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# Cost-Sharing Options Under the State Children's Health Insurance Program

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## **COST-SHARING OPTIONS UNDER THE STATE CHILDREN'S HEALTH INSURANCE PLAN**

Under the Children's Health Insurance Program (CHIP) states are permitted to impose premiums and other forms of cost sharing on the families of all participating children, within certain limits set out in the Title XXI legislation. States may elect to charge the maximum amounts allowed, to establish a system of lesser charges, or to eliminate some or all cost sharing completely. Through cost sharing states may be able to open their CHIP program to more uninsured children, since to whatever extent participants share in the cost of their coverage, public costs per enrollee can be reduced. However, the anticipated benefits associated with cost sharing obviously need to be balanced against the potential for reduced enrollment and service utilization.

This issue brief -- the third in our CHIP series -- is intended to assist state policymakers in structuring reasonable policies for CHIP participants. It provides a guide for states in examining the implications of alternative cost-sharing approaches with respect to such issues as family income, number of eligible siblings, and children's health or disability status. The brief begins with an overview of allowable cost-sharing arrangements, along with a discussion of the range of potential cost-sharing amounts that could be imposed. This is followed by an analysis of the cost-sharing options and issues that states confront:

- premiums,
- deductibles,
- copayments or coinsurance, and
- the five percent cost-sharing maximum.

The Maternal and Child Health Policy Research Center prepared this issue brief with assistance from the Health Policy Economics Group of Price Waterhouse. We also relied on reviews of approved and proposed CHIP plans, a literature review, and interviews with health services researchers.

## THE POTENTIAL COST-SHARING OPTIONS UNDER CHIP

### *Brief Overview of Allowable Cost-Sharing Arrangements*

Title XXI established two sets of policies regarding cost sharing for CHIP participants: one for children in families whose gross incomes are at or below 150 percent of poverty and the other for children in families with higher incomes. For the former group, premium and other cost-sharing charges can be no more than nominal. For the latter group, cost-sharing requirements can be far more significant, provided that total charges for all participating children in a family do not exceed five percent of the family's gross income. When CHIP children are enrolled into Medicaid programs, however, Medicaid's rules generally prohibiting premium and other cost-sharing requirements for categorically needy children apply.<sup>1</sup>

The nominal cost-sharing charges permissible under the statute for children in families living at or below 150 percent of poverty and enrolled into non-Medicaid plans are those established by the Secretary for medically needy individuals. Currently, the maximum allowable premium charge for a single child in a two-parent family with an income that places them between 75 and 150 percent of poverty<sup>2</sup> ranges from \$13 to \$16 monthly, or \$156 to \$192 annually. Maximum allowable premium amounts vary by family size as well as income. A state may also impose charges on each health care service, but they may only be of one type. If a deductible is applied, it may not exceed \$2 per month per family. If coinsurance is required, the charge may not exceed five percent of the payment the state Medicaid agency makes for the particular service. If copayments are required, amounts for

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<sup>1</sup> States that operate their Medicaid programs under an 1115 demonstration waiver may have approval to charge monthly premiums for children who are demonstration-eligibles. These states may charge monthly premiums for CHIP-eligible children as well. In addition, the Medicaid statute apparently permits any state to impose monthly premium charges on pregnant women and infants under age one whose family incomes are between 150 and 185 percent of poverty [42 U.S.C. 1916 (c) (1)]; although, federal regulations prohibit premium charges for the categorically needy [42 CFR 447.51].

<sup>2</sup> Income for the purpose of premium requirements is based on a family's total gross income, whereas income for the purpose of eligibility may be based on countable income.

outpatient services cannot exceed those in the HCFA schedule for services of different costs. The Secretary intends to propose regulations that would set copayments at \$1 for services reimbursed at \$15 or less; \$2 for services reimbursed at between \$15.01 and \$40; \$3 for services reimbursed at between \$40.01 and \$80; and \$5 for services reimbursed at more than \$80. For hospital admissions, HCFA rules will continue to require that the maximum deductible, coinsurance, or copayment amount charged to an individual may not exceed 50 percent of the Medicaid agency's payment for the first day of care. By contrast, states have considerably more latitude in structuring CHIP cost-sharing policies for children in families with gross incomes that are above 150 percent of poverty. They are able to charge premiums, apply deductibles, and also require copayments or coinsurance for any service except preventive care. These charges may be set in accordance with a sliding-scale fee based on family income or they may be flat charges imposed on some or all participants with incomes above 150 percent of poverty. Overall, however, the state must assume that cost-sharing charges do not favor children in families with higher incomes over those in families with lower incomes.

### **Potential Cost-Sharing Charges to Families**

For children in non-Medicaid CHIP plans whose family incomes are at or below 150 percent of poverty, there is some variation in how much they could be expected to contribute to the cost of their coverage. While one state might elect not to require any cost sharing for children in this income category, another might elect to impose the maximum amounts allowed by the Secretary. In such a state, as Table I shows, the average child in a two-parent family with an income at 75 percent of poverty could be required to pay annual charges of \$187 and the same family with an income at 150 percent of poverty could be required to pay annual charges of \$223 -- more if coinsurance rather than copayments were applied. This would amount to 1.8 percent of income at 75 percent of poverty and 1.1 percent at 150 percent of poverty. If two children in the same family were participating in CHIP, annual charges could be \$446, or 3.6 percent of income for the family at 75 percent of income and 1.8 percent for a family at 150 percent of poverty.

The range of potential cost-sharing charges for children in higher income families would be somewhat wider. At one extreme, a state might forgo all premium, deductible, and coinsurance or copayment charges for all children in families with incomes above 150 percent of poverty. At the other extreme, it might impose cost-sharing charges amounting to five percent of a family's gross income. As shown in Table I, maximum annual charges for a two-parent family living at 185 percent of poverty would be \$1,263 with one child participating in CHIP and \$1,522 with two children participating. At 250 percent of poverty, maximum annual charges would be \$1,706 for one child and \$2,056 for two children.

Table I reveals two important facts regarding the imposition of maximum allowable cost-sharing charges on families of varying incomes. First, a significant disparity exists between what a family of four with an income of 150 percent of poverty might be required to contribute for two CHIP-enrolled children and what the same size family might be required to contribute if its income rose to 151 percent of poverty. At 150 percent of poverty there is essentially a "cliff" where families would be subject to significantly greater cost-sharing amounts, both in actual dollars and as a percentage of income. Second, and perhaps more surprising, is the fact that families living at 75 percent of poverty would be required to pay substantially more as a proportion of their income than families whose incomes are twice as high. This is because the maximum allowable premium rate set by the Secretary is the same for families living at 75 percent of poverty as those living at 150 percent of poverty. Moreover, since the per-child amount decreases only very slightly as family size increases for children living at or below 150 percent of poverty, families with four or five CHIP-enrolled children would have greater outlays at 75 percent of poverty than they would at 250 percent of poverty.

**Table I**

**Maximum Allowable Cost-Sharing\* Estimates Under CHIP  
by Family Income and Number of Children, 1998**

Percent of Federal Poverty Level	Number of Children				
	1	2	3	4	5
<b>75 percent</b>					
Family Income	\$10,238	\$12,338	\$14,438	\$16,538	\$18,638
Maximum Allowable Cost Sharing	\$187	\$446	\$633	\$844	\$1,055
Percentage of Income	1.83%	3.61%	4.38%	5.10%	5.66%
<b>100 percent</b>					
Family Income	\$13,650	\$16,450	\$19,250	\$22,050	\$24,850
Maximum Allowable Cost Sharing	\$223	\$446	\$633	\$844	\$1,055
Percentage of Income	1.63%	2.71%	3.29%	3.83%	4.25%
<b>101 percent</b>					
Family Income	\$13,787	\$16,615	\$19,443	\$22,271	\$25,099
Maximum Allowable Cost Sharing	\$223	\$446	\$633	\$844	\$1,055
Percentage of Income	1.62%	2.68%	3.26%	3.79%	4.20%
<b>150 percent</b>					
Family Income	\$20,475	\$24,675	\$28,875	\$33,075	\$37,275
Maximum Allowable Cost Sharing	\$223	\$446	\$633	\$844	\$1,055
Percentage of Income	1.09%	1.81%	2.19%	2.55%	2.83%
<b>151 percent</b>					
Family Income	\$20,612	\$24,840	\$29,068	\$33,296	\$37,524
Maximum Allowable Cost Sharing	\$1,031	\$1,242	\$1,453	\$1,665	\$1,876
Percentage of Income	5.00%	5.00%	5.00%	5.00%	5.00%
<b>185 percent</b>					
Family Income	\$25,253	\$30,433	\$35,613	\$40,793	\$45,973
Maximum Allowable Cost Sharing	\$1,263	\$1,522	\$1,781	\$2,040	\$2,299
Percentage of Income	5.00%	5.00%	5.00%	5.00%	5.00%
<b>200 percent</b>					
Family Income	\$27,300	\$32,900	\$38,500	\$44,100	\$49,700
Maximum Allowable Cost Sharing	\$1,365	\$1,645	\$1,925	\$2,205	\$2,485
Percentage of Income	5.00%	5.00%	5.00%	5.00%	5.00%
<b>225 percent</b>					
Family Income	\$30,713	\$37,013	\$43,313	\$49,613	\$55,913
Maximum Allowable Cost Sharing	\$1,536	\$1,851	\$2,166	\$2,481	\$2,796
Percentage of Income	5.00%	5.00%	5.00%	5.00%	5.00%
<b>250 percent</b>					
Family Income	\$34,125	\$41,125	\$48,125	\$55,125	\$62,125
Maximum Allowable Cost Sharing	\$1,706	\$2,056	\$2,406	\$2,756	\$3,106
Percentage of Income	5.00%	5.00%	5.00%	5.00%	5.00%

\* For two-parent families with incomes above 150 percent of poverty, we indicated the five percent maximum cost-sharing amount. For two-parent families with incomes at or below 150 percent of poverty, we projected the likely maximum cost sharing for an average child who would receive the following care annually: 1 preventive visit; 2 physician visit; 1 specialist office visit; 1 non-physician visit; 4 prescriptions; and 3 dental visits. As required under CHIP, we assumed the following copayments based on the Secretary's proposed schedule of charges for the medically needy: \$3 for physician office visits; \$5 for specialist office visits; \$3 for non-physician visits; \$2 for prescriptions; and \$3 for dental visits. We used the premium rates contained in federal regulations for the medically needy.

**Source:** Estimates were developed by the Health Policy Economics Group of Price Waterhouse for Fox Health Policy Consultants.

## ANALYSIS OF COST-SHARING OPTIONS

### Premium Options

All states using a non-Medicaid option need to consider whether to impose premium charges on some or all CHIP participants and, if so, how to structure the schedule of charges. With respect to children in families with incomes above 150 percent of poverty, a state could choose to establish a single premium rate or develop a rate schedule based on a sliding scale. These might be per-child rates that would decrease substantially for additional siblings or be capped at two or three children. Alternatively, a state could impose premium charges as a percentage of income, possibly stepping the percentages so that higher income families were required to pay a greater percentage of their income in premiums than lower income families. This type of arrangement might or might not take into account the number of siblings enrolled. With respect to children in families with incomes at or below 150 percent of poverty, a state that wanted to impose premiums could adopt the maximum allowable premium rates established by the Secretary or establish an alternative rate schedule that would eliminate charges for poor and near-poor families. As with children in families with higher incomes, a state could establish sliding-scale premium charges based on specific rates or a percent of family income.

In implementing any type of premium rate structure, states will want to consider the fairness of charges for children in families with varying incomes. They may not want to have lower income families pay more than higher income families as a percentage of income or have a dramatic increase in rates at a particular income level. An obvious way for a state to avoid these problems is to institute a single, graduated rate structure for all enrollees from the lowest to the highest incomes.

States will also want to consider how premium rates will influence the amount and composition of enrollment. As premium charges increase, enrollment undoubtedly will decrease, except perhaps for children who have chronic or significant health problems. A recent Urban Institute

study found that when premiums are one percent of income, a majority (57 percent) of the uninsured would participate in a publicly subsidized insurance program. If premiums are increased to three percent of income, however, then only 35 percent would participate, and at five percent of income, only 18 percent would participate.<sup>3</sup>

Yet states might be concerned about whether very low premiums will contribute to the “crowd out” of private insurance by creating a financial incentive for families to drop dependent coverage from their employer to take advantage of the lower cost sharing available through CHIP. Evidence from employer-based plans suggests that people are indeed price sensitive to premiums, at least in situations where plan disenrollment and enrollment are relatively easy. An analysis of the University of California’s 1994 move to discontinue subsidizing more costly plans found that roughly 25 percent of those facing premium increases of less than \$10 per month switched to lower cost plans and that greater premium increases led to even greater rates of plan switching.<sup>4</sup> Moreover, a recent survey of 450 employers nationwide reported that nine percent of respondents said that, while they would not drop or consider dropping dependent coverage for children if publicly subsidized insurance became available, they would increase the employees’ share of the premium for dependent coverage. The same survey found that 21 percent of employers currently contribute less than 35 percent toward the premium cost for dependents’ health insurance and an additional 16 percent contribute between 36 and 60 percent.<sup>5</sup>

Although crowd out could be a legitimate problem under CHIP -- (analyses of national data sets generally show a small, but significant, proportion of new Medicaid enrollees were estimated to

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<sup>3</sup> The Urban Institute’s study examined the uninsured in three states: Hawaii, Minnesota, and Washington. The uninsured fell into family income categories of 133 to 300 percent of poverty in Hawaii, 100 to 275 percent of poverty in Minnesota, and 25 to 200 percent of poverty in Washington. Ku L, Coughlin T: *The Use of Sliding Scale Premiums in Subsidized Insurance Programs*. Washington, D.C.: The Urban Institute, March 1997.

<sup>4</sup> Buchmuller TC, Feldstein PJ: Consumer’s Sensitivity to Health Plan Premiums: Evidence from a Natural Experiment in California. *Health Affairs* 15(1): 143-151, Spring 1996.

<sup>5</sup> Fox HB, and McManus MA.: *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.

have been privately insured)<sup>6</sup> -- it will be due to factors other than simply the pricing of CHIP premiums. For reasons related to CHIP or to the dynamics of the market place, an employer might eliminate health insurance coverage for employees or employees' dependents. While states could elect to structure premium charges so that CHIP participation is not particularly less expensive than dependent coverage offered to low and moderate income workers, this would have the effect of reducing CHIP participation by those without access to employer-based coverage.<sup>7</sup> Other strategies to address crowd out could have fewer unintended consequences. These would include financial penalties (through the tax code or labor code) for employers that drop or substantially reduce the value of coverage for dependent children to encourage their CHIP enrollment, a required period of uninsurance for children as a condition of CHIP eligibility, or contributions by CHIP toward the purchase of reasonable employer-based dependent coverage.<sup>8</sup>

Administrative costs are another concern for states in designing premium schedules. Costs may vary depending on the complexity of the premium schedule. A complex design with a heavily stepped schedule would be costlier to administer than one flat rate for all families with incomes

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<sup>6</sup> See Cutler DM and Gruber J: Medicaid and Private Insurance: Evidence and Implications. *Health Affairs*. 16:194-200, 1997; Dubay LC and Kenney GM: The Effects of Medicaid Expansion on Insurance Coverage of Children. *The Future of Children*. 6:152-161, 1996; Sheppard LD: Stemming the Tide: *The Effect of Expanding Medicaid Eligibility on Health Insurance Coverage*. Pittsburgh, PA: University of Pittsburgh. Manuscript submitted for publication, November 1997; Thorpe KE and Florence CS: Health Insurance Among Children: The Role of Expanded Medicaid Coverage. New Orleans, LA: Tulane University. Paper prepared for the Commonwealth Fund, November 1997; and Yazici EY and Kaestner R: *Medicaid Expansions and the Crowding Out of Private Health Insurance*. New York: Baruch College. Manuscript submitted for publication, January 1998.

Three of these studies used cross-sectional data from the Current Population Survey and estimated crowd-out rates -- measured as the proportion of new Medicaid enrollees who previously had employed-based coverage of 22 percent (Cutler and Gruber), 17 percent (Dubay and Kenney), and 15 percent (Sheppard). The remaining two studies used longitudinal data from the National Longitudinal Study of Youth and estimated rates of 16 percent (Thorpe and Florence) and 14.5 percent (Yazici and Kaestner). For Sheppard and Yazici, the above studies are revisions to earlier papers that found no evidence of crowd out.

<sup>7</sup> Of children in families with incomes between 133 and 185 percent of poverty, only about 50 percent have employer-based coverage and about five percent have non-group coverage. The Kaiser Family Foundation: *Choices Under the New State Child Health Insurance Program: What Factors Shape Cost of Coverage*. Washington DC: Kaiser Commission on the Future of Medicaid, January 1998.

<sup>8</sup> See our Fact Sheet #3, entitled *The Potential for Crowd Out Due to CHIP: Results From a Survey of 450 Employers* for a more in-depth discussion of these options.

above 150 percent the level of poverty. At the same time, however, there are certain fixed costs associated with premium collection, making it potentially as costly to collect a small premium as a large one. Thus, states may find that administrative costs are large as a percent of revenues if they choose complex premium schedules or if they collect small premiums. One way to reduce administrative expenses might be to offer families a financial incentive to purchase coverage on a quarterly, rather than monthly, basis.

### **Deductible Options**

Deductibles are another option that states may want to consider in structuring cost sharing. For children in families with incomes at or below 150 percent of poverty, deductibles cannot exceed \$2 per family per month. For children in families with incomes above 150 percent of poverty, however, deductibles may be structured in various ways. A single deductible may be required for medical services overall or separate deductibles may be applied to specific services (other than preventive services), and deductibles may be set for each child or all children in a family.

Although states might value deductibles as an easy way of maximizing cost sharing under CHIP, deductibles are best suited to traditional fee-for-service insurance, where coverage is in the form of reimbursement for services. Under managed care arrangements deductibles would function like a very high copayment. Moreover, regardless of the type of insurance, deductibles may discourage families, particularly those with the lowest incomes, from seeking necessary care for their children. Those whose children have special health care needs or are very sick would be the most likely to incur the full deductible expense.

### **Copayment or Coinsurance Options**

Copayments and coinsurance are the third type of cost-sharing option permissible under CHIP. States will need to determine whether to require copayments or coinsurance and, if so,

whether these should be applied to some or all CHIP participants. For children in families with incomes above 150 percent of poverty, a state would have substantial flexibility. It could set a schedule of copayment or coinsurance charges that could vary not only by type of service but also by family income. Presumably, however, copayments (a set charge per service) would be used where children were enrolled in a managed care organization, and coinsurance (a charge based on a particular percentage of the provider's fee) would be used where children were enrolled in a traditional fee-for-service insurance plan. For children in families with incomes at or below 150 percent of poverty, a state could choose to require participants, at least at certain income levels, to pay the maximum copayments or coinsurance amounts established by the Secretary, or it could choose to develop its own system of charges that would require lower payments.

In setting policies requiring copayments or coinsurance, states will want to consider the extent to which such charges would affect appropriate service utilization and impact future costs. Copayments and coinsurance are intended to reduce unnecessary care, but research has shown that families, particularly those with little discretionary income, may forgo necessary care as well. Studies that include children have reported reductions in service utilization for: all physician office visits;<sup>9</sup> mental health office visits for persons initiating treatment, regardless of their clinical history;<sup>10</sup> dental office visits, which were related to an increase in tooth decay;<sup>11</sup> emergency room visits, including those for conditions categorized as often likely to require hospitalization (such as asthma or sickle

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<sup>9</sup> Families enrolled in Medicaid were subject to a copayment of \$1 (approximately \$3.85 in 1997 dollars using the Consumer Price Index for all items). Helms J, Newhouse JP, Phelps CE: Copayments and Demand for Medical Care: The California Medicaid Experience. *The Bell Journal of Economics*. 9(1): 192-208, Spring 1978.

<sup>10</sup> Families enrolled in private health plans were subject to a copayment of \$20 (approximately \$28.25 in 1997 dollars). Simon GE et al: Impact of Visit Copayments on Outpatient Mental Health Utilization by Members of a Health Maintenance Organization. *American Journal of Psychiatry*. 153(3): 331-338, March 1996.

<sup>11</sup> Families enrolled in private health plans were subject to coinsurance rates of 0%, 25%, 50% or 95% or individual deductibles. Bailit HL et al: Dental Insurance and the Oral Health of Preschool Children. *Journal of the American Dental Association*. 113: 773-776, 1986.

cell crisis);<sup>12</sup> and prescription drug purchases for both discretionary and essential medications.<sup>13</sup> Two of these studies examined the effects of different copayment amounts and found that they were more pronounced with higher charges.<sup>14</sup> Moreover, the RAND Health Insurance Experiment found a pattern of greater cost-sharing effects on participants with lower incomes. Despite maximum expenditure limits based on income, the RAND study found that persons with lower incomes were likely to use outpatient services less frequently than those who had higher incomes.<sup>15</sup>

Another issue that states may want to address is the differential impact that copayments and coinsurance would have on children with or without serious chronic conditions. Since the annual amount of such charges is based on the number and type of services a child needs, a family whose child has a serious chronic condition would be expected to incur significantly greater copayment or coinsurance obligations than a family whose child has no chronic condition. As Table II shows, a family living at or below 150 percent of poverty might expect to have annual copayment charges of \$18 for a child without a chronic condition, \$153 for a child with a chronic neuromuscular condition, and \$211 for a child with a psychiatric disorder. A family living above 150 percent of poverty might

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<sup>12</sup> Families enrolled in private health plans were subject to copayments of either \$25 or \$35 (approximately \$27.75 or \$38.90 in 1997 dollars). Selby J, Fireman BH, Swain BE: Effect of a Copayment on Use of the Emergency Department in a Health Maintenance Organization. *The New England Journal of Medicine*. 334(10): 634-641, March 7, 1996.

<sup>13</sup> Families enrolled in private health plans were subject to a copayment of \$1.50 and \$3.00 (approximately \$2.40 and \$4.85 in 1997 dollars). Harris BL, Stergachis A, Reid DL: The Effect of Drug Copayments on Utilization and Cost of Pharmaceuticals in a Health Maintenance Organization. *Medical Care*. 28(10): 907-917, October 1990.

<sup>14</sup> When the copayments for mental health services increased from \$20 to \$30, utilization for persons already in treatment as well as for those initiating treatment decreased (Simon GE et al, 1996) and when prescription drug copayment increased from \$1.50 to \$3, purchases for essential as well as discretionary drugs decreased (Harris BL, Stergachis A, Reid D, 1990).

<sup>15</sup> Newhouse JP and the Health Insurance Experiment Group: *Free for All?: Lessons From the RAND Health Insurance Experiment*. Cambridge: Harvard University Press, 1993. The RAND study began fully enrolling participants in 1974. They were included in the lower income group if their family income was \$9,000 or less, which in 1974 was at or below 230 percent of the poverty level for a family of three. They were included in the higher income group if their family income was 15,000 or more, which in 1974 was at or above 318 percent of the poverty level for a family of three.

**Table II**

**Comparison of Likely Annual Copayments Under CHIP for a Two-Parent Family with One Child According to Health Status of Child,\* 1998**

<b>Percent of Federal Poverty Level</b>	<b>Child without a Chronic Condition</b>	<b>Child with a Chronic Neuromuscular Condition</b>	<b>Child with a Psychiatric Disorder</b>
<b>75 percent</b>			
Family Income	\$10,238	\$10,238	\$10,238
Likely Annual Copayments	\$18	\$153	\$211
Percentage of Income	0.18%	1.49%	2.06%
<b>100 percent</b>			
Family Income	\$13,650	\$13,650	\$13,650
Likely Annual Copayments	\$18	\$153	\$211
Percentage of Income	0.13%	1.12%	1.55%
<b>101 percent</b>			
Family Income	\$13,787	\$13,787	\$13,787
Likely Annual Copayments	\$18	\$153	\$211
Percentage of Income	0.13%	1.11%	1.53%
<b>150 percent</b>			
Family Income	\$20,475	\$20,475	\$20,475
Likely Annual Copayments	\$18	\$153	\$211
Percentage of Income	0.09%	0.75%	1.03%
<b>151 percent</b>			
Family Income	\$20,612	\$20,612	\$20,612
Likely Annual Copayments	\$29	\$242	\$344
Percentage of Income	0.14%	1.17%	1.67%
<b>185 percent</b>			
Family Income	\$25,253	\$25,253	\$25,253
Likely Annual Copayments	\$29	\$242	\$344
Percentage of Income	0.11%	0.96%	1.36%
<b>200 percent</b>			
Family Income	\$27,300	\$27,300	\$27,300
Likely Annual Copayments	\$29	\$242	\$344
Percentage of Income	0.11%	0.89%	1.26%
<b>225 percent</b>			
Family Income	\$30,713	\$30,713	\$30,713
Likely Annual Copayments	\$29	\$242	\$344
Percentage of Income	0.09%	0.79%	1.12%
<b>250 percent</b>			
Family Income	\$34,125	\$34,125	\$34,125
Likely Annual Copayments	\$29	\$242	\$344
Percentage of Income	0.08%	0.71%	1.01%

\* We assumed that annual care for a child without a chronic condition would consist of: 1 preventive visit; 2 physician office visits; 3 prescriptions, including refills; and 2 dental visits. We assumed that a child with a chronic neuromuscular condition would receive: 2 preventive office visits; 3 physician office visits; 3 specialist office visits; 1 emergency room visit; 24 prescriptions, including refills; 20 occupational therapy, physical therapy, and speech therapy visits; 2 dental visits; 1 durable medical equipment (wheelchair); and 1 vision exam and glasses. We assumed that a child with a psychiatric disorder would receive: 1 preventive office visit; 3 physician office visits; 1 specialist office visit; 18 prescriptions, including refills; 1 emergency room visit; 50 outpatient mental health visits; and 2 dental visits.

For families with incomes at or below 150 percent of poverty, as required under CHIP, we assumed the following copayments based on the Secretary's proposed schedule of charges for the medically needy: \$3 for physician office visits; \$5 for specialist office visits; \$2 for prescriptions; \$3 for dental visits; \$5 for emergency room visits; \$5 for vision exam and glasses; \$5 for occupational therapy, physical therapy, speech therapy visits; \$5 for durable medical equipment; and \$3 for mental health visits. For families with incomes above 150 percent of poverty, we have assumed the following copayments based on state CHIP copayments: \$5 for physician office visits; \$5 for specialist office visits; \$3 for prescriptions; \$5 for dental visits; \$10 for emergency room visits; \$5 for vision exam and glasses; \$5 for occupational therapy, physical therapy, and speech therapy visits; \$5 for durable medical equipment; and \$5 for outpatient mental health visits.

Source: Estimates were developed by Health Policy Economics Group of Price Waterhouse for Fox Health Policy Consultants.

expect to incur annual copayments of \$29 for a child without a chronic condition, \$242 for a child with a chronic neuromuscular condition, and \$344 for a child with a psychiatric disorder. Moreover, within both income groups, families with the smallest incomes could pay substantially more as a percent of their income than those with the largest incomes.

States could eliminate much of this disparity in copayment and coinsurance charges by limiting these charges and relying more on premiums, which are not affected by service utilization, or by capping the total amounts that families may be required to pay.<sup>16</sup> Alternatively, states could structure their copayment or coinsurance requirements so as to minimize the financial burden on families whose children have serious chronic conditions. A state could, for example, choose to cap cost-sharing charges for specific therapies, impose only one charge for multiple therapies furnished on a given day, permit a single charge to cover a three- or six-month supply of prescription drugs for a chronic condition, and eliminate cost sharing for visits related to chronic care management.

Since copayment and frequently also coinsurance charges are collected by providers, administrative issues associated with copayment and coinsurance requirements are not directly the states' concern. Yet states may want to consider the impact of these copayment and coinsurance charges on provider income and satisfaction. To whatever extent they are absorbed by providers, they function like a provider tax, reducing reimbursement for services. Given that CHIP-enrolled children are low income, some providers may choose not to collect the family's share of the service payment if they perceive that the family cannot afford to pay or they determine that the cost of collecting the copayment is not worth the effort.

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<sup>16</sup> This would be a particularly important strategy for states to consider with respect to children in families with incomes at or below 150 percent of poverty, since their overall cost-sharing charges are not capped. However, it also would be important with respect to children in families with incomes above 150 percent of poverty if premiums were set relatively low.

### **Five Percent Cost-Sharing Maximum**

States may pursue two different approaches for assuring that families with incomes over 150 percent of poverty in non-Medicaid plans do not exceed the five percent maximum out-of-pocket limit. One approach is to purposefully set premium rates and copayment or coinsurance charges at levels low enough so that no family would reach the five percent limit. Presumably this could be achieved by setting premium rates that were no more than two or three percent of family income and by capping copayment or coinsurance charges at an amount equal to one or two percent of family income. The state then would not have to establish any formal tracking or administrative mechanism to comply with the five percent maximum. The second approach is to establish reasonable premium and other cost-sharing requirements and assume that a small proportion of families would exceed the ceiling. Under this approach, each family, and its plan as well, would need to be informed at or shortly after enrollment of what its five percent maximum obligation was and how copayment or coinsurance charges would be handled after that amount was reached.

States following the second approach will need to determine whether cost-sharing payments will be tracked by each family or by the plan in which their children are enrolled. If the family is given the responsibility, it is likely to rely on a basic “shoe-box” approach. Such a system will be burdensome not only to families, particularly those with children who have chronic or substantial health problems, but also to states, which will be left to review families’ receipts to determine if the five percent cap has been exceeded. Having plans track out-of-pocket expenditures would seem to be more administratively efficient. Using their encounter database, plans could monitor premium, deductible, copayment or coinsurance amounts and immediately flag families who reach their five percent maximum.

States that choose not to cap all forms of cost sharing also will need to consider how provider reimbursement will be handled once a family has reached the five percent cost-sharing limit. Assuming that relatively few families will incur cost-sharing obligations greater than five percent of their incomes and that capitation amounts could be adjusted sufficiently, a state could simply require

plans to begin reimbursing providers in full. Alternatively, it could choose to have providers bill the CHIP program for the copayment or coinsurance amounts unpaid by families who had reached their limit, but this would be administratively burdensome and time consuming for both the provider and state. A state could also choose to have families continue to be responsible for their copayment or coinsurance obligations and then request a refund; however, given that CHIP families have little discretionary income, this arrangement could pose a financial hardship and possibly result in foregone care.

## **SUMMARY AND CONCLUSIONS**

States implementing non-Medicaid CHIP plans have several cost-sharing choices to consider. Premium charges can be eliminated altogether for at least some groups of children or they can be set as a single rate or as multiple rates adjusted according to income and also family size. Deductibles, if used, can be applied to some or all services. Copayments or coinsurance also can be eliminated, selectively used, or capped. Finally, compliance with the five percent maximum cost-sharing requirement can be achieved either by carefully structuring the combined charges for premiums, deductibles, and copayments or coinsurance or by establishing administrative mechanisms to track families' out-of-pocket expenses and reimburse providers or families after the five percent limit has been exceeded.

Research suggests, however, that different cost-sharing policies have different implications for program enrollment and service utilization. High premiums tend to reduce enrollment, while high coinsurance or copayments tend to reduce the utilization of services. Therefore, high premiums and minimal coinsurance or copayments might result in lower participation rates, with children who do participate utilizing many services. Alternatively, low premiums and high coinsurance or copayments might result in a large number of children enrolling but utilizing relatively few services.

States' cost-sharing decisions are likely to be based on numerous other factors as well, including the amount of state funds available, the size of the uninsured child population, the cost and complexity of administration, and concerns about fairness and personal responsibility. Deciding whether to impose premiums and other forms of cost sharing and, if so, how to structure a schedule of charges is obviously essential to the long-term success of a state's CHIP program. Arriving at the most appropriate cost-sharing policy may be difficult. States may have to experiment with these charges for the first few years of CHIP implementation while they monitor take-up and utilization rates for children in families with different incomes.