). Available at: http://www.urban.org/entitlements/premium.htm. Unless otherwise noted, income refers to family's total gross income with no disregards.

[3] S. Cohan, *State Tools to Provide Family Health Insurance Coverage* (online). Available at: http://www.nga.org/Pubs/IssueBriefs/1999/990104SCHIP.asp.

the rate at which enrollees use services. However, there is little actual experience or evidence about how cost-sharing affects the low-income population. In their absence, policymakers are making cost-sharing decisions based mainly on philosophical beliefs, the political environment, the CHIP requirements, and state-specific program objectives.

The reasons states give for including cost-sharing provisions when designing health insurance expansions include:

- raising revenue to offset program costs;
- fostering a sense of personal responsibility in enrollees;
- reducing the association of publicly funded health insurance programs with welfare programs by modeling them after private insurance programs;
- influencing or modifying participants' use of health care services;
- limiting the potential for substitution and crowd-out, that is, substituting free or reduced-price public benefits for private sector benefits, either by individual choice or because employers have reduced or eliminated coverage in response to public insurance expansions; and,
- making the new programs similar in design and benefits to programs offered in the private health insurance market.

Study Methodology

The Lewin Group prepared this paper and a companion paper on access to coverage issues under CHIP with funding from The Commonwealth Fund, a New York City–based private foundation that supports independent research on health and social issues. The study was conducted in three phases.

The first phase involved conducting literature reviews of academic studies, papers, state CHIP plans, and supporting information relevant to access issues and cost-sharing for public programs. The second phase consisted of a series of interviews with nationally recognized experts to gain their views on the issues that states faced as they designed CHIP programs. Then, drawing on the advice of national and state policy experts, the Lewin Group, in consultation with the Fund, selected six states—California, Colorado, Florida, Massachusetts, New York, and Washington—for intensive case studies. In selecting the focus states our goals were to:

- learn from the experience of states that had implemented significant insurance expansions for children and adults, particularly through state-designed programs predating CHIP;

- select a set of states that were geographically representative and included a mix of large urban and rural populations and significant immigrant and minority communities; and,

- study states that used CHIP funds to implement Medicaid expansion programs as well as states that built stand-alone state CHIP programs.

Although Washington State did not have a CHIP program, it was included in the study for several reasons. The state had considerable experience with insurance expansion initiatives, including experience and data related to enrollee cost-sharing. It had developed a program that covers families as well as children, two topics we addressed in this study.

The Lewin Group conducted site visits to the six target states from August 1998 to January 1999. An average of 20 interviews were conducted at each site with state legislators, state Medicaid and CHIP program administrators, advocacy and community groups, policy analysts and researchers, health plan officials, providers, and representatives of local government agencies. Respondents discussed:

- CHIP implementation;

- design of eligibility criteria, outreach, enrollment, and cost-sharing processes;

- barriers to enrollment and health care services;

- interaction and coordination between CHIP and Medicaid and other state programs;

- the effect of cost-sharing on the maintenance of CHIP enrollment and continuing participation in the program; and

- and the impact of cost-sharing provisions and recommendations for improving program implementation.

To provide a context for the discussion, Table 1 shows the number of Medicaid-eligible adults and children as of 1997 and CHIP enrollment by the end of 1999 in each of the study states.

Table 1. Medicaid Eligibles and CHIP Enrollment[4]

	California	Colorado	Florida	Massachusetts	New York	Washington
Total Medicaid (FY 1997)	6,386,720	351,961	2,086,479	810,075	3,229,052	907,542
Children	3,206,566	161,402	1,064,892	352,124	1,556,791	504,161
Adults	1,612,642	72,674	403,565	176,790	594,480	203,503
Aged, blind, and disabled	1,440,935	103,865	597,999	280,971	992,205	181,522
Other or unknown	126,577	14,020	20,023	190	85,576	18,356
Medicaid and cash or other assistance	3,525,086	178,994	1,140,754	445,599	1,966,569	425,345
Children	1,670,246	71,412	508,263	183,235	881,984	197,102
Adults	744,915	35,098	221,464	81,743	396,470	115,553
Aged, blind, and disabled	1,109,925	72,484	411,027	180,621	688,115	112,690
Medicaid only	2,861,634	172,967	945,725	364,476	1,262,483	482,197
Total CHIP (or other programs) (1999)						
Adults	—	—	—	489,197	—	127,841
Children	222,351	24,116	154,594	392,895	425,522	80,664

Sources: Medicaid enrollment from Health Care Financing Administration, *HCFA-2082 Report, Fiscal Year 1997;* California, Colorado and Florida as of 9/99 from Health Care Financing Administration, *The State Children's Health Insurance Program Annual Enrollment Report, October 1, 1998 – September 30, 1999;* New York Department of Health 12/99, www.health.state.ny.us; MassHealth http://www.state.ma.us/dma/masshealthinfo/applmemb_IDX.htm and Washington State Health Care Authority 12/99 www.wa.gov/hca/basic.htm.

[4] "Medicaid eligibles" refers to the number who have actually enrolled in Medicaid, not to those who are potentially eligible by income level. "CHIP enrollment" refers to the number of individuals enrolled in a state's CHIP program or, in the case of Massachusetts and Washington, comparable programs.

II. BACKGROUND ON COST-SHARING POLICY OPTIONS

For this report, cost-sharing is defined as any mechanism through which beneficiaries share in their health care costs. The most common types of cost-sharing include monthly premiums, annual enrollment fees, copayments, and coinsurance. Premiums and enrollment fees refer to those charges levied on enrollees as a condition of coverage; copayments and coinsurance refer to those fixed or percentage fees charged for each service rendered.

Cost-sharing requirements are a departure from the Medicaid program. Those who maintain that cost-sharing may help to accustom participants to the requirements of employer-sponsored insurance view it as a means to build a bridge from fully subsidized coverage to private coverage. Others are concerned that it may undermine program participation and erect financial barriers to obtaining needed health care. It may also act as a barrier to continuous coverage: low-income families may wait until their children are sick before seeking coverage, or they may transfer in and out of health plans depending on current health care needs. In addition, policymakers face the challenge of maximizing the participation of those who are eligible while simultaneously deterring substitution of public coverage for private coverage.

Thus, states contemplating cost-sharing mechanisms should consider these important issues, which are discussed in detail below:

- the impact that barriers to enrollment and to services will have on those eligible for the program;
- the importance of minimizing the welfare stigma associated with public programs;
- the creation of costs and complex administrative processes; and
- the ability of the cost-sharing mechanisms to deter substitution of private coverage.

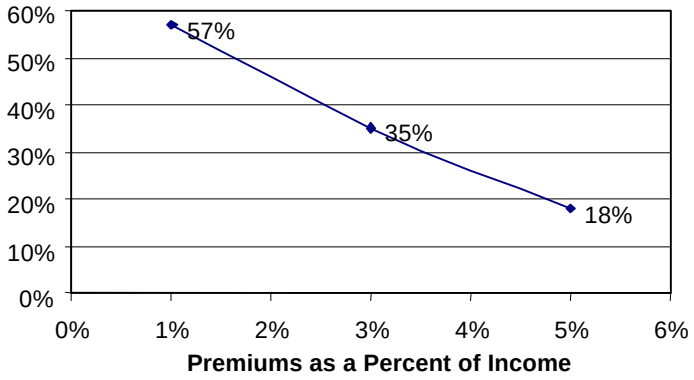
To what extent does the use of premiums as a cost-sharing arrangement affect family participation in subsidized health insurance programs?

Past studies indicate that low-income families' program participation is likely to be highly sensitive to premium costs. A 1998 Urban Institute analysis conducted for the Henry J. Kaiser Family Foundation estimated that if health insurance were free and easy to obtain, approximately 80 percent of uninsured families with children and with incomes up to twice the poverty level

might enroll in a plan. However, with a moderate insurance premium of $17 per month, participation would drop by 24 to 38 percent, depending on the family's income level.[5]

A 1997 study by Ku and Coughlin for the Urban Institute analyzed the effects of premium levels on participation for Washington, Minnesota, and Hawaii's subsidized insurance programs. It found that as premiums rise relative to income, participation rapidly declines (Figure 1).

Figure 1: Estimated Participation as a Function of Premium Levels in WA, HI, and MN, 1995



Source: Urban Institute March 1997 analysis.

The authors estimated that 57 percent of the uninsured would participate when premiums were 1 percent of income. If premiums were to rise to 3 percent of income, however, only 35 percent would participate, and with premiums equal to 5 percent of income, only 18 percent would participate.[6] Kenneth Thorpe, et al., found the same inverse relationship between premium levels and participation in a 1997 study reported by the United Hospital Fund of New York. Thorpe estimated that participation would decrease from 75 percent of the eligible population when the program involved no cost-sharing to roughly 40 percent when cost-sharing exceeded 2 percent of family income.[7] Reaching a similar conclusion, John Sheils' 1998 Lewin Health Benefits Simulation Model shows that participation in subsidized insurance programs would range from more than 70 percent with no cost-sharing to less than 45 percent when premium costs reach 5 percent of income.[8]

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[5] Judith Feder and Larry Levitt, *Choices Under the New State Child Health Insurance Program: What Factors Shape Cost and Coverage?* (Policy Brief #2104). Menlo Park, CA: Kaiser Family Foundation, January 1998.

[6] Ku and Coughlin, March 1997.

[7] Kathryn Haslanger, Robert E. Mechanic, Mary Jo O'Brien, and Kenneth E. Thorpe, *Taking Steps, Losing Ground: The Challenge of New Yorkers Without Health Insurance.* New York: United Hospital Fund of New York, 1998.

[8] John Sheils, *Estimates of Eligibility, Enrollment and Program Costs Based on the Indiana CHIP Program Design.* Fairfax, VA: The Lewin Group, July 1998.

Few would take issue with the finding that enrollment tends to decrease as premium levels increase. However, the magnitude of this effect is far more difficult to predict. Moreover, relatively low participation in Medicaid for those eligible for health insurance only, indicates reaching high levels of program participation among eligible low-income families is difficult even without premium cost-sharing.

States experiences to ease some of the noncost barriers to Medicaid enrollment while at the same time implementing new cost-sharing requirements thus offer an opportunity to examine effects on families and programs. With little guidance on mix of cost-sharing from past experiences, state programs present a plethora of different premium schedules and payment mechanisms as states try to balance the goal of enrolling eligible populations with other objectives, including discouraging substitution of public for private insurance and asking participants to accept some financial responsibility for their own health care.

What effect do point-of-service copayment requirements have on beneficiaries' utilization of services?

Copayments and other types of point-of-service cost-sharing were first introduced in the commercial insurance market as tools to increase patient accountability for health care spending. Their existence is predicated on the simple economic theory that if people have to pay to use something, they will use it less frequently and more effectively. Indeed, a primary goal of this strategy was to decrease inappropriate or unnecessary health service utilization. However, numerous studies have shown that most point-of-service cost-sharing arrangements reduce the use of both highly effective and less-effective services by the same amount. Several other studies have found that copayments have an especially pronounced effect on the pediatric, low-income populations who are the target of new insurance expansions. This has given rise to the argument that point-of-service cost-sharing discourages families from seeking needed medical care and penalizes the sickest beneficiaries the most.

The RAND Corporation's Health Insurance Experiment (HIE), conducted in the 1970s and early 1980s, employed a controlled experimental design to examine the effect of point-of-service cost-sharing on the utilization of medical services and on patients' health status. This remains the most comprehensive and often-cited study on this topic to date. It found that among children from low-income families, those in coinsurance plans used only 56 percent as much highly effective care as did similar children with free care.[9] Moreover, the HIE found that cost-

[9] T. Rice and K. Morrison, "Patient Cost-Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform," *Medical Care Review* 51 (Fall 1994):235–287.

sharing produced negative health effects only on lower-income people.[10] Results indicated that cost-sharing reduced by 39 percent the number of nonelderly adults with low incomes (those below the 33rd percentile) who sought "highly effective care for acute conditions."[11] The HIE also revealed that use of preventive services, especially among children, appeared to be lower in groups with direct cost-sharing.[12]

Five other studies, reported in Rice and Morrison's exhaustive review of the literature, confirmed that point-of-service cost-sharing reduces utilization in low-income populations.[13] A study by the Institute for Child Health Policy in Florida had contradictory findings. In that study, children in programs with cost-sharing were more likely to use health services than were those in programs without such provisions.[14]

Do nominal cost-sharing payments help reduce a "welfare" stigma and therefore improve participation?

Some argue that CHIP program enrollment and utilization would be maximized if no cost-sharing were included. Others believe that appropriately priced cost-sharing mechanisms can foster a sense of responsibility among participants while helping to diminish the "welfare" stigma often associated with public programs. They hypothesize that cost-sharing will make the program appear more like private insurance. This desire to reduce "welfare" stigma is one major reason states cite for using cost-sharing in CHIP programs. A previous Lewin Group study of cost-sharing arrangements in nine pre-CHIP insurance expansions concluded that cost-sharing was instituted not to increase revenue or reduce program costs, but rather to instill in participants a sense of ownership for their health care and to minimize the "welfare" stigma associated with public programs.[15]

Do the costs and complexity of administrative burdens associated with collecting premium payments outweigh potential benefits?

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[10] Ibid.

[11] M. Edith Rassell, "Cost-Sharing in Health Insurance: A Re-Examination," *New England Journal of Medicine* 332 (April 27, 1995):1164–68.

[12] Rubin and Mendelson, 1996.

[13] Rice and Morrison, 1994.

[14] E. Shenkman, J. Pendergast, J. Reiss, E. Walther, R. Bucciarelli, and S. Freedman, "The School Enrollment-Based Health Insurance Program: Socioeconomic Factors in Enrollees' Use of Health Services" (abstract), *American Journal of Public Health* 86 (December 1996):1791–93.

[15] *Children's Health Insurance Expansions: State Experiences in Developing Benefit Packages and Cost-Sharing Arrangements*, Fairfax, VA: The Lewin Group, February 1998.

The implementation of cost-sharing mechanisms greatly increases the administrative complexity of a program. How will premiums be collected? What happens if a payment is missed? How can the state monitor copayments to determine when a family has reached a cost-sharing ceiling? In addition, states must develop an infrastructure to collect and track small funds, manage accounts receivable, and process numerous changes in enrollment. These are among the reasons why some believe that the challenges and expenses of implementing cost-sharing are not balanced by the value (monetary or philosophical) that cost-sharing might bring to a program.

Others are concerned about the administrative burdens cost-sharing can impose on providers who may find that collecting copayments from patients is often challenging. In addition, there is a reluctance to turn away patients in need and resistance to the extra administrative paperwork that the collection of copayments engenders. Two problems can arise from providers' reluctance to enforce copayments: providers who do not consistently collect copayments undermine the reasons for implementing the policy, and providers who view copayments as a reduction in reimbursement may choose not to participate in the program, which could affect access to needed services.

Yet, premium shares offer a potential administrative aid in tracking enrollment files and payment to plans. With most state expansions contracting with health plans to provide coverage with up to 12 months eligibility, premium payments provide states with regular updates on current addresses and that families are still participating in the health plan.

Are cost-sharing mechanisms an effective way to limit substitution of publicly subsidized coverage for private health insurance?

Many policymakers argue that because copayments and premiums for subsidized insurance mimic the cost-sharing requirements of employer-sponsored coverage, they help bridge the gap between public and private insurance and serve as a deterrent to substitution for families who have access to affordable private or employer-sponsored health insurance. Many policymakers also consider cost-sharing an effective way to prevent those who are eligible for Medicaid from attempting to enroll in new expansion programs, since Medicaid programs have no or little cost-sharing for children's insurance.

Factors Affecting the Design of Cost-Sharing Mechanisms

Given these considerations, it is no surprise that the major issue for most states in designing their cost-sharing structures was neither revenue generation nor administrative simplicity. Rather, policymakers based cost-sharing design decisions mainly on the political environment,

philosophic beliefs, and state-specific program objectives. They focused on the normative and political consequences of cost-sharing, such as the personal responsibility many feel it could engender among enrollees. Factors that influenced policymakers as they debated and made decisions about the cost-sharing components of their insurance expansions included:

- **Political realities.** All states we studied designed their cost-sharing mechanisms in response to their unique political environments. Several respondents indicated that their state legislators felt it was important to include cost-sharing in these new programs in order to avoid creating a new entitlement and to increase public and political support for the programs. Political realities in certain states dictated the creation of a separate, nonentitlement program with cost-sharing provisions intended to reduce crowd-out and instill a sense of "ownership" and "personal responsibility" in enrollees. Some respondents also reported that their state wanted to develop a program that was not an entitlement and resembled private sector insurance as closely as possible.

- **Normative beliefs.** Many of the "political realities" cited above are driven by normative or philosophic beliefs about cost-sharing. Such beliefs include the idea that cost-sharing will instill a sense of ownership in participants, which may translate into increased motivation to use a service for which they have already paid. A study by the Institute for Child Health Policy in Florida has documented this effect, finding that children in programs without cost-sharing were less likely to use health care services than were those in programs with cost-sharing provisions.[16] Similarly, many respondents indicated that cost-sharing may help reduce the "welfare stigma" associated with many public or "free" programs. Indeed, one of the most commonly cited reasons for including cost-sharing in CHIP programs was the belief that by instituting moderately priced copayments and premiums, families would be more likely to enroll in these new programs, utilize services, and not view the program as "welfare."

- **Program history.** Certain states used their experiences from programs that predated CHIP to inform their cost-sharing design. States considered the difficulty of administering various forms of cost-sharing when designing their programs. Some states also included a "look back" provision which excluded children from enrolling for a certain period of time after being covered by private insurance. This definitive approach to controlling substitution reduces the need to use cost-sharing for this purpose.

[16] Shenkman et al., 1996.

- **Avoiding substitution or crowd-out.** Many states attempted to reduce the substitution of public for private insurance coverage by including premiums and copayments that mirrored cost-sharing requirements in the private market. Respondents in every state cited concerns over crowd-out as a reason for the inclusion of cost-sharing in their insurance expansions.

In this paper, a "lockout" period refers to required disenrollment from plans for late payments and the period of time that a family must wait before it can re-enroll. The term "look back" is used to refer to the length of time that states require families to be disenrolled from their private insurance before being eligible to participate in CHIP.

III. APPROACHES TO COST-SHARING DESIGN IN THE SIX STUDY STATES

This section details the cost-sharing provisions of each of the six state programs we studied and the various factors that helped form the states' plans.[17] Figure 3 (page 17) summarizes cost-sharing in each of our study states. Following that is a basic description of each state plan's premium and copayments, a summary of how each handles nonpayment of premiums (often through "lockout" provisions), and the provisions states have made to address crowd-out or substitution (these terms will be used interchangeably throughout the remainder of this report). Each state summary also briefly discusses the groups and beliefs that helped shape its cost-sharing mechanisms. Appendix B presents the Department of Health and Human Services' 1998 Federal Poverty Guidelines by family size and FPL level to help relate these premium and FPL levels to real family incomes.

Of those states submitting Title XXI CHIP plans (48, plus the District of Columbia[18]) before March 1999, the majority (25 of 48) chose to require some form of cost-sharing. Of these 25 programs, 12 required both premiums and copayments, seven required only premiums, and six relied on other forms of cost-sharing. Figure 2 below outlines each state's cost-sharing strategies. Appendix A provides a complete listing of cost-sharing arrangements under all 49 plans. This information may not reflect recent plan amendments that have been adopted as state programs evolve.

[17] Further information about the background, administration, eligibility, delivery systems, benefit packages etc. is available from many sources, including the National Academy for State Health Policy's *How Are States Implementing Children's Health Insurance Plans*?, available at http://www.nashp.org/pubs/chip.htm; the Health Care Financing Administration's web site, http://www.hcfa.gov/init/chpa-map.htm; or the National Governors' Association web site, http://www.nga.org/MCH/Implementation.htm.

[18] At the time this report was written, Wyoming had announced its intention to submit a CHIP plan to HCFA, but had not yet done so.

Figure 2: CHIP Program Cost-Sharing Arrangements by State

Cost-Sharing in 48 States and D.C.	
Premiums and Copayments (12)	AL, AZ, CA, CO, CT, DE, FL, KY, NH, NJ, NY, VT
Premiums Only (7)	GA, KS, MA, ME, MI, NM, WI
Other (6)	MT, NC, NV, RI, TN, UT
No Cost-sharing (24)	AK, AR, DC, HI, IA, ID, IL, IN, LA, MD, MN, MO, MS, ND, NE, OH, OK, OR, PA, SC, SD, TX, VA, WV

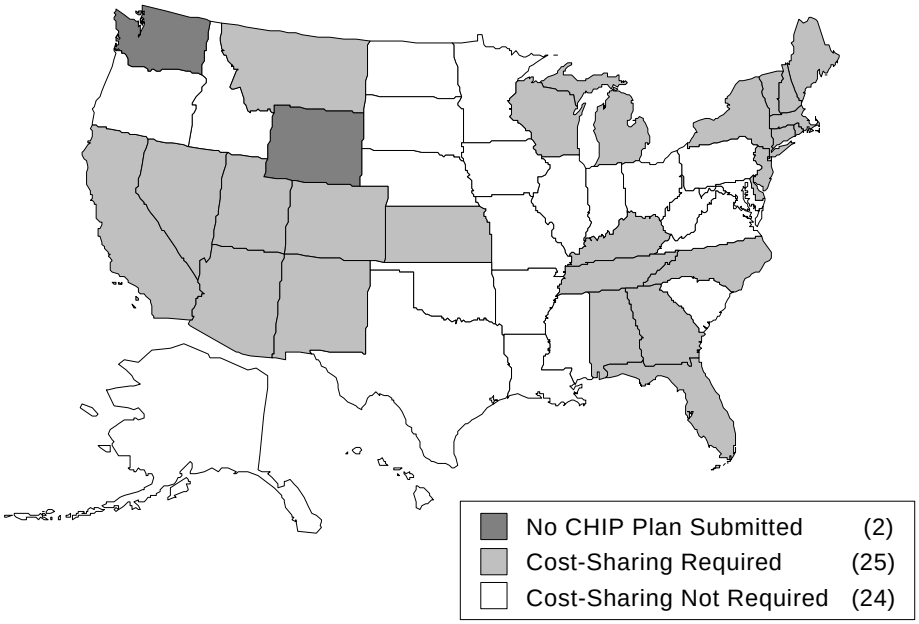


Figure 3: Summary of Six Study States' Cost-Sharing Provisions

State	California	Colorado	Florida	Massachusetts	New York	Washington	
Plan Type	Combination	State-Designed	Combination	Combination	State-Designed	State-Designed	
% FPL	Family Value Plan*			Mass Health Family Assistance		Children	Adults
230					223%–230% FPL: $13 premium per child per month, no copay	> 200% FPL: Full-premium program. See Appendix D	> 200% FPL: Full-premium program. See Appendix D
220					160%–222% FPL: $9 premium per child per month, no copay		
200	151%–200% FPL: $9 premium per child per month + $5 copay		100%–200% FPL: $15 premium per family per month + $3–$10 copay	150%–200% FPL: $10 premium per child per month No copay		< 200% FPL: No premiums, no copayments. See Appendix D	100–200% FPL: $0–$150 premium per person per month + $0–$500 copay. See Appendix D
185		150%–185% FPL: $10–$40 premium per child per month + $0–$5 copay					
160							
150	100%–150% FPL: $7 premium per child per month + $5 copay	101%–149% FPL: $7.50–$15 premium per child per month + $0–$2 copay					
100		82%–100% FPL: $5–$10 premium per family per month + $0–$2 copay					
82		63%–81% FPL: $2.50–$5 premium per family per month + $0–$2 copay					
62		41–62% FPL: Premium waived. $0–$2 copay					
40		< 40% FPL: Premium waived. $0–$2 copay					
0							

* California's Community Provider Plan issues lower rates for coverage in both the 100%–150% and 151%–200% FPL groups. For more information on Community Provider Plan coverage, see the text as well as Appendix E.

Description of Cost-Sharing Arrangements in the Six Study States

California

Basic Description and Premium Requirements

California's CHIP program is a combination Medicaid expansion and separate program. The Medicaid expansion covers children ages 14 to 18 up to 100 percent of FPL. With it, California's Medicaid program, Medi-Cal, now covers:

- children ages 0 to1, up to 200 percent FPL;
- children ages 1 to 5, to 133 percent FPL; and,

- children ages 6 to 18, to 100 percent FPL.

Medi-Cal is administered by the Department of Health Services (DHS), the state's Title XIX agency. The Medicaid expansion requires no cost-sharing.

The state's separate program, known as Healthy Families, is administered by the state's Managed Risk Medical Insurance Board (MRMIB), an entity that is not involved with Medicaid administration. The state uses a third-party administrator (TPA) to collect premiums for the expansion program. Healthy Families provides coverage for children ages 1 through 19 in families with incomes from 100 to 200 percent of FPL.

There are two options for coverage under Healthy Families: the Family Value Plan and the Community Provider Plan. The standard Family Value Plan option is a combination of health, dental, and vision plans that offer the best prices to the program in a geographic area. Under this option, the premium for families with incomes from 100 to 150 percent of FPL is $7 per child per month, with a $14 monthly family maximum. Those families with incomes from 151 to 200 percent FPL pay $9 per child per month, with a $27 monthly family maximum. The state also designates one "Community Provider Plan"—the plan with the highest percentage of "traditional and safety net providers"—in each geographic area. Families with incomes from 100 to 150 percent of FPL who select the Community Provider Plan pay a reduced premium of $4 per child per month, with an $8 monthly family maximum. Families with incomes from 151 to 200 percent FPL pay $6 per child per month, with an $18 monthly family maximum.

Both programs offer private sector health insurance plans, chosen regionally by MRMIB through a sealed-bid contract process. For this reason, the plan's payment and capitation rates may vary by region. There is, however, a statewide average capitated rate of about $70 to $80 per enrollee per month. Medi-Cal has different rates and benefits for different plans and populations, but plans participating in Healthy Families must provide one uniform rate for a given region, regardless of the population. Although the Healthy Families contracts with plans call for capitated rates, the plans can contract on a fee-for-service basis with providers should they so choose. Respondents report that payment rates are nearly identical for Medi-Cal and Healthy Families.

The benefit package offered under both Healthy Families options is standardized, and includes:

- well-child services/primary care;

- urgent care;

- specialty medical care;
- mental health services (20 outpatient and 30 inpatient visits plus county mental health services for children with serious emotional disturbances. The county mental health system coordinates care);
- ongoing treatment of chronic conditions;
- dental services;
- vision services;
- home- and community-based services;
- pharmacy (including over-the-counter medications);
- speech and physical therapy; and
- special equipment.

Insurance plans may offer benefits in addition to this baseline package, but interviewees report that the baseline level is already so high and profit margins are so slim that plans may have difficulty offering any additional benefits.

California's premium payment system has several innovative features. Families can prepay three months of premiums and are given the fourth month free. None of the other states studied for this report offers this discounting option, and only Florida allows prepayment of premiums. California families may pay premiums by certified check, money order, or credit card directly to the state. Healthy Families also offers the unique option of paying premiums in cash at payment stations located in Rite Aid pharmacies throughout the state.

Copayments

California requires a $5 copayment for office visits, prescriptions, and vision coverage. There are no copayments for preventive services. Capped at $250 per family per year, copayments are collected by providers. Some respondents indicated that copayments are low enough to assure that most families will not reach the cap unless they have children with chronic illnesses. Nonetheless, the state has developed a system for families to monitor their copayment

contributions. Families are responsible for collecting their copayment receipts in a "shoebox" and notifying their insurance plan when they have reached the $250 cap. Once they have notified the plan, they are issued a new membership card that says that they do not have to pay additional copayments until their annual coverage is renewed. The plans' contracts require them to track the family contributions, but some respondents indicated that most plans don't know when a family has reached the cap because tracking this information is administratively burdensome.

In total, the program limits the combined cost of copayments and premiums to a maximum of 2 percent of family income.

Lockouts and Previously Uninsured (Look-Back) Requirements

A family that has failed to make its premium payment for 60 days receives a 30-day warning of discontinuation of coverage from MRMIB. After these 30 days have expired without payment, MRMIB disenrolls the family. Children of disenrolled families are ineligible for new coverage for the next six months. One respondent reports that recent data indicates that about 25 percent of the families are overdue in their payments (by 30, 60, or 90 days) in a given month. However, the majority appear to "catch up" during the 60-day notice period. Other respondents indicate that there is no evidence of the impact of cost-sharing on participation in Healthy Families. One advocacy group has proposed implementing exit calls to ask former enrollees why their children are no longer enrolled in the program. The state has said that it will administer disenrollment surveys sometime in the future; the new program began implementing these in February 1998. Meanwhile, Healthy Families is conducting welcome calls to families who enroll in the program, in which they ask a limited number of questions which may or may not address cost-sharing.

California's CHIP program prohibits covering children who have had employer-sponsored coverage within the past three months, with an option to extend this period to six months. Interviewees said that it was too early in the program's implementation to analyze data about the effect of cost-sharing on substitution.

Factors Influencing Program Design

Respondents reported that California program administrators met behind closed doors and discussed what would be "reasonable" and "acceptable" given political realities, patterns in the private insurance market, and program objectives. Several respondents indicated that the state's Republican administration felt it was important to include cost-sharing in these new programs in order to avoid creating a new entitlement and to increase public and political support for the programs. Although respondents reported that many California advocates supported a Medicaid expansion, political realities dictated the creation of a separate, nonentitlement program with

cost-sharing provisions intended to reduce crowd-out and instill in enrollees a sense of "ownership" and "personal responsibility."

Thus, California's cost-sharing provisions were modeled on the state's benchmark CalPERS plan (for state employees) only to some extent. Ultimately, the state's elected officials had the greatest impact on the design of the Healthy Families cost-sharing structure—many respondents cited the governor's office as the staunchest supporter of the inclusion of cost-sharing in the CHIP program. The ultimate design decisions were made in conference committee meetings with the governor's staff, which wanted cost-sharing in order to encourage both "personal responsibility" and a sense of ownership in the program.

Colorado

Basic Description and Premium Requirements

The Colorado Department of Health Care Policy and Financing administers the Child Health Plan Plus (CHP+), a program separate from Medicaid that covers children age 17 and under with family incomes at or below 185 percent of FPL. The administrative agency is responsible for determining payment levels, explaining and collecting premium payments, monitoring grace periods, and initiating disenrollment procedures. Eventually, a third-party administrator—which is also the vendor for the state's Medicaid program—will collect premiums. However, at the time of our site visit in August 1998, the state was not yet collecting premiums because of administrative and contracting difficulties.

Under CHP+, families with incomes below 100 percent of FPL will not be required to pay premiums. Single-child families with incomes from 101 percent to 149 percent of FPL will be charged $9 per month, and families with two or more children will pay $15 per month. From 150 percent to 169 percent of FPL, families with one child will pay $15 per child per month. Families with two or more children will pay $25 per family per month. Single-child families from 170 percent to 185 percent of FPL will pay $20 per child per month, and families with two or more children will pay $30 per family per month. Families with incomes above 186 percent FPL may buy into the program at full cost, which is $68 per child per month with no family maximum. Premium payments may be in the form of either a check or a money order.[19]

CHP+ was designed to be a managed care program. However, only 24 of Colorado's 63 counties have a managed care presence. As a result, the state is continuing to contract with

[19] Note: Due to discrepancies in various sources, we are still attempting to verify the premium structure for Colorado.

providers in those 24 counties on a fee-for-service basis. The state is exploring options to increase managed care's penetration in those areas, but administrators recognize that success in that effort will probably cause a decrease in the number of providers who participate in CHP+ because of the discrepancy in rates between health plans and fee-for-service reimbursement. In addition, respondents indicated that a lot of providers and plans do not want to participate in CHP+ because of a legislative requirement that CHP+ providers also serve Medicaid recipients. The current provider supply is sufficient, but interviewees expect that problems will arise when the program rolls exceed 25,000.

Copayments

Copayments vary depending on whether the enrollee is covered through the CHP+ provider network (reimbursed through fee-for-service) or through an HMO. The provider network imposes a maximum $2 copayment for many nonpreventive services regardless of the patient income level. The HMO option charges copayments that vary by income level—families with incomes at or below 150 percent of FPL copay a maximum of $2 for nonpreventive services; those above 150 percent of FPL pay a maximum of $5. The HMO option also requires families to pay a $15 emergency medical transportation copayment regardless of income level, but the payment is waived if the child is admitted for inpatient care.

Providers are currently responsible for collecting copayments from enrollees. Several interviewees reported that this might pose a problem because providers are often willing to waive copayments if patients cannot pay them. Respondents said that the Department of Insurance has responded by issuing a statement to providers that says noncollection of copayments violates state law. There are also reports that some health plans are considering building copayments into their rates in the future because they are often unable to collect them at the time of service.

Like California, Colorado employs the "shoebox method" to ensure compliance with the 5 percent copayment cap. When families enroll, the state tells them what their 5 percent limit is and instructs them to save all of their health care receipts. If a family incurs health expenses in excess of its 5 percent limit, it then submits its receipts to the state. Upon verification, the state sends the family a sticker to place on their insurance cards that indicates to providers that the family is exempt from copayments until plan renewal.

Lockouts and Previously Uninsured (Look-Back) Requirements

The Colorado CHIP plan provides no details on termination for failure to pay premiums. However, respondents reported that there is a three-month grace period for enrollees to get up to date with their premium payments. After the grace period has lapsed, they are automatically

disenrolled and subjected to a three-month lockout. After the lockout period, premiums are forgiven. Families may pay the back premiums earlier in order to shorten the lockout period. Colorado children are not eligible for CHP+ if they participated in an employer-sponsored plan with at least a 50 percent employer contribution during the three months preceding the date their parents seek to enroll them.

Respondents indicated that it was too early in the program's history to track the effect of cost-sharing on participation, enrollment, or substitution.

Factors Influencing Program Design

Political pressure to include cost-sharing was pivotal in the design of Colorado's cost-sharing provisions. Respondents in Colorado claimed that the state legislature mandated cost-sharing in the final CHP+ legislation in order to develop a program that was not entitlement and resembled private insurance. CHP+ was envisioned as a "transition program," offering families a bridge between Medicaid and employer-sponsored insurance.

The "benefit and price team" that reports to the Colorado Child Health Policy Board was the most influential force in the actual design of CHP+ cost-sharing requirements. According to one respondent, Colorado's overall philosophical approach to government emphasizes "personal responsibility," which dictated the inclusion of cost-sharing provisions in their CHIP program.

Florida

Basic Description and Premium Requirements

The Florida KidCare Program is a combination program for children of families with incomes of less than 200 percent of FPL. It has three main components: MediKids, a Medicaid "look-alike," covers children up to age 5; the Healthy Kids program (which predates KidCare and is now a part of that program) provides subsidized insurance to children ages 5 to 19; and the Children's Medical Services (CMS) Network covers children ages 5 to 19 with special health care needs.

Both MediKids and Medicaid itself offer a wider benefits package than Healthy Kids. The former two include transportation, broader behavioral health benefits, and the full EPSDT benefit. The Department of Children and Families (DCF) runs MediKids and Medicare. The Department of Health (DOH) runs the CMS Network. The Healthy Kids program is administered primarily by the Florida Healthy Kids Corporation (FHKC), a nonprofit organization created by the Florida legislature in 1990. FHKC uses a third-party administrator to assist with both enrollment and premium collection.

The KidCare programs levy a $15 per family per month premium, regardless of income. Counties may opt to reduce the Healthy Kids program premium using their own matching funds. Families with incomes that exceed 200 percent of FPL may buy into Healthy Kids at full cost. Premiums may be paid up to one year in advance by check or money order to the Florida Healthy Kids Corporation. Unlike California, however, the program offers no discount for prepayment.

While Healthy Families is strictly a managed care program, the Medicaid and MediKids programs are still divided between fee-for-service (MediPass) and HMOs, depending on the county. There is little overlap in providers between Healthy Families and MediKids.

Geographic location plays a large role in determining the ease of program implementation. Some rural communities have no HMOs, making it difficult to implement Healthy Kids. As part of the effort to cover rural communities, the Healthy Kids Corporation has offered 200 funded slots to each rural county. Should the county choose to cover more children, it needs to come up with matching funds. Still, many small, rural counties don't have the resources to cover this. The state has also put out several RFPs to attempt to bring insurers into the rural areas and build provider networks.

Potential enrollees are confused about the various Florida programs and are not sure what KidCare is. FHKC's Healthy Kids seems to have established a separate identity from MediKids, Medicaid, or CMS, and recognition that all of these programs are part of a larger umbrella program is not widespread. While the state would like to present its four insurance options to the public as one unified program, the fact that the programs are run out of multiple departments and agencies makes this difficult.

Copayments

The MediKids and CMS Network levy no copayments on enrollees. Healthy Kids charges a $3 copayment for most outpatient services; there is no copayment for preventive services. The program also assesses a $10 copayment for "inappropriate use" of the emergency room or emergency transportation, as well as for prescription eyeglasses.

Families must track cost-sharing payments and seek reimbursement if they exceed 5 percent of the family's yearly income. However, many respondents felt that, given the low copayment levels, most families would not reach the 5 percent cap. A study by the Institute of Child Health Policy using historical data from the Healthy Kids program found that the most any family would contribute to the cost of their coverage would be about 3 percent of their annual income.

Lockouts and Previously Uninsured (Look-Back) Requirements

KidCare requires premiums to be paid one month in advance. Families whose payment for the following month is not received by approximately the 20th day of the preceding month are disenrolled from coverage. There is no grace period. Following disenrollment, the family is not eligible for reinstatement for 60 days. While Florida currently has no look-back provisions, the KidCare legislation requires the state to monitor the incidence of families substituting KidCare for private insurance. The legislation also requires the state to implement a three-month period of CHIP ineligibility for families previously covered by private insurance, called a look-back requirement, if the state determines that substitution is occurring.

Administrators reported that it was too early to tell whether cost-sharing affected program enrollment or substitution.

Factors Influencing Program Design

Florida respondents, like those in several other study states, indicated that their legislature felt it was important to include cost-sharing in the state's new programs in order to avoid creating a new entitlement, to increase public and political support for the programs, to control crowd-out, and to encourage personal responsibility. Many respondents felt that cost-sharing could help enrollees become better health care consumers, reasoning that enrollees might feel more inclined to learn about and use the "product" if they were actually paying for it.

Florida used its Healthy Kids program as a reference point for establishing KidCare, its new program, and maintained similar cost-sharing structures under the expansion. Respondents in Florida indicated that the state arrived at its flat $15-per-month family premium by analyzing historical Healthy Kids expenditure data and setting premiums at a level that would ensure that families would not exceed the 5 percent spending cap mandated under CHIP. As a result, premiums actually decreased in the Healthy Kids program. Previously, members had paid on a scale ranging from $10 to $48 per child per month.

Florida is the only study state that does not use a sliding scale for premiums and several Florida respondents took issue with the $15 flat premium. Although flat premiums are far easier to administer, many questioned the equity of charging the same rate to all families regardless of income and family size. They argued that cost-sharing should be more targeted, because $15 per month may be expensive for a family at 101 percent of poverty, but too low to encourage true personal responsibility or avoid welfare stigma in a family at 199 percent of FPL.

Even though respondents did indicate that copayments were very popular politically in Florida, the state's MediKids program decided not to require copayments in order to prevent administrative difficulties and to avoid setting up additional barriers to care for sick and very young children.

Massachusetts

Basic Description and Premium Requirements

Massachusetts implemented CHIP through a combination plan. Medicaid eligibility has been expanded to children under age 19 in families with incomes at or below 150 percent of FPL, and the MassHealth CommonHealth program covers disabled children under age 19 from families with incomes from 150 to 200 percent of FPL. Neither program assesses premiums on members, although children from families with incomes of more than 200 percent of FPL can buy into the CommonHealth program on a sliding-scale basis. A third program, the MassHealth Family Assistance program, covers children under 19 from families with incomes from 150 to 200 percent of FPL. Family Assistance members pay premiums of $10 per child per month, with a maximum of $30 per family per month.

The Family Assistance program offers two coverage options. The Premium Assistance program subsidizes premium payments for families with access to employer-sponsored insurance (ESI). The employer plans must meet a basic benefit level (BBL), be cost-effective for the state, and be funded by an employer contribution of at least 50 percent.[20] The Direct Coverage option covers Family Assistance program members who do not have access to a qualifying ESI plan. Direct Coverage is similar to, although slightly less rich, than the standard Medicaid package. A unique aspect of Massachusetts's CHIP program is that parents may be covered under Premium Assistance as a spillover effect, because ESI does not break out children separately in family coverage offerings.

The state's Division of Medical Assistance (DMA) administers all MassHealth programs. Third-party administrators are employed only in the Premium Assistance plan, where several contracted organizations conduct benefit analyses and help coordinate premium payments.

Massachusetts continues to operate the Children's Medical Security Plan (CMSP), a state-subsidized health insurance program for children in families with incomes of more than 200 percent FPL, and undocumented children who are not Medicaid-eligible. The Department of

[20] CHIP federal regulations, in general, require a 60 percent employer premium share as well as demonstrated cost-effectiveness. Massachusetts' 50 percent employer share is part of an exception agreement.

Public Health (DPH) administers CMSP, which offers a benefit package that is less rich than Medicaid to children who are not eligible for any other MassHealth program. Before CHIP's enactment, children enrolled in CMSP who were from families with incomes of less than 200 percent of FPL paid no premiums. Those from families with incomes above this level paid on a sliding scale. Children below 200 percent of FPL have since been moved into the MassHealth program and are exempt from paying premiums if they enroll in the Direct Coverage option of the Family Assistance plan. Families with incomes ranging from 200 to 400 percent FPL whose children remain in CMSP pay $10.50 per child per month, with a family maximum of $31.50. A family that earns more than 400 percent of FPL may buy into the program at full cost—$52.50 per child per month.

Copayments

Employer-sponsored insurance plans approved under the Premium Assistance plan may require copayments; otherwise, no MassHealth program requires them. ESI members are reimbursed by the state for copayments associated with preventive care visits and for all charges should a family's overall cost-sharing exceed 5 percent of its income. A MassHealth "C.A.R.E. Kit," which explains cost-sharing rules and provides worksheets and examples to help ensure compliance with the 5 percent rule, are issued to each family. Copayments in the state-funded CMSP range from $1 to $5, depending on family income.

Lockouts and Previously Uninsured (Look-Back) Requirements

Families are afforded a 60-day grace period for failure to pay premiums. DMA will work with them during this time to develop a repayment plan. Following this period, however, families who still do not pay premiums will be disenrolled and locked out of the program for one full year. State officials report that Massachusetts has not yet begun to disenroll families. Massachusetts has no look-back requirements, but the state plans to monitor crowd-out and has indicated its intention to impose a three-month look-back provision should crowd-out be identified as an issue.

Factors Influencing Program Design

The inclusion of premiums in the CHIP program was intended to make the new program look like a private sector insurance product, thus reducing its "welfare" stigma. Several respondents said that premiums were adopted in Massachusetts because Republican legislators felt people needed to contribute toward the cost of their care. Many believe this feeling is valid because premiums cost more to collect than the revenues that they generate. Several other respondents believed that the cost-sharing provisions in Massachusetts were put in place largely to address concerns about crowd-out.

In nearly every study state, the legislature, in coordination with the governor, had the largest impact on the decision about whether to include cost-sharing mechanisms in the program. In Massachusetts, the Senate opposed premiums, while the governor's office and the House supported them. The House and the administration felt very strongly that premiums would strengthen personal accountability and responsibility, while also avoiding crowd-out. Respondents indicated the decision was not a budgetary issue. The advocacy community joined the Senate in its opposition to premiums.

The premium issue was not settled until July 1998, delaying implementation of the state's CHIP program by roughly six months. The Senate compromised, but only after reducing the premium levels from $14 to $81 per month to the current $10 to $30 per month. The premium structure was also simplified. The original premium plan had 81 different premium levels and scenarios. Many respondents credited advocates' efforts for the imposition of the $30 monthly cap and the simplification of the premium structure. The advocacy community has continued to work very closely with the state to develop materials that explain cost-sharing regulations. Advocates appeared to have had more impact on the design of cost-sharing mechanisms in Massachusetts than any other state in this study.

New York

Basic Description and Premium Requirements

New York's Child Health Plus (CHPlus), the largest state-subsidized health insurance program in the nation, was one of three programs grandfathered into the CHIP legislation. The program was implemented in 1990 to provide primary and preventive outpatient health insurance coverage for children under age 13 not eligible for Medicaid. Over the last several years the program expanded its coverage to include inpatient services, and treatment for substance abuse and mental health, as well as short-term outpatient therapeutic services. In addition, in 1996 the state broadened eligibility to include children under age 19 from families with incomes at or below 230 percent of FPL. Child Health Plus is a stand-alone state program administered by the New York Department of Health which uses a managed care product to deliver health care with an emphasis on prevention.

The CHPlus program has been popular with families and providers alike since its inception in 1990. Families enjoy the ease of application, reasonable cost-sharing measures, and the extensive benefits package. In addition, enrollees do not associate the program with the stigmas of the Medicaid program. Providers are also eager to participate in the program given the high reimbursement rates they receive from the state.

Participating health plans, which also initiate disenrollment for failure to pay, collect premiums. Families with incomes below 160 percent of FPL pay no premiums. Families with incomes from 160 to 222 percent of FPL pay $9 per child per month with a $27 per month family cap. Families with incomes from 223 to 230 percent of FPL pay $15 per child per month, with a $45 per month family cap. Premiums are paid by check or money order and are due one month in advance.

Because they are responsible for program eligibility, plans are concerned about the increasing administrative responsibilities in the complex eligibility determination, especially for families currently in the CHIP program who are really Medicaid-eligible.

Copayments

CHPlus levies no copayments on enrollees.

Lockouts and Previously Uninsured (Look-Back) Requirements

Families are given a 30-day grace period in which to pay premiums. Their health plan sends them a reminder notice during this time. At the expiration of this period, families are disenrolled; the state imposes no lockout period, however. There is also no look-back requirement in CHPlus. The state plans to perform an analysis in 1999 to determine whether substitution is occurring. If this study finds that more than 8 percent of new enrollees have substituted CHPlus coverage for private insurance, the state will implement a look-back requirement.

Factors Influencing Program Design

In New York as in Florida, the experience from programs that predated CHIP informed cost-sharing design. In both cases, new programs maintained existing cost-sharing structures while lowering the participant's contribution. Families with incomes of more than 120 percent of FPL in New York's CHPlus previously paid $36 per member per month; under CHIP, they now pay no more than $27 or $45 per family per month depending on income (see section above for details). Several respondents in New York indicated that the state did not use formal or scientific methods to devise its cost-sharing structure.

New York eliminated copayments from its program in June 1998 in response both to lobbying by advocates and complaints from insurers and providers about the administrative burden involved in the collection of copayments. There was also concern about the burden of the shoebox approach on enrollees.

Washington

Basic Description and Premium Requirements

Washington is one of two states—Wyoming is the other—that has not submitted a CHIP state plan to date. Washington's Healthy Options Medicaid program and its Basic Health Plan Plus, which is administered through the state-funded Basic Health Plan (BHP), have both provided coverage for children age 19 and under from families with incomes less than 200 percent of FPL since 1993.

Healthy Options is Washington's mandatory managed care program for Medicaid beneficiaries and is administered by the Medical Assistance Administration, which is a part of the Washington Department of Social and Health Services. While the Healthy Options program receives federal money, the Basic Health Plan is funded entirely by the state through the Washington State Health Care Authority.

In addition to Medicaid and BHP, families can enroll children in BHP Plus, a special program that offers Medicaid benefits for Medicaid-eligible children whose families are enrolled in BHP, thereby covering both parents and children with the same umbrella program. While neither Healthy Options nor BHP Plus levies premiums for covered children, BHP has imposed cost-sharing on its adult members since its inception in 1988. Children from families with incomes above 200 percent of FPL are also subject to premiums.

Individuals and families with incomes less than 200 percent of FPL qualify to participate in BHP's reduced-premium program. Members pay premiums on a sliding scale based on their income, age, family size, and health plan choice. Premiums in this program range from $0 to $150 per month. Members with incomes above 200 percent of FPL pay the full cost of coverage, plus a small additional amount to cover administrative costs. These members pay anywhere from $114.20 to $412.36 per month. Employers can buy into the program, at slightly higher rates, to cover their employees.

Copayments

Neither Healthy Options nor BHP Plus levies copayments for visits made by children from families with incomes less than 200 percent of FPL. In BHP's reduced-premium program, adult members pay $10 for each nonpreventive care office visit, $25 for each outpatient visit, $50 for emergency room visits, and $100 per hospital admission. Pharmaceutical copayments range from $1 to 50 percent of the drug's cost, depending on drug type. BHP's full-premium members pay $18 for each nonpreventive office visit, $75 for each emergency room visit, and $200 per day for

hospital admissions with a five-day maximum copayment ($100 per day for children under age 19). Pharmaceutical copayments range from $3 to 50 percent of the drug's cost, depending again on drug type.

Lockouts and Previously Uninsured (Look-Back) Requirements

When BHP members do not pay their premiums on time, they receive a delinquency notice. If they fail to pay their premium by the date indicated on the notice, their coverage is suspended for one month. If they do not pay their overdue premium by the end of the one-month suspension, they are disenrolled from the program and are locked out for one full year. BHP has no look-back requirement.

Factors Influencing Program Design

Washington State did not elect to apply for CHIP funds until recently. Having already raised Medicaid eligibility levels in 1996 to 200 percent of the federal poverty level for children up to age 19, Washington's conservative legislature did not want to expand eligibility to 250 percent of FPL, which would have been required if the state had applied for federal funding. Furthermore, only 10,000 more children would have been eligible for coverage under such an expansion, less than the number of uninsured children already eligible but not enrolled in existing state programs. Consequently, many believed that it would be wiser to focus state efforts and resources on enrolling the latter group.

At the time the case studies were conducted, Washington was only in the preliminary stages of creating a CHIP program. However, several trends that have emerged in the creation of other state CHIP programs can also be seen in the formation of Washington's Basic Health Plan. Many Washington respondents believed the inclusion of premiums was a major reason for the widespread political support the BHP program enjoys. Additionally, BHP's premium structure was formulated in such a way as to encourage enrollees to be cost-conscious. By offering an array of health plans from which beneficiaries can choose, Washington makes BHP enrollees assess whether the value of the more comprehensive coverage is worth the higher premium.

IV. IMPLEMENTATION OF COST-SHARING UNDER CHIP

This section of the paper explores the experiences of the six study states as they relate to these central questions:

- To what extent do variations in cost-sharing arrangements affect family participation in the states' children's health insurance programs?

- Do administrative complexity and costs associated with collecting premiums and copayments outweigh their potential benefits?

Study states hypothesize that cost-sharing will limit substitution of publicly subsidized coverage for private health insurance, increase personal responsibility for appropriate health care utilization, and reduce the "welfare" stigma associated with Medicaid. Can these potential benefits be obtained without discouraging enrollment? Are there income limits beyond which cost-sharing erects barriers to participation for near-poor families with children that offset the potential advantages of cost-sharing? Which mechanisms for implementing cost-sharing are most effective and least likely to discourage enrollment? Quantitative data that might answer these questions were not available at the time that case studies were conducted, but qualitative information, in the form of the experiences of our six study states as reported by program administrators, advocates, and other decision-makers, might begin to answer them.

The Impact of Cost-Sharing on Family Enrollment and Continuous Coverage

Results of interviews in the six states produced some evidence that cost-sharing can negatively affect family enrollment and continuous coverage under CHIP. In all of the six study states except Florida, program administrators or other informants cited premiums as an issue and potential barrier to enrollment or incentive to leave the program once immediate needs for health care had been met. Based on interviews, copayments appear to be less of a barrier to coverage. The scope of this study did not allow for investigation of the copayments' impact on utilization.

Cost-sharing provisions can influence family participation in CHIP programs in three ways:

- Although generally low, the financial burden of paying premiums or copayments varies depending on family income level, debt obligations, and the amount of health care needed. The greater the financial burden, the less likely families are to commit to a program that requires out-of-pocket expenses.

- The logistical complexity of making payments and tracking payment due dates is more difficult for some families to manage than others. Because many low-income families live day to day in a "cash economy," without checking accounts and record keeping systems, they have difficulty making periodic premium payments.

- In order for families to become willing to follow through with cost-sharing requirements, they need to understand the value of insurance and prospective payment for health services. Many low-income families are not motivated to participate in paying monthly health insurance premiums because they are not familiar with insurance programs, expect to pay for services at the time they are needed, and do not necessarily see the value of health insurance coverage for preventive health care and prospective health care service needs.

Findings from enrollment analysis in the six study states lend support to these assertions. One indicator of family financial burden is the number of families who disenrolled from CHIP or were disenrolled by the program for nonpayment of premiums. Two states, Washington and California, have collected some disenrollment information. In California, where the state third-party administrator tracks disenrollment data, 3,258 families (2.6 percent of total enrollment) disenrolled from CHIP from July 1998 to May 1999. Of that number, 1,511 (46.4 percent) were disenrolled because of failure to pay premiums.[21] In Washington, premiums increased in January 1998 by approximately 9 percent for BHP members in the subsidized program and approximately 62 percent for members in the unsubsidized program. Following the premium increase, enrollment dropped by 4 percent in the subsidized program and by 40 percent in the unsubsidized program. A Washington Health Care Authority survey indicated that cost was the reason for leaving the program for 37 percent of those in the subsidized program and 74 percent in the unsubsidized program.

Another indicator that premiums are a burden for some families is the emergence in several states of various charitable efforts to help them pay premiums. For example:

- In Washington, the state-sponsored insurance program allowed community agencies, insurance plans, and providers to sponsor members by paying their premiums. The policy was changed in 1998, and advocates believe this forced many people to drop coverage. At least one charitable organization has offered to fund premium payments to fill the

[21] Program administrators note that some of those disenrolled for failure to pay premiums may have moved, or found out they were eligible for Medi-Cal or other insurance.

void. State administrators are concerned that such subsidies contribute to adverse selection of members in the BHP plan.

- In California, the state pays staff based in community agencies to help people fill out applications for public insurance. In San Gabriel Valley, 80 of these application "assistors" are pooling their assistor fees to pay premiums for needy families. While program administrators do not support such efforts, they say they have no way to track who actually pays premiums.

- In Colorado, the Kellogg Foundation gave a grant to Denver Health Plan to help subsidize premiums for families. Foundations, through their grantmaking decisions, may be exhibiting concerns about the barrier cost-sharing creates for enrollment.

- In Florida, some communities are devising ways to give grants to families who are unable to pay their premiums for a month or during a more extended period because of financial difficulties. The Florida CHIP legislation does not expressly forbid such payment assistance, although program administrators note that it is counter to the intent of the law.

Agencies and individuals appear to be taking charitable action because they perceive that income levels for cost-sharing are set too low for some families and that adjustments based on family debt burden are appropriate in some situations. Some agencies may also be philosophically opposed to premiums and copayments, as well as concerned about access to care.

Clearly, state program administrators are concerned about this trend; it is counter to state policy and may have unintended consequences, such as adverse selection of plan membership. However, states do have the option to adjust the income levels used to define cut-off of cost-sharing requirements, and of using program dollars to finance coverage rather than allowing ad hoc community subsidies to spring up in fragmented fashion.

Some of the evidence from state experiences indicates that premium payments may need to be set at higher federal poverty levels. Further study will be required to assess varying starting points for CHIP programs.

For the most part, state CHIP programs have implemented premium payment systems with little flexibility and few options for families to pay premiums conveniently. Table 2 below shows the forms payments can take in each state. Study respondents in Massachusetts, New York, and Colorado expressed concern that families who do not have checking accounts may

have problems making premium payments. Some states, such as New York, do not accept cash payments. In New York City, anecdotal reports indicate that 50 percent of premiums are paid with money orders, which is an additional expense for families. California has the most flexible system for premium payments. They can be made by credit card, certified check, money order, or cash at Rite Aid pharmacies throughout the state.

Table 2: Premium Payment Mechanisms in the Six Study States

State	Payment Place	Payment Form
New York	Mail in	Check or money order
Massachusetts	Mail in	Personal or certified check
Colorado	Mail in	Check or money order
Florida	Mail in	Check or money order
Washington	Mail in	Check, cashier's check, or money order
California	Mail in or in person	Cash, check, credit card, money order, or electronic fund transfer

Some families also have difficulty making payments on time and keeping track of when payments are due. This is of particular concern because of program lockout provisions for nonpayment of premiums. Of the six study states, all but New York impose lockout provisions. Washington and Massachusetts bar families from re-enrollment for one year, California for six months, Colorado for three months, and Florida for 60 days. The length of time for lockouts translates to longer uninsured periods because families must reapply and wait for eligibility determinations.

Notably, all of the options available for paying CHIP premiums are more difficult than the employer payroll deduction typically used by most middle and upper income families for health insurance. None of the study states had a comparably easy or "automatic" mechanism for low-income families to pay their children's premiums.

In every state, study respondents expressed concern about the impact of lockout provisions on the continuity of coverage. They suggested reducing the length of lockout time and increasing support efforts (e.g., as payment reminders).

Some states are intensifying their efforts to work with families when payments are late. For example, Massachusetts develops tailored payment plans and follows up one-to-one with families. With the exception of Florida, each state sends reminder notices and has a grace period (generally about 30 days) for late payment. California and Florida allow families to prepay

premiums, which may help to relieve some families of the burden of keeping track of payment due dates. In California, families who pay three months of premiums get the fourth month free, or they can pay for nine months and get one year of coverage. Three-quarters of members are participating in the prepay option. New York is considering quarterly premium collection, which it thinks would be easier administratively and easier for families.

As CHIP programs grow and other insurance expansions are developed, states need to design flexible cost-sharing payment procedures and limit family record-keeping requirements to reduce the impact of logistical barriers on the ability of families to meet cost-sharing provisions and maintain continuous coverage.

Many policymakers and program managers believe that some families targeted for CHIP enrollment are not experienced with the concept of insurance or paying for health care prospectively. These families may have little motivation to enroll in health insurance even when it is available, and cost-sharing requirements probably inhibit them even more. Anecdotal reports from study respondents provide some support for this belief. A provider in Colorado reported a number of incidents of enrollees demanding premium refunds if they did not need any health services during the month. California respondents also indicated that families do not understand "prepayment" of health care. They claim "people are used to paying as they go."

CHIP programs need to increase their efforts to educate the target population about insurance concepts and specific cost-sharing requirements in order to reach enrollment targets and encourage families to follow cost-sharing requirements. States need to adjust program implementation strategies to help families learn about and use health insurance effectively.

The Impact of Cost-Sharing Requirements on Program Administration

Cost-sharing requirements are expensive to administer and their implementation demands expanded infrastructure. In most states, cost-sharing requirements are set at low levels and are not likely to generate significant revenue for the states—thus the theoretical benefits of cost-sharing create most of the value necessary to offset the administrative price of cost-sharing provisions. Solid data that would quantify whether the benefits of cost-sharing outweigh its expense are not available. Qualitative information tends to support the notion that the way cost-sharing provisions are managed now is too expensive. Since states do not have prior experience with collecting premiums, they do not have the needed business systems in place, and report they have difficulty tracking premium payments and managing the disenrollment process. Systems for collecting late payments, tracking accounts receivable, and monitoring bad debt are costly to

develop. The charts in Appendix D depict decisions that program administrators must make in order to implement cost-sharing in CHIP programs.

To handle the administrative burden and to reduce pressure on the 10 percent administrative cap imposed by federal regulation, some states shift administrative costs to health providers and plans; others seek ways to implement cost-sharing without increasing agency staff. For example, New York has shifted responsibility for administering cost-sharing onto health plans under contract with the state. Health plans with which the state contracts are responsible for collecting premiums and initiating disenrollment.

Three study states, California, Florida, and Colorado, outsource their premium collection operations to third-party administrators (TPAs). They have had different experiences with this approach. Colorado, for example, had problems with its TPA. The computer system for premium collection was not in place at the time of the site visit in August. Billing and follow-up were being done manually and most families were not yet paying premiums. California, on the other hand, had well-functioning arrangements with a TPA that was responsible for billing and monitoring of premium payments. The TPA implemented a data system to report monthly application and enrollment data. As a result, California is able to monitor disenrollment by cause.

Massachusetts was the only state that reported minimal difficulty with the administration of cost-sharing mechanisms. The commonwealth's Division of Medical Assistance (DMA) is the responsible entity. It uses the state accounting and billing system, M-Mass, which was already in place. DMA estimates that only one full-time equivalent employee has been added to collect premiums.

It is difficult to compare the relative merits of implementing administrative systems within the CHIP program or outsourcing the job, given that program implementation is so recent. However, as insurance programs for low-income families expand, states need to evaluate their systems carefully to assure that they will function effectively.

Another area in which states have little previous administrative experience is in setting up mechanisms to assure compliance with the 5 percent rule for family cost-sharing limits. There are not comparable models for such systems in the private sector, although there may be some similarities with the way that private insurance plans track deductibles and total patient out-of-pocket expenses for catastrophic limits. States are devising completely new systems to monitor family contributions, and some seem to be implementing procedures that are not likely to work well when programs expand and the number of enrollees increases.

Many states have chosen procedures that shift some of the burden for tracking expenses to families. For example, Colorado, Florida, California, and Massachusetts have copay requirements and expect families to track their own health care expenditures through what is commonly referred to as the "shoebox method." The state computes the annual dollar amount each family would have to spend on copayments in order to exceed 5 percent of their incomes, taking into account the amount the family would spend on annual premiums. The burden of keeping receipts and reporting to the state when the 5 percent level has been reached then falls on the family.

However, all four states set copayment rates at levels that are low enough to ensure that most families are not likely to accumulate enough expenses to equal 5 percent of income. Families most at risk for exceeding the 5 percent level of cost-sharing are those with large numbers of children and those with children who have serious or chronic medical needs. Indeed in California, rates are set low enough that families are unlikely to exceed 2 percent of their income.

Florida program administrators reported that when they petitioned to monitor family expenses directly using their own data system, the Health Care Financing Administration (HCFA) encouraged them to use the "shoebox method." Apparently, HCFA was skeptical about the state's capacity to manage this. Florida did commission the Institute for Child Health Policy to study family contributions to the cost of care using historical data from the Healthy Kids program. The study found that the highest amount contributed by any family was approximately 3 percent of annual income. This type of retrospective review may be one way to monitor state compliance with the 5 percent rule without setting up individual tracking procedures, but some families could potentially pay more than required with such an approach.

Another administrative complexity that affects both programs and families is the need to change procedures when family contributions do exceed the 5 percent level. Now, states either issue new membership cards informing providers to bill the state for copayments, or the states reimburse members for out-of-pocket expenses upon submission of receipts. Advocates are concerned about the latter approach, which puts the burden on families. Massachusetts, as part of its "shoebox" approach, issues a "C.A.R.E. Kit" to families that explains cost-sharing rules and procedures for submitting copayment receipts.

The complexity of administering any kind of system to monitor state compliance with the 5 percent rule contrasts starkly with typical private sector insurance arrangements. Since copayments are set at such low levels, they are not likely to generate significant revenue. In

many cases, providers view copayments as an insurer's way of discounting rates, and they frequently do not collect from low-income families. Providers interviewed during site visits reported that they do not deny care because a family cannot pay copayments. Because copayments do not come to the state, developing a system to monitor payment would be difficult.

Given the complexity of administration, states might want to assess their policies on copayments. Across all forms of cost-sharing for low-income families, states need to rethink or develop efficient mechanisms for tracking family cost-sharing investments so as to relieve families of record-keeping burdens and to develop sustainable cost-sharing systems that are more like commercial insurance and will function efficiently as the number of covered members expands.

V. BUILDING ON EMPLOYER-SPONSORED INSURANCE COVERAGE

As states begin to plan their next steps for insurance expansions to low-income families and individuals, working with employer-sponsored insurance plans (ESI) is an option with practical and theoretical advantages that should be considered. Within the scope of this study, the Lewin Group looked at how the states were using ESI to help inform decisions about the future. At the time of the study, only Massachusetts and Washington had established programs that subsidized ESI plan payments for children and parents. Wisconsin and Florida have petitioned HCFA for permission to use CHIP funds to insure parents and children through ESI arrangements. Program managers speculate that whole-family coverage will be more attractive to potential members. Florida's proposal for an ESI program would cover premiums for non-Medicaid eligible children under age 19 from families with incomes of less than 200 percent of FPL whose families have access to ESI. The premium subsidy would be paid directly to the insurance plan and the employer would deduct $15 from the employee's paycheck. This plan calls for a 20 percent employer contribution level. Under CHIP, however, HCFA rules require 60 percent employer contribution. Advocates think this will probably prevent HCFA approval of the plan.

Massachusetts' Experience with an Employer-Sponsored Insurance (ESI) Option

Massachusetts' program is called the MassHealth Family Assistance Premium Assistant Option. An entire family can be covered under this option since ESI plans do not separate coverage for dependents from the primary member's coverage. Families with employer plans that provide benefits deemed equivalent in benefits to the state benchmark plan and cost-effective by state standards can receive a state subsidy to pay for their ESI monthly premium. The employer is required to contribute 50 percent of the cost of coverage, the family pays its portion of the premium as set by state cost-sharing procedures, and the state pays the balance. Massachusetts uses the HMO with the largest commercial enrollment in the state as its benchmark plan for defining "basic benefit levels." Under the ESI plan, employer-sponsored plans must be deemed consistent with the benchmark plan. The limit for state contributions for the plan to be adjudged cost-effective is $150 per child per month. State program managers are reaching out to small businesses and chambers of commerce to educate them about the ESI plan and encourage them to help identify and enroll eligible employees.

The MassHealth Family Assistance ESI option requires family cost-sharing. Premium payments are capped at $10 per child per month, with a maximum of $30 per month. The state is working with employers and third-party administrators to establish payroll deductions for family premium payments. Copayments depend on the particular plan offered by the employer. The state will reimburse families for copayments on well-child care and cover costs if the family contribution exceeds 5 percent of its annual income.

Massachusetts uses an outside contractor to manage the eligibility and benefit equivalency determinations for the program. One of the issues this arrangement raises is whether or not the contractor can perform all of the determination procedures quickly enough to meet the 60-day limit for determining eligibility under CHIP. If the 60-day limit is not met, the state plans to default-enroll children into their Direct Coverage program (see Chapter II for a description of this program). Some study respondents voiced concern that the contractor would have difficulty with implementation because it was experienced with evaluating plan benefits but not experienced with time-sensitive eligibility determinations. Massachusetts's experience with its ESI plan provides an illustration of the potential and problems inherent in ESI program options.

Potential Problems with Employer-Sponsored Insurance Options

Children's advocates and respondents in our study states express concern that ESI options may erode the content and standards for children's benefit packages—particularly compared with the comprehensiveness of EPSDT coverage. If states use commercial plans as their benchmark plans, benefit packages could be less rich than in traditional public programs. The Massachusetts basic benefit level is based on a small-group insurance market standard that does not cover dental or vision and limits pharmacy coverage.

Another issue is whether or not ESI rules might encourage employers to lower their contributions to premiums. Employers who now pay more than 60 percent might lower their contributions and still qualify to participate in the program. Several of Massachusetts' study respondents voiced concerns that their ESI plan might have this effect. Massachusetts plans to monitor this issue, as well as substitution, with surveys being developed by the Division of Medical Assistance and the Division of Health Care Finance.

Florida's experience raises the issue of employer participation in the plans. Florida found HCFA's 60 percent employer contribution rule was too restrictive. Only 45 percent of Florida employers contribute anything to workers' insurance costs, and most employers are small businesses. Another issue that Florida program administrators raised was the problems they encountered with ERISA plans, which are not subject to insurance regulations. Florida intends to have ERISA employers sign contracts describing benefits and quality monitoring activities. While concerns about expanding ESI access will need to be addressed in ways that assure children and families interests are paramount, creative solutions can surely be found. Movement in this direction is timely for states as decision-makers across the insurance industry begin to recognize the potential inherent in coordination between public and private insurance plans, e.g., increased enrollment in all plans and maximum use of new funding streams.

VI. CONCLUSION

States implemented cost-sharing to achieve certain objectives—creating a CHIP distinct from welfare and Medicaid to reduce the stigma of participating in public programs, creating ownership for health care among enrollees, promoting effective use of health services, and limiting substitution of public insurance for commercial insurance. The scope of our study limited inquiry regarding the extent to which cost-sharing has achieved any of these objectives. However, state experiences indicate that cost-sharing can also have anticipated and unanticipated negative effects on families and program requirements. The study also suggests some ways that programs might mitigate the negative consequences.

In most states, political environments drove early cost-sharing decisions. Legislatures were turning away from entitlements and emphasizing family and personal responsibility. Many were disenchanted with public insurance programs because of the poor performance and reputation of some Medicaid programs. This was the environment when most programs were being designed, and accordingly, most states felt compelled to implement cost-sharing—including both premium contributions and copayments for services—as part of CHIP.

Cost-sharing in the form of premium payments appears to introduce enrollment and logistical difficulties for families within the premium-sharing income range (150 percent of poverty or higher for CHIP; lower for state-only programs). Many low-income families live in a "cash economy," which means that they pay their bills with cash, do not have checking accounts, and find it difficult to track due dates for monthly bill payments. These constraints create barriers to paying premiums, which in turn affects the continuity of coverage. Premium payments also create administrative complexity and difficulties for program managers. For example, programs must develop systems to handle many small monthly payments, track bill payment, disenroll members for nonpayment, and monitor member contributions to assure they do not exceed 5 percent of annual family income.

Cost-sharing in the form of copayments for services at the point of service appears to create fewer complications for program administrators, but does create additional obligations for providers, who are expected to collect the copayments. Families also bear some burden when copayments are expected. In addition to the necessity to have cash at the time of service, families in most states must track their health care expenses and seek reimbursement from CHIP programs when their costs exceed 5 percent of their annual incomes. This is an unrealistic expectation for families who have difficulty maintaining records and managing finances.

From today's vantage point, it appears that states would benefit from an evaluation and assessment of premium issues. While the goal is to set up insurance systems that closely resemble private insurance, higher-income families typically do not face monthly premium bills of coverage nor need to track their own cost-sharing obligations. These functions are usually supported by employer-sponsored systems that collect premiums through payroll deductions and insurance plans that track or simplify cost-sharing. As program memberships expand, states will likely need to explore administrative options for cost-sharing that reduce burdens on programs and participants.

In general, implementation of any cost-sharing provisions should be carefully evaluated to determine if the value outweighs the administrative costs and impact on families.

States might also benefit from examining alternative designs' effects on enrollment. As declines in Medicaid threaten to overshadow gains in CHIP coverage, states may well confront an increase in the number of uninsured children despite CHIP enrollment growth. With state reserves of unspent CHIP funds and savings in Medicaid, states have the opportunity and health resources to concentrate on finding, enrolling, and maintaining coverage for eligible families with the goal of assuring that all children in families with incomes under 200 percent of FPL have continuous health insurance coverage. To achieve this goal, program policies must be simple, practical, reinforced, and enforceable.

Appendix A
Taxonomy of State Cost-Sharing Strategies, April 1999

State	Program Name	Medicaid Expansion or State-Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Alabama	AL CHIP Phase I :	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
	AL CHIP Phase II:	State-Designed Program	100-150% FPL $0 150-200% FPL: $50 PCPY OR $6 PCPM	100-150% FPL: No CO 150-200% FPL: $1-$5 CO w/ $500 Ymax	Children cannot be reenrolled at the end of the year unless premiums are current. 3-mo wait for those who drop private insurance.
Alaska	AK CHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Arizona	KidsCare	State-Designed Program	100-150% FPL: $0 150-200% FPL: State is submitting amendment for PCPM premiums beginning 7/1/99.	100-150% FPL: No CO 150-200% FPL: $1-$5 CO	6-mo wait for those who drop private insurance
Arkansas	AR CHIP Phase I	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
	ARKids First (Phase II)	Incorporation of ARKids First 1115 Demonstration Waiver	The state has no cost-sharing provisions under Medicaid		
California	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text
Colorado	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text

Abbreviation Key		
PCPM = Per child per month premium	PPPM = Per person per month premium	max = Monthly maximum
PFPM = Per family per month premium	CO = Copayment	Ymax = Yearly maximum

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion or State-Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Connecticut	HUSKY Plan	Combination	< 235% FPL: $0 235-300% FPL: $30 PCPM w/ $50 max >300% FPL: Full Premium Private organizations may subsidize premiums payments	< 185% FPL: No CO 185-230% FPL: State establishing CO for certain services w/ Ymax $650	6-mo wait for those who drop private insurance. May be extended to 12 mo-wait.
Delaware	Delaware Healthy Children Program (DCHP)	State-Designed Program	101-133% FPL: $10 PFPM 134-166%: $15 PFPM 167-200% FPL: $25 PFPM	$10 CO for ER visit.	6-mo wait for those who drop private insurance
District of Columbia	Healthy DC Kids	Medicaid Expansion	The district has no cost-sharing provisions under Medicaid		
Florida	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text
Georgia	GA CHIP	State-Designed Program	Age 0-5: no premium Age 6-18: $7.50 PCPM w/ $15 max $100 Ymax	No copayments.	3-mo wait for those who drop private insurance.

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion or State-Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Hawaii	Hawaii Title XXI Program	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Idaho	ID CHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Illinois	Illinois Child Health Initiative (Phase I)	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid for children and pregnant women		
	A task force is exploring other options for the future				
Indiana	Hoosier Healthwise	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
	The state intends to develop a different plan later				
Iowa	Healthy and Well Kids in Iowa (HAWK-I)	Phase I: Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
	Phase II (not implemented yet): State-Designed				

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion or State-Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Kansas	HealthWave	State-Designed Program	<150% FPL: $0		
			151-175% FPL: $10 PFPM		
			176-200% FPL: $15 PFPM	No CO	6-mo wait for those who drop private coverage
Kentucky	KCHIP	Combination	100-133% FPL: up to $20 PFPY		
			134-149% FPL: up to $0 PFPY		
			150-200% FPL : up to $40 PFPY	<150% FPL, minimal CO	6-mo wait for those who drop private coverage.
Louisiana	LaCHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid.		
Maine	Cub Care	Combination	Medicaid-expansion: The state has no cost-sharing provisions under Medicaid.		
			Cub Care: 150-160% FPL: $5 PCPM w/ $10 max		
			Cub Care: 161-170% FPL: $10 PCPM w/ $20 max.		
			Cub Care: 170-185% FPL: $15 PCPM w/ $30 max	No CO	30-mo wait for those who drop private coverage
Maryland	Maryland Children's Health Program	Medicaid Expansion through 1115 waiver	The state has no cost-sharing provisions under Medicaid.		

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion or State-Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Massachusetts	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text
Michigan	MIChild Program	State-Designed Program	<150% FPL: $0 <151-200% FPL: $5 PFPM	No CO	6-mo wait for those who drop private coverage
Minnesota	MinnesotaCare	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Mississippi	MS CHIP	Combination	The state will have no cost-sharing provisions under either part of the plan (Medicaid expansion or state-designed program)		
Missouri	MC+ Program	Medicaid Expansion through 1115 waiver	The state will have no cost-sharing provisions for children		
Montana	MT CHIP	State-Designed Program	<100% FPL: $0 101-150% FPL: $15 PFPY	100-150% FPL: $3-$25	3-mo wait for those who drop previous coverage
Nebraska	Kids Connection	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion State-Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Nevada	Nevada Check-Up	State-Designed Program	Quarterly premium based on family size and income. Ranges from $10-$50	<150% FPL: No CO	6-mo wait for those who drop private coverage
New Hampshire	Healthy Kids Gold	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
	Healthy Kids Silver	State-Designed Program	185-250% FPL: $20 PCPM w/max $100		
			250-300% FPL: $40 PCPM w/max $100	$5-$20 CO	
New Jersey	NJ KidCare	Combination	Plan A (<133% FPL): No premium	Plan A: No CO	
			Plan B (133-200% FPL): No premium	Plan B: No CO	12-mo wait for those who drop private coverage
			Plan C (>150% FPL): $15 PFPM	Plan C: $1-$10 CO	
New Mexico	SALUD!	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
New York	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text
North Carolina	NC Health Choice for Children	State-Designed Program	>150% FPL: $50 PCPY w/Ymax $100	>150% FPL: $6-$20 CO	6-mo wait for those who drop private coverage
North Dakota	Healthy Steps Program	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion or State–Designed Program?	Premiums	Copayments	Lockout/ Grace Periods
Ohio	Healthy Start	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Oklahoma	OK CHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Oregon	OR CHIP	State-Designed Program			
		Part I: Medicaid look-alike plan	No Premiums	No CO	
		Part II: CHIP component; provides direct subsidies to families to purchase insurance	Premium cost to be determined	CO to be determined	6-mo wait for those who drop private coverage
Pennsylvania	PaCHIP	State-Designed Program	No Premiums	$5 CO for prescriptions	
Puerto Rico	PR CHIP	Medicaid Expansion	Puerto Rico has no cost-sharing provisions under Medicaid		
Rhode Island	R.Ite care	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
South Carolina	Partners for Healthy Children	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
South Dakota	SD CHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Tennessee	TennCare	Medicaid Expansion through 1115 waiver	The state has no cost-sharing provisions under Medicaid		

Taxonomy of State Cost-Sharing Strategies, April 1999 (continued)

State	Program Name	Medicaid Expansion or State-Designed Program	Premiums	Copayments	Lockout/ Grace Periods
Texas	TX CHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Utah	UT CHIP	State-Designed Program	No Premiums	100-150% FPL: Ymax $500 151-200% FPL: Ymax $800	
Vermont		State-Designed Program			
Virgin Islands	VI CHIP	Medicaid Expansion	The Virgin Islands has no cost-sharing provisions under Medicaid		
Virginia	Virginia Children's Medical Security Insurance Plan	State-Designed Program	To speed implementation, initially no premiums; will submit amendment in future	To speed implementation, initially no copayments; will submit amendment in future	
Washington	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text	See Figure 2 in text
West Virginia	WV CHIP	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Wisconsin	BadgerCare	Medicaid Expansion	The state has no cost-sharing provisions under Medicaid		
Wyoming	Plan submitted to HCFA for approval	Combination	<133% FPL: Medicaid expansion 134-150% FPL: Private voucher program		

APPENDIX B
HHS Federal Poverty Guidelines

Size of Family Unit	100%	150%	151%	200%	300%
1	$8,240	$12,360	$12,442	$16,480	$24,720
2	$11,060	$16,590	$16,701	$22,120	$33,180
3	$13,880	$20,820	$20,959	$27,760	$41,640
4	$16,700	$25,050	$25,217	$33,400	$50,100
5	$19,520	$29,280	$29,475	$39,040	$58,560
6	$22,340	$33,510	$33,733	$44,680	$67,020
7	$25,160	$37,740	$37,992	$50,320	$75,480
8	$27,980	$41,970	$42,250	$55,960	$83,940
For each additional person, add	$2,820	$4,230	$4,258	$5,640	$8,460

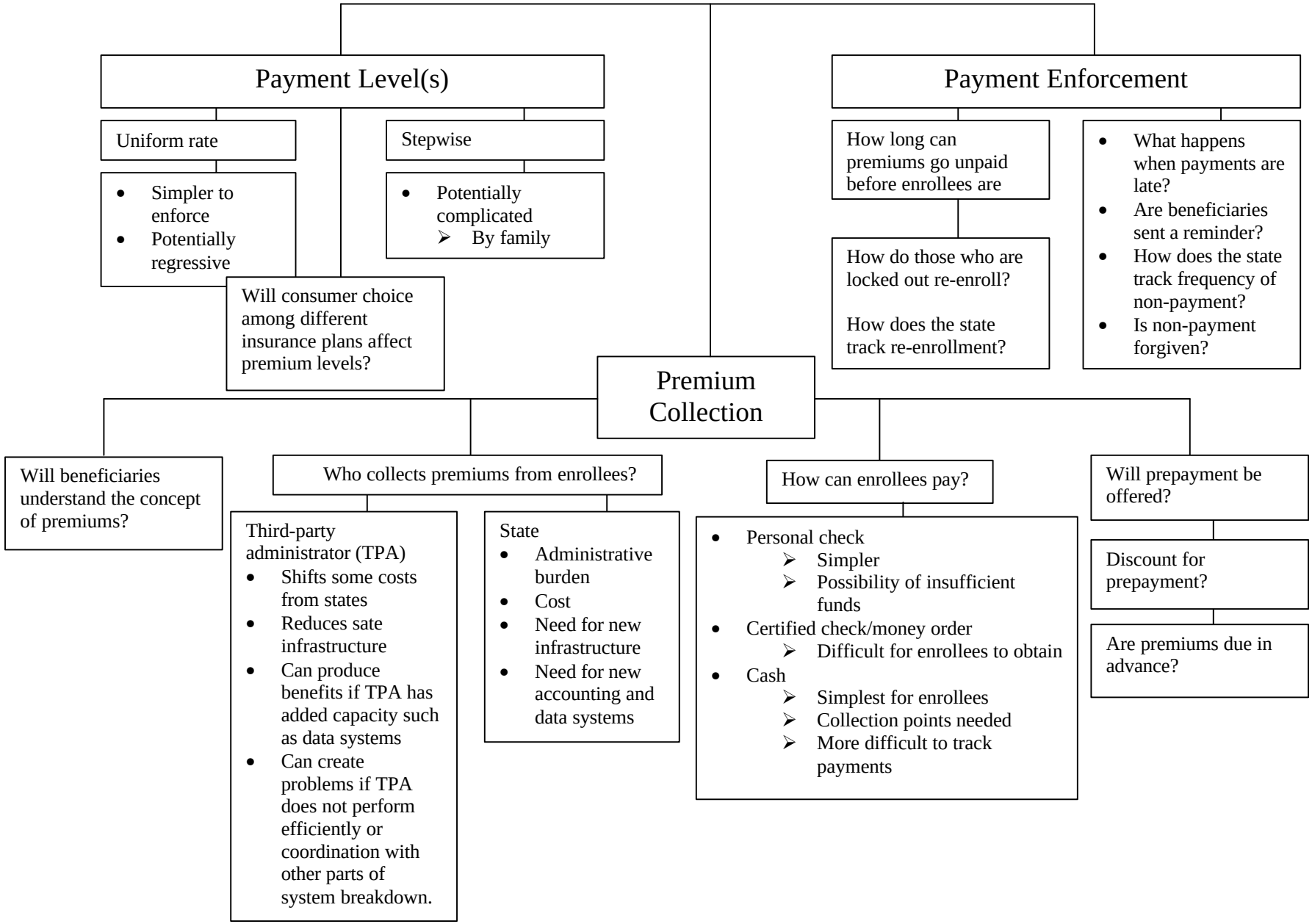
Note: These guidelines apply only to the 48 contiguous states. Alaska and Hawaii's levels are roughly 25% and 15% higher, respectively.

Source: *Federal Register* 64 (March 18, 1999):13428–13430.

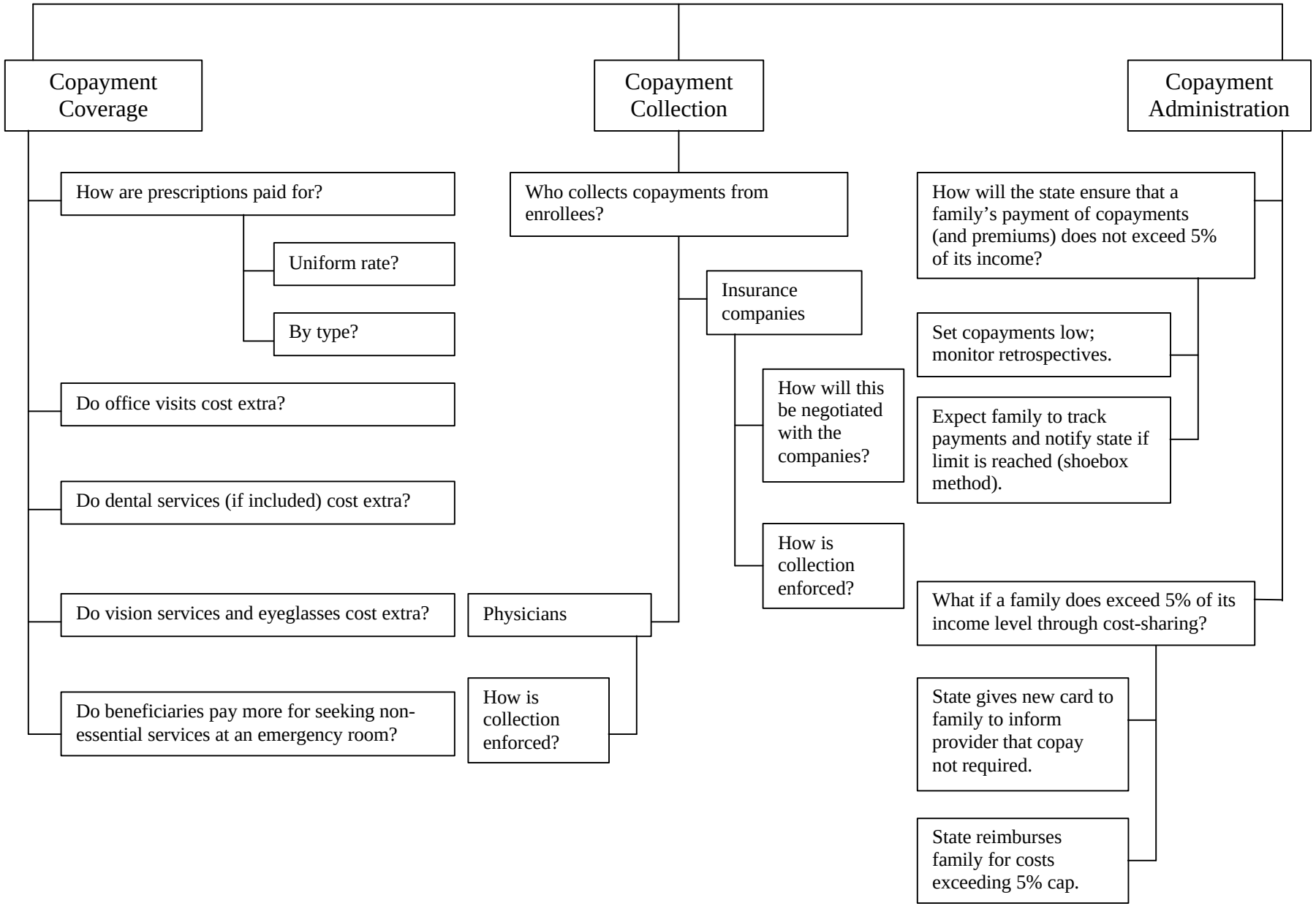
APPENDIX C
WASHINGTON BASIC HEALTH PLAN
COST-SHARING TABLE

Income Index Letter	Number of People in Family						Age	Benchmark Price
	1	2	3	4	5			
A	Less than $427.38	Less than $574.71	Less than $722.05	Less than $869.38	Less than $1016.71		0–18	$0
							19–39	$10
							40–54	$10
							55–64	$10
B	$427.38–$657.49	$574.71–$884.16	$722.05–$1110.83	$869.38–$1337.49	$1016.71–$1564.16		0–18	$0
							19–39	$12
							40–54	$12
							55–64	$12
C	$657.50–$821.87	$884.17–$1105.20	$110.84–$1388.54	$1337.50–$1671.87	$1564.17–$1955.20		0–18	$0
							19–39	$15
							40–54	$15
							55–64	$15
D	$821.88–$920.49	$1105.21–$1237.83	$1388.55–$1555.16	$1671.88–$1872.49	$1955.21–$2189.83		0–18	$0
							19–39	$23.87
							40–54	$30.60
							55–64	$52.33
E	$920.50–$1019.12	$1237.84–$1370.45	$1555.17–$1721.79	$1872.50–$2073.12	$2189.84–$2424.45		0–18	$0
							19–39	$32.82
							40–54	$42.08
							55–64	$71.95
F	$1019.13–$1117.74	$1370.46–$1503.08	$1721.80–$1888.41	$2073.13–$2273.74	$2424.46–$2659.08		0–18	$0
							19–39	$39.78
							40–54	$51.00
							55–64	$87.21
G	$1117.75–$1216.37	$1503.09–$1635.70	$1888.42–$2055.04	$2273.75–$2474.37	$2659.09–$2893.70		0–18	$0
							19–39	$48.70
							40–54	$62.48
							55–64	$106.83
H	$1216.38–$1315.06	$1635.71–$1768.42	$2055.05–$2221.77	$2474.38–$2675.13	$2893.71–$3128.48		0–18	$0
							19–39	$58.68
							40–54	$75.23
							55–64	$128.64
I	More than $1315.06	More than $1768.42	More than $2221.77	More than $2675.13	More than $3128.48		0–18	Full Cost—Must reference selected health plan for premium cost.
							19–39	
							40–54	
							55–64	

Appendix D: Policy and Implementation Decisions About Premiums



Appendix D: Policy and Implementation Decisions About Copayments



BIBLIOGRAPHY

Cherkin, D.C., Grothaus, L., and Wagner, E.H. "The Effect of Office Visit Copayments on Preventive Care Services in an HMO" (abstract). *Inquiry* 27 (Spring 1990):24–38 (online). Available at: http://igm.nlm.nih.gov.

Cohan, S. *State Tools to Provide Family Health Insurance Coverage*, January 1999 (online). Available at: http://www.nga.org/Pubs/IssueBriefs/1999/990104SCHIP.asp.

Cunningham, P., and Kemper, P. "Ability to Obtain Medical Care for the Uninsured." *Journal of the American Medical Association* 280 (September 9, 1998):921–927.

Cutler, D., and Gruber, J. "Medicaid and Private Insurance: Evidence and Implications," *Health Affairs* 16 (January/February 1997):194–200.

Dallek, G. *A Guide to Cost-Sharing and Low-Income People* (Publication 97b-101). Washington, D.C.: Families USA, October 1997.

Families USA. *Premiums and Cost-Sharing Proposed by States Under Title XXI, the New Children's Health Insurance Program*, March 1998 (online). Available at: http://www.familiesusa.org/premium.htm.

Feder, Judith, and Levitt, Larry. *Choices Under the New State Child Health Insurance Program: What Factors Shape Cost and Coverage?* (Policy Brief #2104). Menlo Park, CA: Kaiser Family Foundation, January 1998.

Fox, H.B., and McManus, M.A. *The Potential for Crowd Out Due to CHIP: Results from a Survey of 450 Employers.* Washington, D.C.: Maternal and Child Health Policy Research Center, March 1998.

Hegner, R. *The State Children's Health Insurance Program: How Much Latitude Do the States Really Have?* (Issue Brief #725). Washington, D.C.: The National Health Policy Forum, October 1998.

Holahan, J. *Expanding Insurance Coverage for Children*. Washington, D.C.: The Urban Institute Press, May 1997.

Ku, Leighton, and Coughlin, Teresa. *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*, March 1997 (online). Available at: http://www.urban.org/entitlements/premium.htm.

Lohr, K.N.; Brook, R.H.; Kamberg, C.J. et al. "Effect of Cost-Sharing on Use of Medically Effective and Less Effective Care," *Medical Care* 24 (9, Supplement 1986):S31–S38.

National Association of Child Advocates. *Good Ideas from State Plans* (April 1998). (online). Available at: http://www.familiesusa.org/goodhlth.htm.

Rice, T. and Morrison, K. “Patient Cost-Sharing for Medical Services: A Review of the Literature and Implications for Health Care Reform,” *Medical Care Review* 51 (Fall 1994):235–287.

Rubin, R., and Mendelson, D. “A Framework for Cost-Sharing Policy Analysis,” *PharmacoEconomics* 10 (2, Supplement 1996):56–67.

Shenkman, E., Pendergast, J., Reiss, J., Walther, E., Bucciarelli, R., and Freedman, S. “The School Enrollment-Based Health Insurance Program: Socioeconomic Factors in Enrollees’ Use of Health Services,” *American Journal of Public Health* 86(December 1996):1791–1793.

Shenkman, E., Wegener, D.H., Pendergast, J., and Hartzel, T. “Changing Premium Subsidies: Patterns of Enrollment, Disenrollment, and Adverse Retention in a Children’s Managed Care Program” (abstract). *Association of Health Services Research Abstract Book* 14 (1997):238–239. (online). Available at: http://igm.nlm.nih.gov.

Stearns, Sally, and Mroz, Thomas. “Premium Increases and Disenrollment from State Risk Pools,” *Inquiry* 32 (Winter 1995/96):392–406.

Williams, Sarah. “Facing SCHIP’s Acid Test: Getting Kids Care Once They’re Covered,” *Faulkner & Gray’s Medicine and Health* (November 9, 1998).

Weil, A. *The New Children’s Health Insurance Program: Should States Expand Medicaid?* Washington, D.C.: The Urban Institute Press, October 1997.

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