

Recent Policy Changes in Medicaid and SCHIP Coverage for Children:

What Works and What Doesn't?

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Recent policy changes at the federal and state levels have raised concerns about the future availability, affordability, and scope of subsidized health coverage for Florida's low-income children through Medicaid and the State Children's Health Insurance Program (SCHIP). Program changes that are looming on the horizon could affect who receives public insurance, the level and type of benefits eligible children receive, how much money their families must contribute, how eligibility will be determined, and how families will learn about available public insurance programs and coverage options. This essay examines key policy changes from 2000 to the present and analyzes the implications of these changes. Consideration of public health insurance for Florida's children is particularly timely due to three important legislative actions: (1) the pending reauthorization of SCHIP in 2007; (2) the section 1115 Florida Medicaid Reform demonstration waiver, which was approved in 2005 and began implementation on July 1, 2006; and (3) the Deficit Reduction Act of 2005 (hereafter, DRA), which was signed into law on February 8, 2006 and authorizes states to implement various changes to Medicaid without applying for and obtaining waivers.

Background:

Medicaid was enacted in 1965 under Title XIX of the Social Security Act as an entitlement program that provides health coverage to various low-income populations, including children. Mandatory eligibility groups include children from birth through age 5 in families with incomes up to 133% of the federal poverty level (FPL) and children ages 6 through 18 at or below 100% FPL (\$20,000 for a family of four in 2006). Optional eligibility groups include infants up to age one whose family income is up to 185% FPL; moreover, states can expand eligibility under section 1115 Medicaid waivers. Medicaid also covers children receiving adoption assistance and foster care under Title IV-E of the Social Security Act. Children covered under Medicaid are on average not only poorer but also sicker than those covered under SCHIP.

SCHIP was established in the Balanced Budget Act of 1997 (PL 105-33) as Title XXI of the Social Security Act to provide coverage for low-income uninsured children who do not meet Medicaid eligibility requirements. SCHIP is not an entitlement program, which means that families meeting the eligibility criteria do not automatically receive benefits. Legislative appropriations place a ceiling on annual federal and state expenditures and on enrollment. States were given the option of using SCHIP funds to expand existing Medicaid programs, create a separate SCHIP program, or employ a combination of the two. Florida elected the combination approach by expanding Medicaid for infants (less than one year old) and creating a separate SCHIP program for children ages 1 through 18 (MediKids for children ages 1-4 and Healthy Kids for children ages 5-18). States also have flexibility in setting income eligibility for their SCHIP programs. Most states – 30 in 2005 – cap SCHIP eligibility at 200% FPL. Eight states, however, set SCHIP eligibility below 200%, and 13 states set SCHIP eligibility above 200%. The lowest eligibility limit is 140% FPL in North Dakota, and the highest eligibility limit is 350% FPL in New Jersey. Table 1 summarizes the Medicaid and SCHIP eligibility requirements for California, Florida, New York, and Texas – the four most populous states with significant diversity among their populations. The SCHIP eligibility limit for Florida's and Texas' programs is 200% FPL, New York's is 208% FPL, and California's is 250% FPL.

Medicaid faces potentially significant changes in the coming years. As described below, the DRA affects program eligibility in Medicaid, allows states to implement increased family cost sharing, and gives states more flexibility in determining benefits. Prior to enactment of the DRA, Florida's Agency for Health Care Administration applied for and obtained a section 1115 demonstration waiver from the Centers for Medicare and Medicaid Services to implement a pilot program. The implications of DRA implementation in Florida for both the pilot program authorized by that waiver and the traditional Medicaid program remain to be seen.

The implementation of Florida's section 1115 pilot program begins in 2006 in Broward and Duval counties, with subsequent expansions to other parts of the state. Counseling to assist beneficiaries with plan selection (choice counseling) was available on July 1, 2006, and program enrollment begins on September 1, 2006.

Under Medicaid's traditional "defined benefit" plan, beneficiaries in counties other than Broward and Duval will continue to receive a guaranteed set of benefits established by the state and within federal guidelines. Under the pilot program, by contrast, beneficiaries in Broward and Duval counties will participate in a "defined contribution" program with risk-adjusted premiums. Beneficiaries can use these premiums to enroll in a Medicaid managed care plan contracted by the state; alternatively, they can opt out of Medicaid and use the risk-adjusted premium amount toward the purchase of employer-sponsored or private individual coverage that is not contracted by the state. Under the pilot program, families face a more complicated choice for their children because they must weigh the benefits and cost sharing requirements among the state and private plan options.

Traditionally, children are eligible for Medicaid benefits when they are determined to be eligible for the program. Under the reform waiver, children are only eligible for full coverage once they have selected a plan. Thus, families will have less time to make a decision and may feel pressured to make a health plan choice quickly. The pilot program allows for greater flexibility among the participating managed care plans in determining adult benefit limits, but this flexibility is not extended to children. Beneficiaries (including children) who opt out for private coverage, however, are subject to the selected plan's benefit limits and cost sharing requirements. Moreover, the state does not set specific standards for these benefits and requirements. However, the pilot seeks to promote greater utilization of recommended preventive services through its "Enhanced Benefits" program, which enables families to earn "credit dollars" for taking their children to dental exams, vision exams, and preventive care visits. These credits can be used to purchase approved health care products and supplies, such as over-the-counter medicines.

SCHIP also potentially faces major changes when it is due for reauthorization in 2007. Because it is a block grant, it has a fixed annual funding level. According to at least one report, severe shortfalls are anticipated if the annual funding remains frozen at its 2007 level with the reauthorization.¹ States facing shortfalls in SCHIP funding have typically responded by reducing eligibility, eliminating benefits, and/or increasing cost sharing in the form of increased copayments and/or premiums. The impacts of such changes are described later in this essay.

Florida's KidCare Program:

Florida began expanding public health insurance coverage for low-income uninsured children (who are ineligible for Medicaid) in 1990 when the Florida Legislature passed legislation establishing the Florida Healthy Kids Corporation. Following the federal authorization of SCHIP in 1997, the 1998 Florida legislature established the Florida KidCare Act. Florida KidCare provides Medicaid (Title XIX) and SCHIP (Title XXI) coverage to the state's uninsured children through the following four program components:

1. **Medicaid for Children** - provides coverage for children birth through age 18 meeting the eligibility requirements described above with Title XIX funding;
2. **MediKids** - a "Medicaid look alike" program that provides the equivalent of the Medicaid benefit package for children ages 1 through 4 with Title XXI funding;
3. **Florida Healthy Kids** - provides health coverage for children ages 5-18 with Title XXI funding; and
4. **Children's Medical Services Network** (hereafter, CMSN) - provides coverage for children ages 0-18 who have special physical or behavioral health care needs and who are eligible for either Title XIX or Title XXI funding. Children in this program must meet specific medical eligibility criteria.

Figure 1 provides a graphic representation of the age and income eligibility for the four KidCare program components. In addition, children from families with greater than 200% FPL can participate in the Healthy Kids program, but they receive no premium assistance. The full-pay premium for these children is \$98 per child per month for medical coverage and \$110 per child per month for dental and medical coverage. Existing law limits participation of full-paying families to 10% of total enrollees in the Florida Healthy Kids or MediKids program to prevent adverse selection.

Table 2 summarizes additional aspects of Medicaid and SCHIP in Florida. As shown in Table 2, four different state agencies have administrative responsibilities for the KidCare program, requiring

careful coordination of such administrative processes as eligibility determination and application processing. In addition, the Office of Insurance Regulation certifies, with certain statutory exceptions, health benefits coverage plans. Although MediKids and the CMS Network receive Title XXI (SCHIP) funding, they provide the Medicaid benefit package, whereas the Healthy Kids Program has a separate benefit package.

Program Financing:

For Medicaid and SCHIP, the federal government provides a matching rate based on the relative per capita income by state. Table 3 shows Medicaid and SCHIP program enrollment and financing for California, Florida, New York and Texas. In Florida, the federal match for FY 2006 is 58.89% for Medicaid and 71.22% for SCHIP. Although the federal match is more generous for SCHIP than for Medicaid, SCHIP, as a non-entitlement program, is subject to annual allocations. SCHIP programs also have relied on premium payments that are scaled to family income as an additional funding source. Some states, such as Florida and Texas, charge a “per family per month” (PFPM) amount – that is, there is a single premium amount regardless of the number of children covered. Other states, such as California and New York, charge a “per member per month” (PMPM) amount that applies to each child enrolled, but is subject to a maximum amount per family. Premium payments are not eligible for federal matching. The effect of such family cost sharing on program enrollment and disenrollment is described below.

Children with Special Health Care Needs:

Children with special health care needs (CSHCN) comprise a population that deserves comment because their treatment and services are typically more costly than are those for other children, and they are particularly vulnerable to poor outcomes when they lack access to health care. In Florida, for example, Title XXI expenditures per CMSN child were, on average, roughly four times the expenditures per child enrolled in Healthy Kids in SFY 2004-2005. The Maternal and Child Health Bureau’s definition of children with special health care needs are “those who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that required by children generally.”² Examples of diagnoses include diabetes, cerebral palsy, and attention-deficit hyperactivity disorder. In 2003, an estimated 13.5 million children in this nation had special health care needs. Of that total, an estimated 650,000 had no insurance. Of the children with health insurance, roughly two in five or 40% (over 5 million) were enrolled in either SCHIP or Medicaid. CSHCN (38.3%) received coverage through public health insurance programs at a much higher rate (38.3%) in 2003 than did children without special needs (26.9%). Moreover, CSHCN were less likely than other children to be covered by private health insurance, but also less likely to be uninsured. The rate of uninsurance for CSHCN was 4.8% compared to 8.3% for other children. SCHIP has improved coverage and access to care for CSHCN although they may still experience greater unmet needs than children without special needs.³

Similarly, Florida’s trends reflect the national findings of disproportionate enrollment of CSHCN in Medicaid and SCHIP. Although children with the most severe conditions are cared for in CMSN, CSHCN also are enrolled in other KidCare program components: 26% of Healthy Kids enrollees, 20% of MediKids enrollees, and more than 25% of Medicaid enrollees have a special health care need. This compares to an estimated 13-14% of CSHCN among the Florida’s children generally.⁴ Parents who believe their children have greater health care needs may be more inclined to obtain public insurance than parents of children without special needs because they experience an immediate and ongoing need for their children to receive health care services. It is also possible that if they have access to private-sponsored coverage, such coverage may not have sufficiently generous benefit packages to meet their children’s needs.

CSHCN in Florida’s Medicaid program may face particular challenges under the new Medicaid pilot program, which relies on risk-adjusted premiums. There are certain exceptions to mandatory participation in the pilot program for Florida Medicaid reform, which include children in foster care, those living in inpatient facilities, those enrolled in hospice, and individuals with developmental disabilities. Children with chronic conditions (but not with developmental disabilities), however, are in the mandatory participation group. The current risk adjustment model for these children is to consider those enrolled in CMSN as an already risk adjusted pool. Premiums for these children are determined based on their past health care utilization. However, there are children in Medicaid who have special health care needs that are not severe enough to qualify for enrollment in CMSN. It is not clear how well the risk-adjusted

premiums will reflect individual health needs of CSHCN who are not enrolled in CMSN or how the changes in the financing and delivery of care will affect their access to needed health services

Profile of Uninsured and Covered Children – Florida and the Nation:

Figure 2 reflects the nationwide uninsurance rate of children from 2000-2004. The percentage of uninsured children in the nation decreased from 12.3% in 2000 to 11.6% in 2004, although that change is not considered to be statistically significant. During the same period, the percentage of children covered by Medicaid increased by roughly 4 percentage points, from almost 17% in 2000 to almost 22% in 2004. The uninsurance rate for children declined at the same time as the uninsurance rates for nonelderly adults increased and employer-based coverage declined by about 5 percentage points. Total SCHIP enrollment nationally grew from 1.8 million in 1999 to 3.9 million in 2004. SCHIP enrollment has stayed fairly steady at around 3.9 million since 2003, peaking in March 2003, then declining in June 2004 and rebounding to almost the March 2003 level in December 2004.

Mirroring the national trend, the uninsurance rate of Florida's children (under age 19) has likewise declined from 13.9% in 1999 to 12.1% in 2004. During that time period, coverage for children under Medicaid and SCHIP increased from 17.2% in 1999 to 30.8% in 2004.⁵ In addition, employment-based coverage decreased by 10% over the five-year period, from 58.4% in 1999 to 48.5% in 2004. Employment-based coverage trends should be considered in conjunction with public insurance coverage trends because employment-based coverage and public coverage are linked. However, the degree to which public insurance fills gaps in private coverage versus substitutes for – or “crowds out” – private coverage is subject to debate. “Crowd-out” occurs when individuals drop their private coverage or employers change their insurance offerings because public coverage is available. Have employers reduced their insurance offerings because of increased availability of public insurance? Or has enrollment grown in public insurance programs because employers are offering less coverage due to other factors, such as deteriorating economic conditions and/or increasing inflation in health care costs? Or is it a combination of both causes?

Much of the decline in uninsurance among children has been attributed to SCHIP. A recent report to Congress indicated that SCHIP was successful in nearly all of the areas evaluated: states designed generous programs promptly, designed effective outreach strategies for promoting awareness and enrollment, developed simplified application and enrollment processes, and effectively targeted populations of diverse racial and ethnic backgrounds to be served. These efforts reduced uninsurance rates, improved children's access to health care services, and developed programs that met with general family satisfaction. SCHIP also appears to have promoted greater enrollment among Medicaid eligible children.⁶

Despite the initial rapid decline in uninsurance rates among children after SCHIP implementation, millions of children remain uninsured, and 62% of children who are uninsured qualify for Medicaid or SCHIP – these are the “uninsured eligibles.” In addition, a substantial proportion of children who exit from SCHIP become uninsured rather than moving to another source of coverage, with lower rates of post-SCHIP uninsurance in states that have separate programs compared to those that have Medicaid expansion programs.⁷

Issues Raised by Policy Changes – Florida and the Nation:

Several overarching features of Medicaid and SCHIP have been transformed by programmatic policy changes in recent years. Below we focus on three: (1) eligibility requirements, (2) enrollment and renewal procedures, and (3) cost sharing. We note that other features, including but not limited to outreach activities, the scope and nature of benefits for enrollees, and risk adjustment, have also been affected by policy changes, but these features are not addressed in depth in this essay.

Eligibility Requirements:

Eligibility requirements - such as age, family income, and citizenship status – and eligibility verification procedures have the most direct influence on which children enroll in public health insurance programs. The DRA affects federal Medicaid eligibility by requiring explicit documentation of citizenship for all new applications and all renewals (eligibility redeterminations) occurring on or after July 1, 2006. For children, this requirement would mean that parents would have to present documentation, such as their child's birth certificate, to the state agency handling Medicaid. Prior to that date, families could “self-

declare” their U.S. citizenship in their applications for Medicaid, under penalty of perjury, with states subsequently verifying the declarations through state databases. As of June 2006, all states except four (Montana, New Hampshire, New York, and Georgia) exercised the self-declaration option. Although the DRA does not change the eligibility requirements for citizens and immigrants, it makes the process of establishing eligibility more difficult, thereby creating a barrier to Medicaid enrollment. The effects of the DRA are expected to add complexity to the process of applying for and renewing Medicaid, increase costs to state agencies charged with evaluating eligibility (and the DRA does not provide for additional federal funding), and increase delays for children to receive needed care.⁸

State SCHIP programs also have experienced policy changes affecting eligibility requirements and verification procedures. Because SCHIP is not an entitlement program and legislative appropriations place a ceiling on annual expenditures, states have implemented more generous or more restrictive policies in response to changes in the general fiscal health of their budgets, their SCHIP federal allocations, and program enrollment expansions and contractions. This often leads to fluctuating program policies that not only affect eligibility and enrollment, but also create uncertainty for existing and potential enrollees and their families. The experiences of Texas and Florida are illustrative. Figures 3 and 4 show key SCHIP policy changes in each state along with program enrollment trends. Texas took the following actions that affected eligibility determinations: (1) in November 2003, income deductions, such as child care costs, were eliminated in income eligibility determinations, (2) in October 2003, the continuous eligibility period was reduced from 12 months to 6 months, and (3) in August 2004, an asset test was established for families with incomes above 150% FPL.

In July 2004, Florida implemented new income verification procedures for new applicants and renewals. Although the income eligibility requirements did not change, families were required to provide proof of earned income using income tax returns, W-2 forms, or payroll stubs as well as documentation verifying child support payments and proof of unearned income such as Social Security or unemployment benefits. Previously, families self-reported income with separate verification by the state using existing federal and state databases. Other policy changes have tightened eligibility requirements in Florida in recent years:

- A 2004 statutory amendment disqualifies children from benefits if the child is eligible for a family member’s group health policy (e.g., employment-based insurance) provided that the cost of the child’s participation is not greater than 5 percent of the family’s income. A child is ineligible if his or her private coverage was voluntarily cancelled within the last six months.
- The eligibility of children of state employees ended effective January 1, 2005.
- Effective January 31, 2004, noncitizens who do not meet the definition of “qualified alien” may not receive program benefits.

Children ages 1-4, however, will benefit from a legislative change in 2006 (HB 241). This amendment authorizes families with incomes of greater than 200% FPL whose children are ineligible for Title XXI financing for the MediKids component to “buy in” to the program at the full premium. Prior to this change, only children who participated in the Florida Healthy Kids Program (ages 5-18) could avail themselves of this buy-in option.

Enrollment and Renewal Procedures:

Because SCHIP is not an entitlement program, states experiencing fiscal downturns or unexpectedly high enrollment may place enrollment caps or other enrollment limitations in their SCHIP programs to reduce program expenditures. Such was the case in 2003 with Alabama, Colorado, and Florida, where negative political pressure resulted in the subsequent removal of those caps. Florida’s enrollment experiences are illustrative. When the Florida Healthy Kids Program was overenrolled in 2003, a waiting list was implemented. The waiting list persisted until the spring of 2004 when SCHIP insurance for those on the list was funded. At the same time, however, limited open enrollment periods replaced year-round enrollment, and waiting lists were no longer maintained. The first open enrollment period occurred in January 2005. Enrollment was then closed again from February 2005 until July 2005 when year-round (continuous) open enrollment was reinstated.

The limited open enrollment period combined with new income verification requirements in Florida presented enrollment barriers to families. Approximately 44 percent of new enrollees in the KidCare program in FY 2004-2005 who were surveyed as part of the annual KidCare evaluation reported waiting three or more months between their application submission and approval of coverage.⁹ This can be attributed to two main factors: (1) the backlog in application processing due to the high volume of

applications submitted during the January 2005 open enrollment period and (2) families submitting incomplete application information that did not meet the new documentation requirements, thereby necessitating requests from program administrators for additional documentation and clarification in order to complete the application process.

The income verification requirements that applied to new applicants also applied during eligibility redeterminations, or renewals. As a result, the renewal process for the Florida Healthy Kids Program changed from a passive process to an active process by requiring all families to provide documentation to verify program eligibility, including (1) proof of income as described above and (2) information about their access to employer-sponsored family coverage and the cost of such coverage if it is available to them. This documentation must be provided at each redetermination, which currently occurs every twelve months. In the past, families whose children were enrolled in Healthy Kids (and other Title XXI KidCare components) received a letter notifying them about renewing their children's coverage. Families were asked to contact the program to report any changes or to update information about their income and health insurance coverage. Nonrespondent families with no changes to report maintained Healthy Kids coverage for their children if they continued to pay their premiums. Under the active renewal process now in effect, nonresponse results in program disenrollment. Descriptive analyses conducted for the year following the implementation of active renewal found that approximately 79% of Title XXI children up for renewal from September 2004 to January 2005 successfully completed the renewal process. The renewal rate increased to 84% for those due to renew between March 2005 through June 2005, with the highest renewal rates for children enrolled in CMSN Title XXI (87.6%). In general, households with older children and households with incomes closer to poverty (below 150% FPL) were less likely to renew their children's coverage than households with younger children and households with incomes greater than 150% FPL.¹⁰

The combined effects of the limited enrollment periods and increased documentation requirements on new applications and renewals may largely explain the decline in program enrollment that occurred during fiscal year 2004-2005. In July 2003 when the enrollment caps were imposed and the wait list was started for SCHIP, 326,755 children were enrolled; that number increased somewhat when the children from the wait list were allowed to enroll in April 2004 but subsequently declined to 202,433 in July 2005, one year after the income verification requirements and limited enrollment periods were implemented. In addition to the 37% decline in enrollment among Title XXI Healthy Kids enrollees, CMSN Title XXI enrollment declined by 25% during the same time period. A total of 10,053 children were enrolled in CMSN Title XXI in July 2004 when the statutory changes took effect requiring additional documentation. After July 2004 enrollment declined to 7,564 in January 2006, the lowest enrollment since July 2002. In the past several months, however, enrollment has steadily climbed, reaching 9,668 in August 2006.¹¹

States seeking to promote new program enrollment and retention of existing enrollees should examine their enrollment and renewal policies as well as the socio-demographic characteristics of the eligible uninsured and those disenrolling from the program. For example, according to a report of findings from recent telephone surveys of Texas' Medicaid Managed Care Program (known as STAR) and Texas' Children's Health Insurance Program (known as CHIP), a statistical difference existed in the percentage of single parent households renewing (35%) versus not renewing (28%) CHIP coverage. Both the primary language of Spanish in the house and a parental lack of a high school education were also statistically significant factors for nonrenewal in CHIP. Therefore, policies to improve renewal numbers might be most effectively aimed at these target populations. Because missing information in renewal submittals was also found to contribute to lower renewal numbers, the Texas report recommended development of a strategy to review the processes for managing that missing information with enrollment brokers.¹²

Outreach strategies adopted to promote program awareness and to assist families in completing the application process can also affect program enrollment. At the same time that Florida adopted more restrictive enrollment procedures, outreach funding also was severely restricted. However, the 2006 Florida Legislature allocated \$1 million dollars for a matching grant program designed to promote innovative outreach strategies among local communities. This initiative is being administered by the Florida Healthy Kids Corporation, with outreach activities scheduled to begin in fall 2006.

SCHIP and Medicaid participation rates for poor children also might improve if the federal government changed the law or granted state waivers to permit automatic enrollment of uninsured children who qualify for these programs. These waivers could authorize the use of information that state

officials already have to determine eligibility and enroll children rather than require families to apply specifically to SCHIP and Medicaid, as is presently the case. Two impediments that such legislation or waivers could redress are: (1) state computer systems for administering health and non-health programs that currently do not communicate with each other; and (2) current laws that create barriers to using final income determinations from other means-tested programs to determine SCHIP and Medicaid eligibility due to different methodologies for computing household income. The first problem might be resolved through federal funding of an information technology platform that could enable electronic exchange between different systems and the analysis of eligibility information. The second problem could be addressed by allowing states to disregard methodological differences of calculating household income for programs that have substantially similar eligibility requirements to SCHIP and Medicaid.¹³ In addition, the implementation of auto-enrollment would need to address such issues as the protection of privacy, different treatment in public non-health and health programs of the immigration status for income eligible children, and recordkeeping differences in public non-health and health programs.

Cost Sharing:

Enrollee cost sharing (or beneficiary contributions) can take different forms: premium payments for the insurance itself, enrollment fees, and different cost-sharing arrangements for services rendered such as copayments, coinsurance, or deductibles. Proponents believe that cost sharing can make individuals more price-conscious, thereby decreasing the use of potentially unnecessary medical care. The Congressional Budget Office (CBO) estimates \$6.93 billion in savings to the Medicaid program nationally from 2006 through 2015 if states implement higher cost-sharing requirements as permissible under the DRA. The CBO notes that 80 percent of the savings are expected to come from reduced health care or prescription drug use and the remaining 20 percent is expected to come from lower payments to providers. Others believe that while cost sharing may reduce some unnecessary care, it also deters the use of needed services potentially resulting in more severe illness when care is sought. In fact, several studies demonstrate that cost-sharing increases may have unintended consequences such as increased disenrollment from public insurance programs, potentially contributing to increases in those without insurance coverage, increased emergency room use due to the inability to afford the cost sharing for physician visits, and failure to fill needed prescriptions.¹⁴

While cost sharing strategies are commonly used in SCHIP programs, they have not been widely used in Medicaid due to greater federal limitations on beneficiary contributions. However, some states have implemented cost-sharing requirements in Medicaid to the extent permissible or through section 1115 waivers, and others are considering cost sharing as part of Medicaid restructuring proposals. A 2004 General Accounting Office (GAO) report of cost-sharing practices among states summarizes the differences between the two programs.¹⁵ Copayments were more frequently used in SCHIP than in Medicaid. States requiring cost-sharing typically relied on copayments and were less likely to use coinsurance or deductibles. At the time the GAO report was prepared, 21 states required copayments for children in SCHIP but not in Medicaid, two states had copayments for children in Medicaid, and four states required copayments in both programs. The copayment amounts varied from as low as \$1 for physician visits in Missouri's Medicaid Program to as high as \$25 in Tennessee's Medicaid Program. Coinsurance was used in three states for inpatient stays, outpatient hospital use, non-emergency ER use, and dental services.

The Deficit Reduction Act (DRA) of 2005 allows for greater flexibility in the federal Medicaid rules governing premiums and cost sharing. Table 4 summarizes the rules prior to the DRA and the changes that states can introduce as a result of the DRA. These changes allow for limited copayments/coinsurance for children with family income up to 150% FPL and for limited premiums and copayments/coinsurance for children with family income greater than 150% FPL. These new rules went into effect on March 31, 2006.¹⁶ Providers will be permitted to deny care to those who cannot meet the cost sharing requirements; prior to the DRA, this was not permissible. States also can require prepayment of premiums and terminate coverage for those who fail to pay within 60 days.

Analyses of the impact of different cost-sharing practices that have been adopted by the states provide some insight into the potential effects of the DRA. In general, studies have found that required copayments reduce utilization. For example, an analysis by the Center on Budget and Policy Priorities (CBPP) found that copayments for prescription drugs and outpatient hospital care in Utah's Medicaid program reduced prescription drug use and outpatient visits.¹⁷ With double digit annual growth from 1993 through 2003, prescription drug spending has been a primary driver of the growth in health care

expenditures in recent years; therefore, it also has been a primary target for cost sharing. While only four states currently require copayments for prescription drugs for children covered by Medicaid, more than thirty states require copayments for prescription drugs for adult populations covered by Medicaid.¹⁸

Under DRA, it is reasonable to expect an increasing number of states to also charge copayments for prescription drugs for children receiving Medicaid benefits. Such a policy change could lead to a decrease in prescription drug utilization among enrolled children. A study of all 50 states examined states' practices regarding copayments for prescription drugs in their Medicaid programs. It found that copayments were associated with significant reductions in prescription drug use.¹⁹ These findings are consistent with the findings of other studies that largely show a decline in service and prescription drug use for both minor and serious health care needs. Reduced drug use is most pronounced among Medicaid recipients in the lowest income categories and/or in the poorest health.

A missing component of many of these studies, however, is that they typically lack formal assessments of the impact of the reduced utilization on clinical outcomes and patient health status. The impact of cost sharing on utilization, clinical outcomes, and health status is an important area for further analysis, especially among CSHCN who require regular health care monitoring and who often need prescription drugs to ensure good clinical management of their health conditions. States should carefully evaluate and monitor the impact of cost sharing on clinical outcomes and health status to avoid unintended adverse consequences associated with cost sharing requirements.

Whereas copayments have a direct impact on utilization, premiums can affect program enrollment behaviors. Studies of premiums in SCHIP programs in Florida, New York, and New Jersey suggest that the introduction of premiums and premium increases are associated with increased disenrollment. Studies in Florida and experiences in other states indicate that enrollment of low income families is especially sensitive to changes in premium payments.²⁰ Increased disenrollment, in turn, can contribute to increases in the numbers of uninsured and thus to increased ER use and delays in seeking treatment for both minor and serious problems. For example, about two-thirds of those who disenroll from the Florida's KidCare Program become uninsured - a trend similar to that of other states. States experiencing growing disenrollment and uninsurance need to monitor changes in ER use and the response times of disenrollees in accessing treatment for medical problems. Moreover, while reduced program enrollment might lead to savings in state funds, it may also contribute to the loss of some federal match funds. Therefore, states also need to carefully examine the overall budget impact of cost-sharing requirements.²¹

Other Issues:

The above issues have received the most attention in evaluations and research of Medicaid and SCHIP programs. But other issues, such as benefit coverage and the use of risk adjustment in setting premiums, have become increasingly significant in light of recent reforms. At the federal level, DRA allows for greater flexibility in defining the benefits provided. Kentucky is one of the first states to change its Medicaid program under DRA. Its targeted benefit plans include benefit limits relative to the traditional Medicaid package provided prior to DRA, but also include an emphasis on disease management and incentives for health-promoting behaviors. The Kentucky experience will be important to follow to see how Medicaid enrollees' access to health services and health status are affected. At the state level, in the Florida Medicaid reform pilot areas, benefit packages can vary among families who opt out of the state Medicaid program for private coverage. Another important feature of Florida's Medicaid reform is the use of risk-adjusted premiums, which may impact access to care and health outcomes, particularly for CSHCN, but also for the overall population due to budget neutrality requirements.

Pilot demonstrations can be an instructive way to determine the effects of proposed policy reforms before significant changes are implemented on a large scale. Such an example is Florida's Medicaid dental reform effort in Miami-Dade County. This reform implemented a prepaid dental health plan (PDHP) where the health plan forms the provider network and bears the financial risk of beneficiary care. An initial evaluation of this pilot has resulted in mixed findings. On the one hand, a greater percentage of parents reported that their children saw a dentist since enrolling in the PDHP compared to reports of dental use by children covered by Medicaid in other parts of the state. On the other hand, analyses of administrative claims and encounter data found a decline in dental use rates and access to dental care after the change to the PDHP. There also was significant dissatisfaction among dental providers with the dental plan administering the PDHP.²² In addition to these initial findings which highlight the initial progress and shortcomings of this pilot initiative, the evaluation process itself has been

valuable in soliciting feedback from a variety of stakeholders – families, dental providers, and the participating dental plan. The dental plan provided extensive documentation and is working to improve the areas in which deficiencies were identified as well as to promote better data collection among its participating providers. Consequently, the evaluation process itself not only informs future policy, but it also results in recommendations about how to improve the provision of care and the methods for collecting and evaluating data. The lessons from dental reform in Miami-Dade County can provide guidance for the Medicaid reform efforts underway in Broward and Duval counties. These pilot sites would benefit from careful and ongoing evaluation and monitoring before reform efforts are extended to other parts of the state.

Finally, as mentioned above, carefully targeted outreach efforts can help to improve program enrollment. But outreach need not only be focused on generating new applications, it also can promote greater utilization of recommended preventive health services among enrolled children. Community based organizations (CBOs) play an important role in the various types of outreach efforts; therefore, it is important to have strong channels of communication among the state agencies, participating health/dental plans, and CBOs. Because of federal legal restrictions on sharing personal health information, these parties need to identify ways to effectively target outreach efforts without violating privacy laws, such as sharing de-identified information about the characteristics of the populations that are not taking up insurance, dropping out of the program, and experiencing low utilization rates for needed services.

The View From Here: Are We Meeting the Goals of Providing Affordable and Accessible Health Care Coverage for Children?

The Florida Legislature's original intent in crafting the KidCare legislation in 1998 was to ensure that Florida's low-income children would have access to affordable health care coverage. To ensure *affordability*, the statement of purpose for the Florida KidCare Program reads:

The Florida KidCare program is created to provide a defined set of health benefits to previously uninsured, low-income children through the establishment of a variety of *affordable* health benefits coverage options from which families may select coverage and through which families may contribute financially to the health care of their children.

We also know that the Legislature was concerned about the *availability* of comprehensive health insurance coverage:

The Legislature finds that increased access to health care services could improve children's health and reduce the incidence and costs of childhood illness and disabilities among children in this state. Many children do not have comprehensive, affordable health care services available. It is the intent of the Legislature that the Florida Healthy Kids Corporation provide comprehensive health insurance coverage to such children. The corporation is encouraged to cooperate with any existing health service programs funded by the public or the private sector.

The lessons learned from states' experiences with recent policy changes affecting Medicaid and SCHIP eligibility requirements, enrollment and renewal procedures, and cost sharing – give rise to several questions as we look to the future of these programs:

- What are the potential impacts on the Florida KidCare Program of recent and pending changes at the federal and state levels – DRA, Florida Medicaid reform, and SCHIP reauthorization?
- What are the opportunities and challenges these recent/pending changes pose for affordability, access to care, and health outcomes?
- Are certain populations likely to be disproportionately affected? If so, what measures can the state take to address potential disparities?
- Given limited resources for SCHIP and the current uncertainty regarding future federal funding, what actions can the state take to maximize the effectiveness of SCHIP?
- What are the strengths of the administrative, enrollment, and program transition processes between the different KidCare components, and what are the opportunities for further improvement? Should Florida pursue a section 1115 waiver to move towards auto-enrollment or a similar mechanism?
- How can outreach efforts be improved to target more effectively those who are eligible but have never enrolled and to promote improved utilization of recommended preventive care among those who have enrolled?

- What should be the key priorities for Medicaid and SCHIP programs as we look to the future?
- What research gaps need to be addressed in order to help inform policy decisions that will promote better health outcomes for children?

Addressing these questions is critical to ensuring that Florida's legislative goals are effectively realized.

Conclusion:

The impact of DRA, Florida Medicaid Reform, and the upcoming SCHIP reauthorization on Florida's poorest children is uncertain. There is no crystal ball to predict accurately the effects of policy changes on the access of poor children to health care. But we know that these changes are likely to affect: who is eligible; what medical services are available and used; how these services are financed; what financial risks are assigned to eligible children's families, providers and insurance plans; how income verification, enrollment, disenrollment, and renewal processes are handled; and how families are informed about the programs and the associated health plan and benefit options. We also know that there will be ongoing debate about the best ways to assess the impact of policy changes on public insurance enrollment and retention; the affordability, availability, and use of covered services; uninsurance rates; "crowd-out;" families' satisfaction and dissatisfaction with benefits received; and health outcomes from covered services. Although it is unclear how the DRA provisions, the section 1115 waiver program, and a reauthorized SCHIP will interface in the longer term, it is clear that we are entering into uncharted territory and the necessary first step is to ask the right questions and begin a meaningful dialogue about these important issues.

Acknowledgements: The authors appreciate the comments of Dr. Elizabeth Shenkman, Dr. David Colburn, and Dr. Lynn Leverty, University of Florida, on an earlier version of this essay.

Table 1: Age and Income Eligibility for Medicaid and SCHIP

State	Medicaid Title XIX	SCHIP-Medicaid Expansion Title XXI	SCHIP-Separate Program Title XXI
California	0-1: 0-200% FPL 1-5: 0-133% FPL 6-18: 0-100% FPL	One month bridge from Medicaid to SCHIP.	0-1: 201-250% FPL 1-5: 134-250% FPL 6-18: 101-250% FPL
Florida	0-1: 0-185% FPL 1-5: 0-133% FPL 6-18: 0-100% FPL	0-1: 186-200% FPL	1-5: 134-200% FPL 6-18: 101-200% FPL
New York	0-1: 0-200% FPL 1-5: 0-133% FPL 6-18: 0-100% FPL	NA	0-1: 201-208% FPL 1-5: 134-208% FPL 6-18: 101-208% FPL
Texas	0-1: 0-185% FPL 1-5: 0-133% FPL 6-18: 0-100% FPL	NA	0-1: 186-200% FPL 1-5: 134-200% FPL 6-18: 101-200% FPL

Notes: NA=Not Applicable

Source: National Academy for State Health Policy. 2005. "Income Eligibility and Cost Sharing for Children in Medicaid and SCHIP and Other Populations Covered with SCHIP Funds;" available at: http://www.nashp.org/Files/Elig_and_cost_sharing_Aug_2005.pdf.

Table 2: Florida’s Medicaid and SCHIP Programs

	Medicaid Title XIX	SCHIP Title XXI
Program Components	<p>Medicaid: Coverage for children, families, pregnant women, the elderly, and disabled people who meet financial and categorical eligibility requirements</p> <p>CMS Network: Title XIX eligible children with special health care needs</p>	<p>Medicaid expansion: children under age 1 with family income 186-200% FPL</p> <p>MediKids: Children ages 1-4</p> <p>Healthy Kids: Children ages 5-18</p> <p>CMS Network: Title XXI eligible children with special health care needs</p>
Program Administration	<p>Department of Children and Families – determines Title XIX program eligibility – administers the Behavioral Health network</p> <p>Department of Health – administers CMS Network and determines clinical eligibility</p>	<p>Department of Children and Families – administers the Behavioral Health network</p> <p>Department of Health – administers CMS Network and determines clinical eligibility</p> <p>Agency for Health Care Administration – administers the MediKids program</p> <p>Florida Healthy Kids Corporation – determines non-Medicaid KidCare program eligibility</p>
Description	<p>Entitlement: State must cover all individuals who meet financial and categorical eligibility requirements</p> <p>Services Provided: – State must cover certain services at specified level – Comprehensive health benefits including dental and transportation services are included.</p>	<p>Non-entitlement: State may limit enrollment based on funding availability</p> <p>Services Provided: – State has greater discretion in service offerings compared to Title XIX – MediKids and CMS Network: Medicaid benefit package – Healthy Kids: Comprehensive benefits, including dental</p>
Eligibility Requirements	<ul style="list-style-type: none"> – Meet age and income eligibility – May have other health insurance – U.S. citizen or qualified non-citizen – May be a dependent of state employee eligible for state health benefits – Not in a public institution or institution for mental diseases 	<ul style="list-style-type: none"> – Meet age and income eligibility – Uninsured and ineligible for Medicaid – U.S. citizen or qualified non-citizen – Not a dependent of state employee eligible for state health benefits – Not in a public institution or institution for mental diseases

Source: Florida KidCare Coordinating Council FY 2006-07 Annual Report and Recommendations; available at: <http://www.floridakidcare.org/council.html>.

Table 3: Medicaid and SCHIP Enrollment and Financing

<i>State</i>	<i>Enrollment December 2004</i>		<i>Federal Matching Rate</i>		<i>Premiums</i>
	<i>Medicaid</i>	<i>SCHIP</i>	<i>Medicaid</i>	<i>SCHIP</i>	<i>SCHIP</i>
California	3,920,800	771,283	50.00%	65.00%	100-150% FPL: \$7 PMPM (\$14 max) 151-200% FPL: \$9 PMPM (\$27 max) 201-250% FPL: \$15 PMPM (\$45 max)
Florida	1,462,800	271,946	58.89%	71.22%	101-150% FPL: \$15 PFPM 151-200% FPL: \$20 PFPM
New York	2,027,200	452,938	50.00%	65.00%	101-133% FPL: None 134-185% FPL: \$9 PMPM (\$27 max) 186-208% FPL: \$15 PMPM (\$45 max)
Texas	2,251,500	335,751	60.66%	72.46%	101-150% FPL: \$15 PFPM 151-185% FPL: \$20 PFPM 186-200% FPL: \$25 PFPM

PMPM – per member (child) per month; PFPM – per family per month

Sources: Kaiser Family Foundation. 2005. "SCHIP Enrollment in 50 States: December 2004 Data Update," Kaiser Commission on Medicaid and the Uninsured; Georgetown University Health Policy Institute Center for Children and Families, "Medicaid and State Children's Health Insurance Program Federal Match Rate (FMAP), FY 2006; National Academy for State Health Policy. 2005. "Income Eligibility and Cost Sharing for Children in Medicaid and SCHIP and Other Populations Covered with SCHIP Funds.

**Table 4: Federal Medicaid Standards for Premiums and Cost Sharing
Prior to and Post the DRA of 2005***

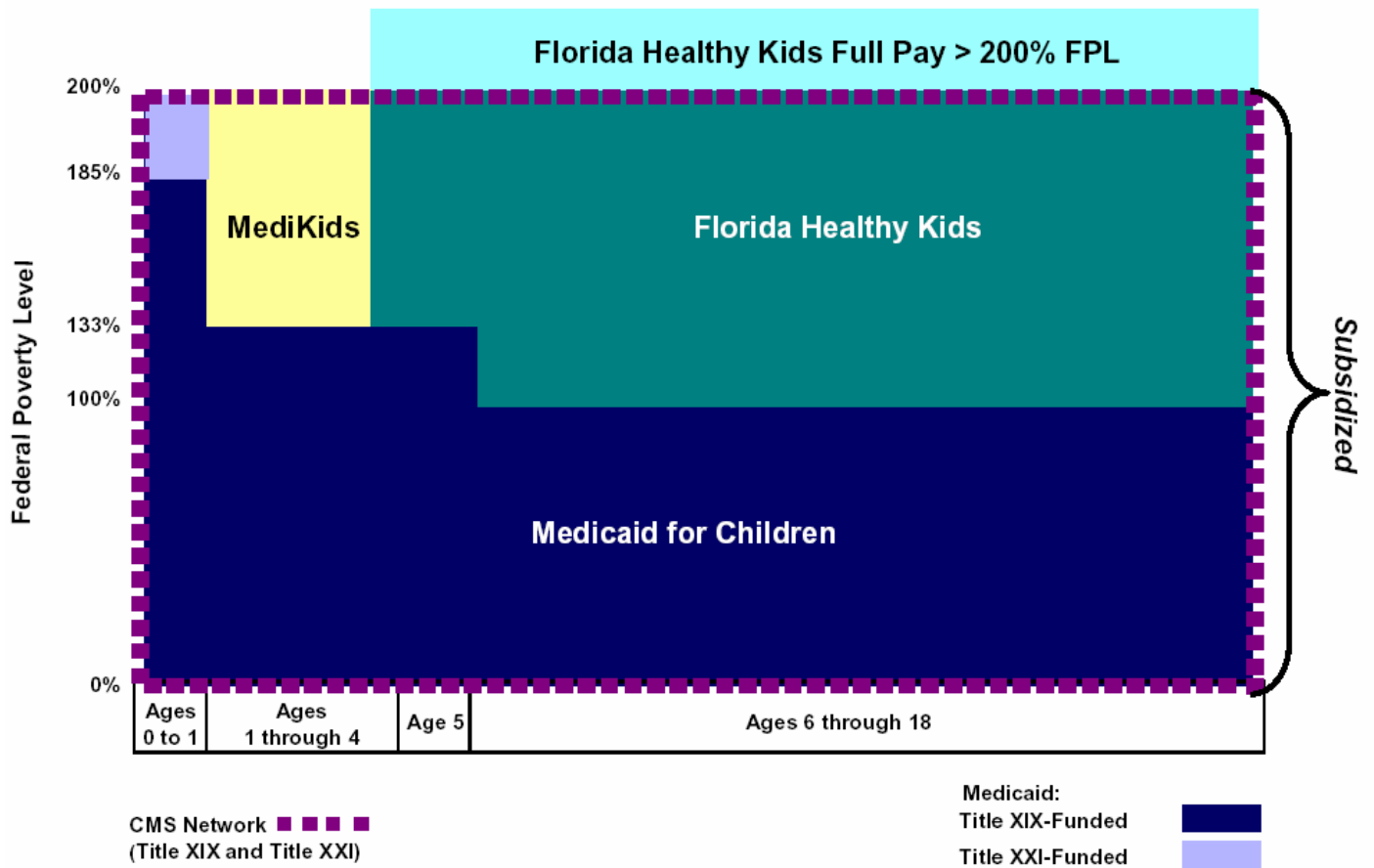
Category	Pre-DRA (March 31, 2006)	Post DRA (March 31, 2006)
Children		
Mandatory Children – Children under 6 with incomes <=133% FPL or ages 6-17 with incomes <=100% FPL	<ul style="list-style-type: none"> • No premiums • No cost sharing 	<ul style="list-style-type: none"> • No Premiums • Copayments up to \$3 (indexed to medical inflation) for non-preferred drugs and for non-emergency use of the ER. These charges are not subject to the 5% aggregate cap • No cost sharing for preventive care or other services
Optional Children – Between 100% and 150% FPL; i.e., children under 6 with incomes between 133% and 150% FPL and those 6 to 17 years with incomes between 100% and 150% FPL	<ul style="list-style-type: none"> • No premiums • No cost sharing 	<ul style="list-style-type: none"> • No Premiums • For most services**, cost sharing up to 10% allowed • For prescription drugs, \$3 (indexed to medical inflation) may be charged for non-preferred drugs and may charge a lower amount for preferred drugs • For non-emergency use of the ER, charges up to \$6 are allowed (indexed for medical inflation) • No cost sharing for preventive care
Optional Children above 150% FPL	<ul style="list-style-type: none"> • No premiums • No cost sharing 	<ul style="list-style-type: none"> • Premiums allowed up to 5% aggregate cap • For most services**, cost sharing up to 20% allowed • For prescription drugs, states may charge up to 20% of the cost of the non-preferred drugs and may charge a lower amount for preferred drugs • For non-emergency use of the ER, no upper limit on charges • No cost sharing for preventive care

*Unless otherwise noted the total premium and cost sharing the state requires cannot exceed five percent of the family income annually or by quarter (as specified by the state).

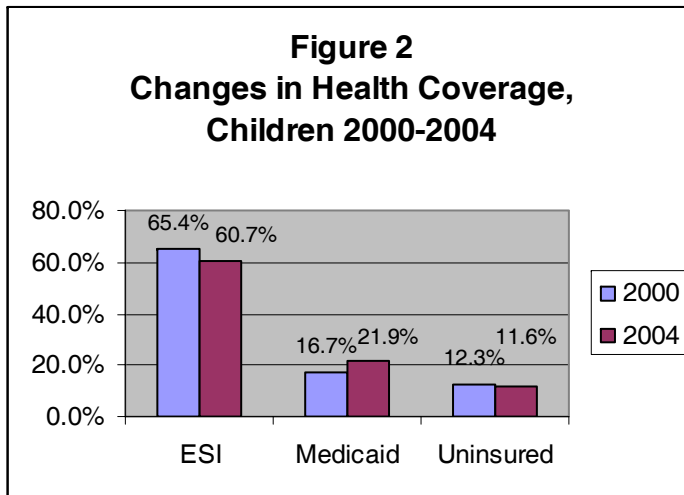
**States are required to exempt the following situations or services from cost-sharing – preventive care, emergency care, family planning, hospice care, and individuals who are medically needy and who are institutionalized.

Source: Elizabeth A. Shenkman. 2006. “Cost Sharing Practices in Medicaid: Lessons Learned.” Report prepared for the Agency for Health Care Administration.

Figure 1: Florida KidCare Eligibility, State Fiscal Year 2004-2005



Source: June Nogle and Elizabeth Shenkman. 2006. *Florida KidCare Program Evaluation Report, 2005*. Institute for Child Health Policy, University of Florida.



ESI is Employer-sponsored Insurance

All 2000-2004 changes are statistically significant except for the change in the number of uninsured children

Source: Holahan and Cook, "Covering the Uninsured – Growing Need, Strained Resources," Kaiser Commission on Key Facts on Medicaid and the Uninsured, the Kaiser Family Foundation, available at: <http://www.kff.org/uninsured/upload/Covering-the-Uninsured-Growing-Need-Strained-Resources-Fact-Sheet.pdf>.

Figure 3: Texas Title XXI Enrollment and Major Program Changes

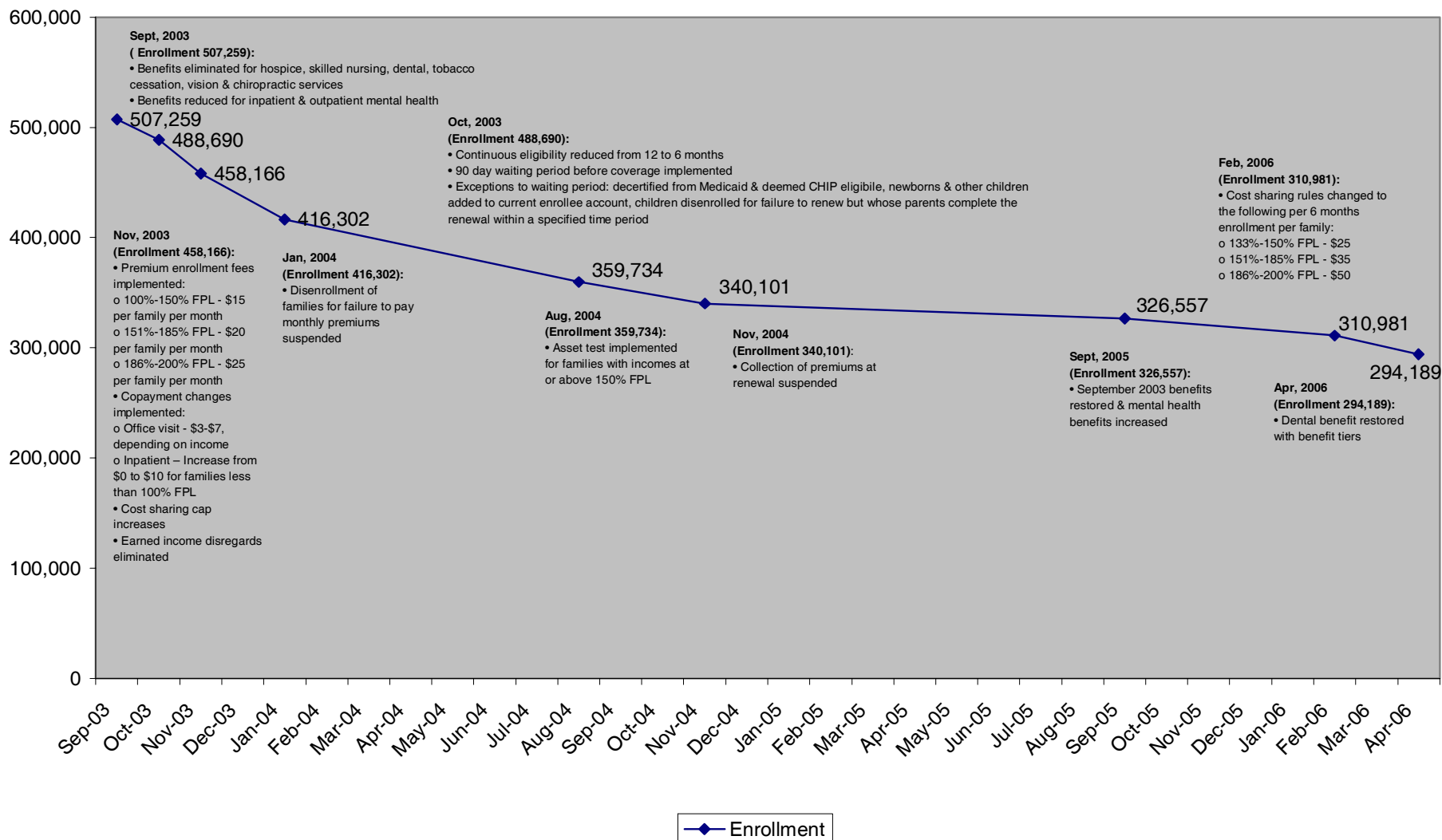
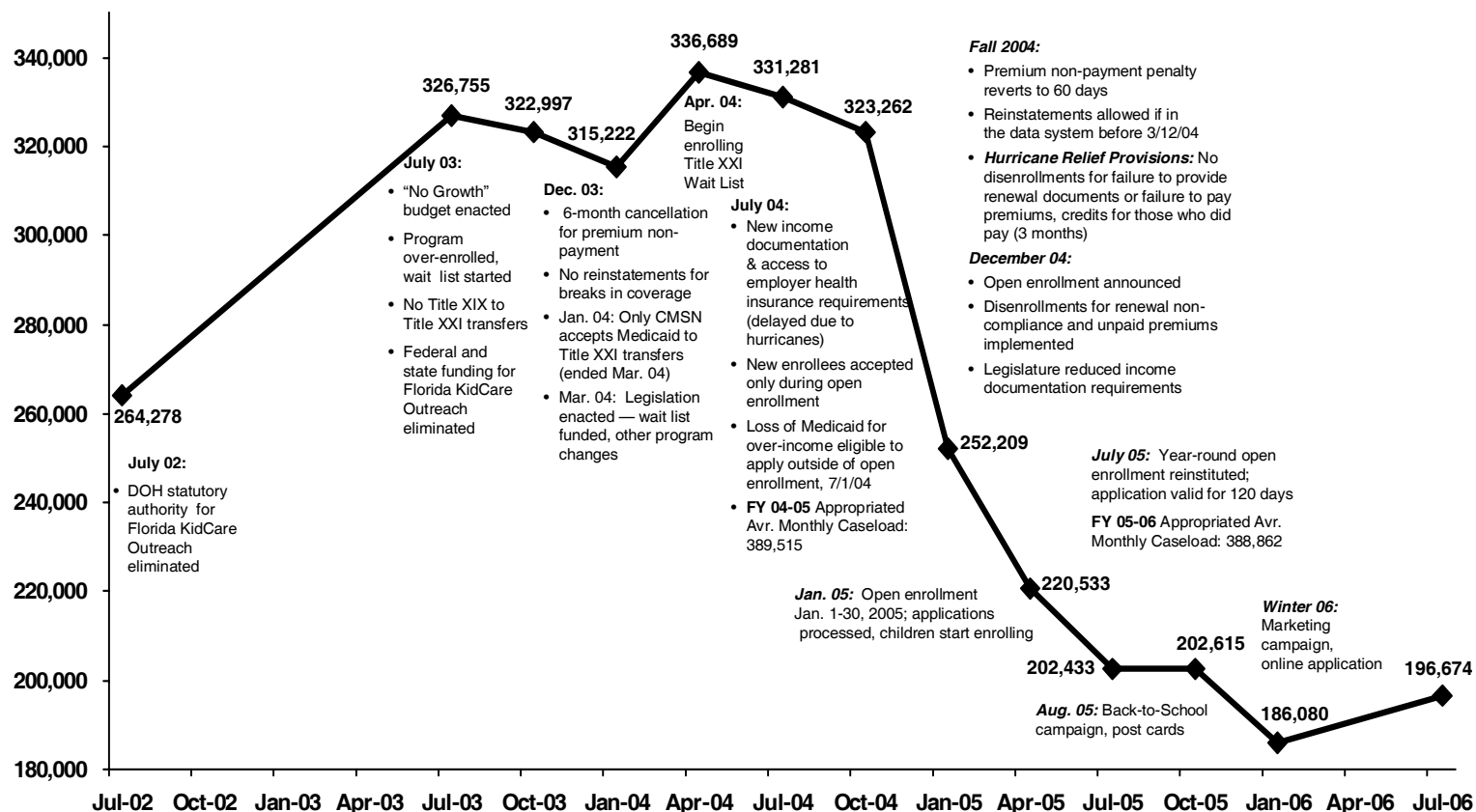


Figure 4: Florida Title XXI Enrollment and Major Program Changes

Title XXI Enrollment and Major Program Changes



End Notes

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⁵ In contrast to previous years, SFY 2004-2005 proved an exception for the Title XXI (SCHIP) funded enrollment trend in Florida. In that year, overall Title XXI enrollment declined by 38.5% from SFY 2003-2004, whereas overall Medicaid enrollment increased by 4.4%. This recent downward trend was due in large part to changes in the state's enrollment and renewal policies explained later in this essay. The growth in the four prior years for Title XXI funded enrollment in the KidCare program was 0.3 percent, 21 percent, 18 percent, and 38 percent. See Nogle J, and Shenkman E. 2006. *The Florida KidCare Program Evaluation, 2005*. Gainesville, Florida: Institute for Child Health Policy, University of Florida, at p. 30.

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¹⁰ Ibid.

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¹² Texas External Quality Review Organization and Institute for Child Health Policy. June 27, 2006. The Texas STAR Medicaid Program and Children's Health Insurance Program (CHIP) in Texas: Renewal/Non-Renewal Survey Report, Fiscal Year 2006. Institute for Child Health Policy, Gainesville, Florida.

¹³ The auto-enrollment approach has been applied effectively to Medicare Part B. Seniors are enrolled into Medicare Part B automatically unless they decline participation, and 96% of eligible seniors are enrolled. This compares to a 33% enrollment rate among the eligible population for the Medicare Savings Programs which requires individual applications. See Dorn S. and Kenney GM. June 2006. Automatically Enrolling Eligible Children and Families into Medicaid and SCHIP: Opportunities, Obstacles, and Options for Federal Policymakers. The Commonwealth Fund. Accessed 3 July 2006; available at: http://www.cmwf.org/Publications/publications_show.htm?doc_id=376814.

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