HEALTH INSURANCE AFFORDABILITY

CONSUMER PREFERENCES IN COST SHARING

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EXECUTIVE SUMMARY

Double-digit increases in the cost of health insurance directly threaten the economic and physical well-being of Idaho's families at the lower end of the economic ladder. This report summarizes research undertaken to inform policy decisions on reasonable approaches to family participation in the cost of health insurance and health care. Qualitative research, in the form of structured interviewing, was carried out to more fully understand consumer preferences in sharing the costs of coverage and to compare recent findings from the research literature to the expressed realities of low-income families in Idaho.

Most nonelderly Idahoans receive health insurance as an employer benefit where the employer contributes significantly to the cost of coverage. However, about one-half of Idaho employers do not offer health benefits. Nearly 80 percent of uninsured workers do not have access to health benefits through their employer or are not eligible for such benefits. Cost is the most frequently cited reason for employers not offering health insurance.

Consumer decisions to participate in health insurance are also highly sensitive to cost. Low-wage (earning less than $7 per hour) and low-income workers (income less than 200% of the Federal Poverty Level) are less likely to be offered employer-sponsored health insurance, and if offered, are less likely to be eligible for insurance, and if eligible, are less likely to enroll in health insurance when they have access to it.

Health insurance take-up rates demonstrate the extreme price sensitivity among low-income, uninsured persons. When coverage is free, 72-83 percent of the uninsured would be expected to participate; however, even with modest cost sharing (1-2 percent of income), participation rates drop off to around 50 percent. At cost sharing levels exceeding five percent of a family's annual income, states risk participation rates low enough that adverse selection and crowd-out would threaten the effectiveness of the program.

An extensive literature documents the relationship between cost sharing and consumer utilization of health care. Clearly, consumers buy less medical care when faced with higher prices. For the general population, this decreased utilization does not appear to have a negative effect on health, overall. However, among the very poor and children, cost sharing has been demonstrated to have some negative effects on certain measures of health.

Consumer price sensitivity can be carefully used to encourage cost-effective use of health services. Examples include charging a higher co-pay for brand-name drugs when used in place of equally effective generic drugs, or a higher co-payment for nonemergent emergency room use to discourage ER use in lieu of available primary care in a physician's office. Lessons from the literature suggest that cost sharing should not be applied to preventive health services to encourage cost-effective use of them.

Low-income, uninsured Idahoans express a willingness to pay for health insurance and health care costs; however, the extent of their willingness is limited by concerns about also being able to pay for other basic needs such as food and housing. The following points summarize key findings from the qualitative research.

- Co-payments were the most popular of the various forms of cost sharing among interviewees, especially among the lowest income group. Premiums were also preferred, while deductibles were identified as the least acceptable.

- Reasons for preferences related to the stability of bills or payments relative to household cash flow and the perceived cost benefit between payments made and the value of services received.
- Premiums of $35-$50 per person per month combined with co-payments of $10 per visit were reported as a maximum affordable amount for adult coverage by over half of participants.
- For family coverage, premiums of $50-$80 per family per month with co-pays of $5-$10 per visit were viewed as affordable to low-income parents.
- Larger families and older participants expressed a willingness to pay more than smaller families and families with children.
- Dental and vision coverage were mentioned as important in their decision to purchase health insurance.

Cost-sharing levels proposed by the HealthLink Policy Team of the Idaho State Planning Grant on the Uninsured and the 1998 Children's Health Insurance Program (CHIP) Task Force are higher than cost sharing policies of other states (the only exception being Hawaii). The premiums are also higher than what low-income, uninsured Idahoans say they can pay. While the maximum amounts that interview participants said they would be willing to pay for the HealthLink plan are fairly close to cost sharing as proposed, only 36 percent of interviewees indicated they would purchase such a plan at that price. Another 29 percent indicated a "maybe" purchase. The proposed HealthLink co-pay of $15 per physician visit for participants with incomes between 150-200 percent of FPG is higher than the average $10 co-pay that participants in that income range said they could pay.

The co-payments of $1-$5 per visit proposed by the CHIP Task Force are less than half the average maximum $10 charge per visit that low-income parents said they would pay. However, for a typical two-child family, the family's share of premiums for child-only coverage as proposed by the 1998 CHIP Task Force is nearly twice as much as families say they can afford for full-family coverage. When asked whether they would purchase an alternative hypothetical CHIP family plan at a premium of $30 per month per family, all but one interviewee expressed a willingness to purchase the plan. The specified average maximum premium of $50-80 per month per family suggests they would be willing to pay a higher amount for such coverage than the $30 amount posed. It should be noted that these preferences primarily reflect the additional coverage of parents in CHIP since the majority of respondents' children were already covered.

In summary, lessons gleaned from the policies of other states and the research literature, as well as the specified preferences expressed by low-income, uninsured families in Idaho, support the use of modest co-payments and premiums for the purchase of subsidized health insurance and health care. Families expressed an ability to pay monthly premiums of no more than three percent of annual income to purchase family coverage and four percent of annual income for adult-only coverage (assuming no children or children already covered at no cost). These findings suggest that Idaho policy makers may wish to revisit cost sharing recommendations of the 1998 CHIP Task Force and models to cover employees of small businesses to ensure that any policies adopted for publicly-subsidized programs reflect the “real” abilities of families to participate.

The stories researchers heard from Idaho families attest to the crisis of being uninsured and the importance of health insurance and health care to their well-being. The unmet need is huge and painful for them. They live in fear of a major illness or accident that would devastate their family's finances and render them unable to provide for their children. They worry about being able to meet each month's expenses for rent, food, and transportation and still be able to pay for health care when needed. They are hopeful and appreciative of efforts being taken to expand coverage for them.

HEALTH INSURANCE AFFORDABILITY

CONSUMER PREFERENCES IN COST SHARING

PURPOSE

Health care increasingly affects the well-being of families and the economy. While medical knowledge and technology have become extremely sophisticated, thousands of Idahoans forego basic health care because they cannot afford health insurance. This report is the second in a series of policy research papers produced by the Center for Health Policy at Boise State University for the Idaho State Planning Grant on the Uninsured. It provides a review of the health services literature on the effects of cost on low-income consumers' access to and purchase of health insurance and health care. This report also summarizes the findings of qualitative research undertaken to more fully understand low income Idahoans' preferences for participating in the cost of a subsidized health insurance product. Structured interviews were conducted to answer the following research questions:

1. Of the various cost-sharing mechanisms, what are the relative consumer preferences for enrollment fees, premiums, co-pays, co-insurance and deductibles in choosing to purchase a subsidized health insurance product?

2. What are the price elasticity points in consumer purchasing decisions for enrollment fees, premiums, co-pays, co-insurance and deductibles?

3. To what extent do these consumer preferences differ by consumer's income level?

BACKGROUND

The Idaho State Planning Grant on the Uninsured, administered by the Idaho Department of Commerce, is one of thirty-one state planning grants funded in the past two years by the Health Resources and Services Administration, U.S. Department of Health and Human Services. The charge of the grant is to identify and describe Idaho's uninsured, to evaluate a wide array of policy options, and to develop a comprehensive plan for providing access to insurance for all Idahoans.

Following a year of data collection and evaluation of policy options, the Planning Grant put forth a series of recommendations to expand coverage for uninsured Idahoans. These recommendations included a strategy for expanding coverage for children and possibly their parents through creation of a stand-alone Children's Health Insurance Program (CHIP) and the implementation of a public-private insurance partnership for working adults. Each of these strategies include cost-sharing so that families would pay at least some portion of their coverage on a sliding scale based on income.

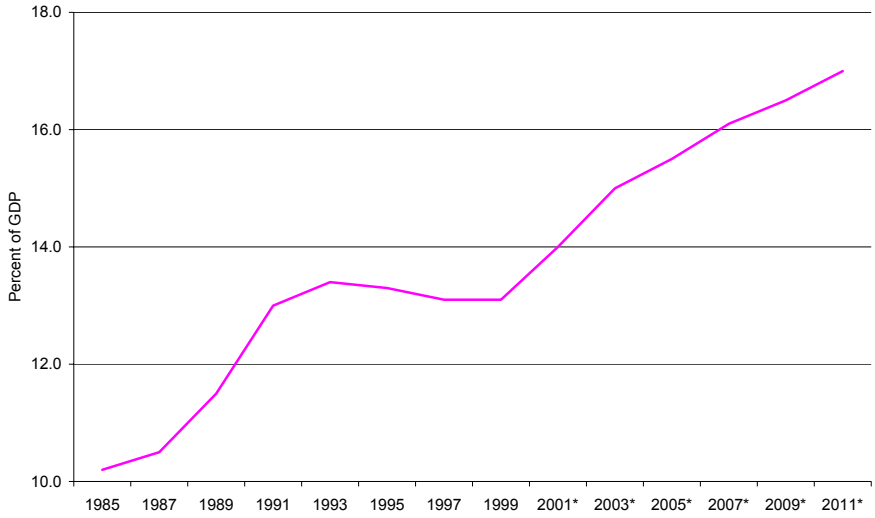
Work groups were convened to continue the design planning of each insurance product, one a coverage product for children and their parents, and the second, a product for working adults called HealthLink. This research serves to inform design decisions regarding the cost-sharing component of both products.

REVIEW OF RESEARCH LITERATURE

TRENDS IN HEALTH INSURANCE COST

The cost of health care is a pressing issue in our economy and a significant driver of increasing rates of uninsurance. After a lull during the 1990s, health care spending has resumed its upward spiral. Actuaries at the Centers for Medicare and Medicaid Services recently updated projections of health care spending. National health expenditures are projected to reach $2.8 trillion in 2011, growing at a mean annual rate of 7.3 percent during the forecast period 2001–2011. That rate is expected to grow 2.5 percent per year faster than the nominal gross domestic product (GDP), so that by 2011, it will constitute approximately 17 percent of GDP, up from its 2000 level of 13.2 percent (Heffler et al., 2002). Figure 1 demonstrates the past and projected trend in health expenditures.

Figure 1: **National Health Expenditures as a Share of Gross Domestic Product (GDP), 1985-2011**



SOURCE: Centers for Medicare and Medicaid Services, Office of the Actuary (2002).
* Projected

Not surprisingly, a national survey of employers found the cost of health insurance rose 12.7 percent from spring of 2001 to spring of 2002, the highest rate of growth since 1990 and the sixth consecutive year of accelerated premium growth (Gabel et al., 2002). This followed an increase of 11 percent between 2000 and 2001 (Gabel et al., 2001). Premium increases in 2002 outpaced the overall rate of inflation by more than eleven percentage points.

For employer-sponsored insurance, the average monthly cost of single coverage in 2002 was $255 (or $3,060 a year), and the cost of family coverage was $663 (or $7,954 a year) (Gabel et al., 2002). These costs represent the sum of the employer and the employee contributions. Typically, health insurance costs in Idaho are not significantly different from the national average (Branscome & Brown, 2001). For example, in 1999, the premium cost for single coverage offered by Idaho employers was $195 per month compared to $194 per month nationally. Likewise, family coverage premiums were $509 per month compared to $504 nationally (MEPS-IC data).

Spiraling health insurance costs are increasingly affecting employees' share of costs. In 2002, employees experienced dramatic increases in their monthly contributions for health insurance, as well as growth in deductibles and co-payments. The average employee contribution for single coverage, which fell during the period of 1996 through 2001, rose 27 percent to $38 in 2002 (Gabel et al., 2002). Likewise, employee contributions for family coverage increased 16 percent between 2001 and 2002. Cost sharing at the point of service rose dramatically as well. For example, the survey found the average deductible in conventional plans increased by 38 percent from $195 to $270 for single coverage and from $528 to $665 for family coverage.

As employers struggle to cope with the increased cost of health insurance, employee cost sharing is likely to continue to rise. Researchers have simulated changes in premium costs when various health plan components were modified. By increasing cost sharing from a $15 in-network co-payment and no deductible to 20 percent coinsurance and a $250 deductible, the premium cost would decrease by 22.1 percent (Lee & Tollen, 2002). Likewise, other research found that the most potent instrument for reducing premium cost is to increase the share of expenses consumers must pay out-of-pocket (Glied, Callahan, Mays, & Edwards, 2002). To achieve a similar reduction in premiums, the authors found that policies would have to include major cuts in benefits. For example, increasing a deductible from $200 to $325 while eliminating all coverage for prescription drugs would result in the same premium cost reduction as increasing the deductible alone from $200 to $1,300. As insurers and employers cope with rising health insurance premiums, they are more likely to achieve greater cost savings by increasing beneficiary cost sharing than by reducing benefits.

ABILITY OF UNINSURED TO PAY FOR HEALTH INSURANCE

Given the high costs of medical care and health insurance today, family income and employment status are key factors affecting access to and affordability of medical care and insurance coverage. For many of the uninsured, the costs of health insurance and medical care are weighed against equally essential family needs. In a recent survey more than one-third, or 37 percent, of low-income (income less than 200% of the federal poverty level) working adults said they experienced a time in the past year when they were unable to pay for basic living costs such as food, rent, or heat or electric bills (Duchon et al., 2001). For uninsured, low-income workers, financial strain is even greater. The uninsured are twice as likely as those with health coverage to live in a household that is having difficulty paying monthly bills for basic costs of living (Kaiser Commission on Medicaid and the Uninsured, 2002).

Many low- and modest-income workers report encountering financial barriers to needed medical care and difficulties paying medical bills when care could not be postponed. More than half (57%) of low-income workers reported having a problem in the past year with either obtaining medical care or paying medical bills, or both (Duchon et al., 2001).

In the current era of competitive health plans, the amount of uncompensated health care that hospitals and other medical providers can absorb is diminished. As health plans negotiate for increasingly lower payment rates, providers are less able to shift costs of uncompensated care to privately insured patients. Thus, the ability of providers to provide uncompensated care for the uninsured is reduced. An often voiced myth is that the uninsured can always get free health care by going to the hospital emergency room. Although this has happened, most of the uninsured do not receive health services for free or at reduced charge. Among families with at least one uninsured member, only a quarter report they have received this kind of charity care in the past year (Kaiser Commission on Medicaid and the Uninsured, 2002).

Spending five percent of income or more on medical expenses puts low-income families at severe financial risk. The likelihood of spending a high share of income on medical expenses drops as income rises. If two families with different incomes spend the same amount for medical care, the

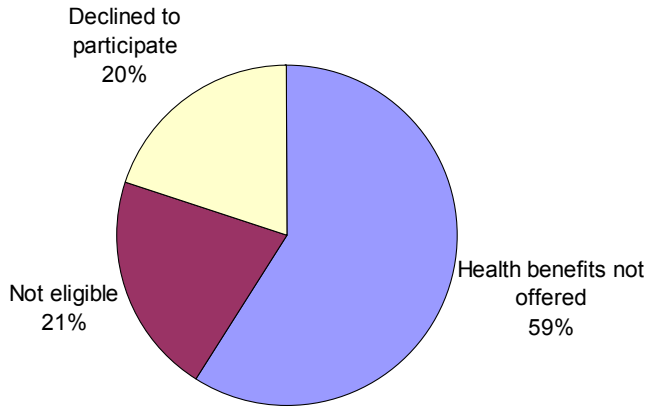
family with the lower income will have spent a higher share. A 1996 study found that one of four (23%) families with income below the poverty line spent more than five percent of their incomes on out-of-pocket expenses for health services (Merlis, 2002). In contrast, only three percent of families with incomes above 400 percent of the poverty line crossed this threshold.

While the uninsured are especially at risk, even those with private health insurance can fall victim to burdensome outlays for health care or be forced to forego needed care. Among families with insurance, those who are most at risk for high out-of-pocket costs are those with individual private coverage. These plans tend to have higher deductibles and coinsurance payments, and are less likely to cap patient liability for health care expenses. In 1996, one of five families with private non-group plans were found to spend more than five percent of income on health expenses, compared with one of 12 families with employer coverage (Merlis, 2002). Although more recent data on out-of-pocket spending are not currently available, recent beneficiary cost sharing increases would most likely have increased these rates.

Having health insurance is closely linked to the availability of employer-sponsored coverage. Most Idahoans under age 65 receive health insurance coverage as an employer benefit. In 1999-2000, 63 percent of non-elderly Idahoans had employer-sponsored health insurance (Kaiser Commission on Medicaid and the Uninsured, 2002).

However, only one-half of Idaho employers offer health benefits (Center for Health Policy, 2001). According to an annual survey of Idahoans, 80 percent of Idaho's uninsured adults are in working families (Bureau of Vital Records and Health Statistics, 2001). Most of these uninsured workers are not offered employer-sponsored health insurance. As shown in Figure 2, 59 percent of uninsured workers across the U.S. were not offered health benefits through their job in 1998; another 21 percent were not eligible for their employer's health plan (Garrett et al., 2001). The remaining 20 percent of uninsured workers had health benefits available to them, but declined to participate. Other research has produced similar findings (Thorpe & Florence, 1997).

Figure 2: **Reasons Employees Did Not Have Job-Based Coverage, 1998**



* Uninsured employees in February 1998; does not include the self-employed.
SOURCE: (Garrett, Nichols, & Greenman, 2001) *Workers Without Health Insurance: Who are they and how can policy reach them?*

Low-wage workers disproportionately lack access to employer-sponsored health insurance. Sixty percent of workers in low-wage businesses were offered insurance compared to 87 percent of workers in other businesses (Long & Marquis, 2001). Low-wage workers were also less likely to be

eligible for employer-sponsored insurance (67 percent) compared to workers in other businesses (86 percent). Small employers in Idaho offer health insurance at significantly lower rates than nationally (Branscome & Brown, 2001). Cost is the most frequently cited reason for employers not offering insurance (Gabel et al., 2002).

EFFECTS OF COST SHARING

…ON CONSUMER TAKE-UP OF HEALTH INSURANCE

Consumer decisions to participate in health insurance are also highly sensitive to cost. When eligible, low-wage workers are less likely to enroll. Seventy-seven percent of low-wage workers enrolled in their employer's health insurance when eligible, compared to 88 percent of workers in other businesses (Long & Marquis, 2001).

During the period of 1987 to 1996, more firms offered health insurance to workers, but fewer workers were covered (Cooper & Schone, 1997). For workers earning less than $7 per hour, offer rates were virtually the same in both years, but take-up rates declined significantly. Both individual and family take-up rates of health insurance were lower for low-wage workers (63 percent and 76 percent, respectively) compared to rates for all workers (80 percent and 89 percent, respectively). The falling take-up rates were attributed to: declining real incomes, especially among workers who were the least likely to have coverage, increasing costs of insurance, rising employee contributions to health insurance premiums, and expansions of Medicaid.

Other researchers have posited the sharp increases in the size of the contribution required from employees as the reason for declining take-up rates (Center for Health Services Research and Policy, 1998). These contributions were found to be rising faster than wages. This problem was exacerbated because employees who were most sensitive to increases were those with the lowest wage; they also have experienced the smallest gains in earnings in recent years.

In addition to the fact that low-wage workers are less able to afford premiums compared to high-wage workers, they often work in firms where employees must pay a larger share of the premium for family coverage. Employers of low-wage workers pay only 62 percent of premiums for family coverage compared to 75 percent paid by higher-wage employers (Kaiser Commission on Medicaid and the Uninsured, 2002).

While low-wage workers are less likely to be offered and enrolled in employer-sponsored health insurance, research indicates that poverty is a better targeting criterion for health insurance expansions than either wages or firm size (Ferry, Garrett, Glied, Greenman, & Nichols, 2002). Since they target the uninsured more efficiently, proposals focusing on poor and near-poor families are likely to be less costly (per newly insured person) than those targeting firms with low-wage workers or small firms.

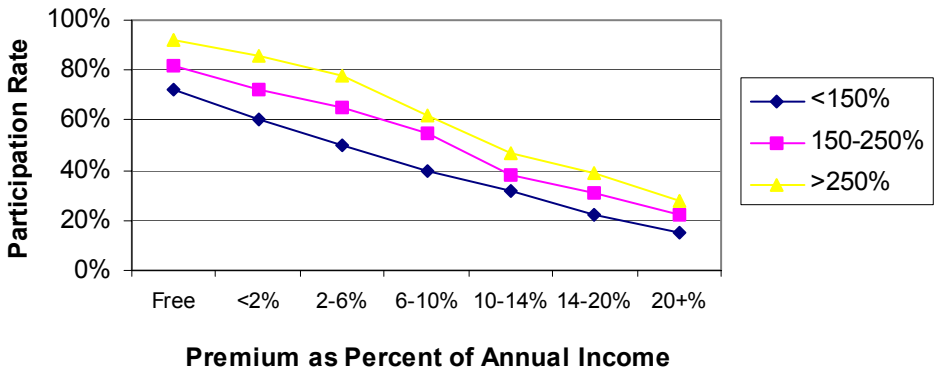
A particularly useful method for estimating the impact of cost on health insurance take-up rates is to calculate premium costs as a percent of annual family income. Idahoans on average spend about one percent of their income on employer-sponsored insurance premiums for individual coverage and four percent of annual income on family coverage (estimated based on average monthly worker premiums across all employer plans in the western region from the 2001 Kaiser/HRET Survey of Employer Sponsored Health Benefits, and 2001 Idaho family median income from HUD).

In a predictive modeling of participation rates among uninsured children done by the Urban Institute for the Kaiser Family Foundation (Feder & Levitt, 1998), it was estimated 79 to 83 percent of uninsured children with incomes from poverty to twice the poverty level would participate if

coverage were free. Even with what appears to be a relatively modest premium -- about $17 per month -- participation drops by an estimated 24 to 38 percentage points, depending upon the income group. Only 41 percent of the uninsured at poverty and 59 percent of those with incomes at twice the poverty level were expected to enroll if the premium for coverage was $17 per month. At a premium of $50 per month, participation for poor children was expected to be 29 percent, and for those twice the poverty level, 49 percent would participate.

More recent simulation research has further elucidated the relationship between the decision of families to purchase insurance and premium costs as a percentage of income (Holahan et al., 2000). The study used an Urban Institute TRIM2 simulation model based on 1995 Current Population Survey (CPS) data on family insurance coverage by family income adjusted to reflect 1998 population structure, and premium data from 1991 HIAA and Blue Cross/Blue Shield surveys adjusted to reflect premium growth to 1998. Using the model, participation rates with respect to premiums as a percentage of income were estimated. The authors concluded that under the current (1998) private insurance system, 72 percent of families who had access to free coverage actually enrolled in the plan (Figure 3). Among families with incomes less than 150 percent of federal poverty level (FPL), 40 percent of families faced with a premium between 6 and 10 percent of income chose to buy insurance and 60 percent chose not to buy.

Figure 3: **Insurance Participation by Premium Cost as Percent of Annual Income**



SOURCE: (Holahan, Uccello, Feder, & Kim, 2000)

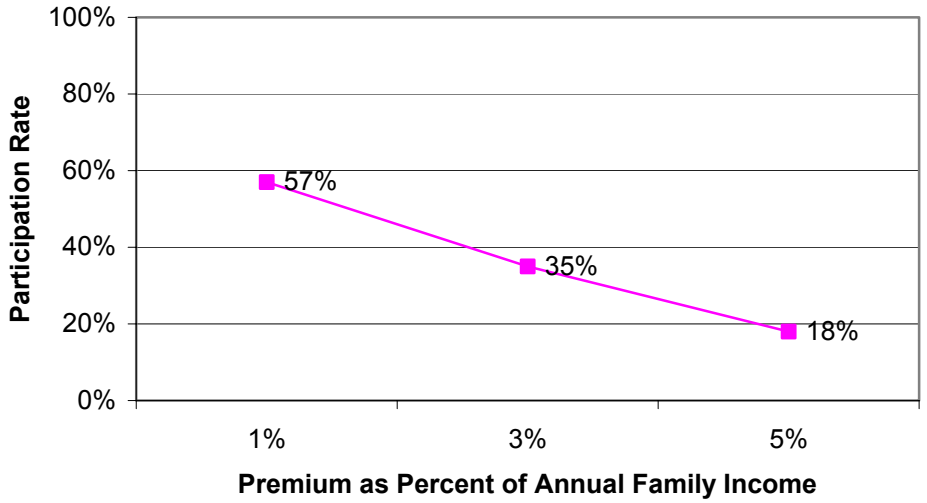
Enrollment in a new subsidized insurance program would reflect take-up by two populations: one, the currently uninsured, and the second, those previously insured who choose to drop private coverage to achieve cost savings by enrolling in a cheaper program. After adjusting for lower participation rates in public programs and crowd-out of private insurance, Holahan et al. estimated 49 percent of uninsured children below 200 percent FPL would be expected to enroll in a subsidized program with no premiums for those under 150 percent FPL and modest premiums (<2% of income) for those between 150-200 percent of FPL.

Actual enrollment in public health insurance programs shows that take-up rates among the uninsured decline significantly when premiums are charged. In a study of three states' (Hawaii, Minnesota, and Washington) experience with publicly-subsidized health insurance programs in 1995, higher premiums (measured as a share of income) significantly reduced the likelihood of participation (Ku & Coughlin, 2000). While just over half (57 percent) of the eligible uninsured participated with

premiums at one percent of income, only 18 percent participated with premiums requiring five percent of income (Figure 4).

Several factors explain differences in health insurance participation rates among the general population compared to enrollment of uninsured in public health insurance programs. Differences in ease of enrollment and premium payment, outreach and marketing efforts, consumers' beliefs about the importance of health insurance, stigma attached to public programs, and perceptions of differences in the quality of participating providers contribute to differing participation rates.

Figure 4: **Insurance Participation Among Uninsured by Premium as a Percent of Family Income**



SOURCE: (Ku & Coughlin, 2000)

Establishing cost-sharing levels in a publicly subsidized health insurance product is an exercise in trade-offs. Premiums need to be low enough to encourage participation by those who lack access to insurance. However, lower premiums may encourage those who have adequate private coverage to drop their coverage to enroll in the publicly-subsidized product. On the other hand, higher cost-sharing amounts can exacerbate adverse selection as healthy, low-income families decide that the cost of the coverage outweighs the benefits, whereas families with chronic health problems would value coverage more and would be motivated to pay the higher costs. Also, at higher premium levels, a larger proportion of enrollment would be from previously insured as participation rates of the uninsured drop. This results in less program efficiency as measured by cost per newly insured person.

…ON UTILIZATION OF HEALTH SERVICES AND HEALTH OUTCOMES

The RAND Health Insurance Experiment remains one of the largest and longest-running social science research projects ever completed. Conducted between 1975 and 1982, the experiment demonstrated the effects of cost sharing on health care utilization and health outcomes (Newhouse & group, 1993). Researchers randomly assigned 4,000 participants ages 14-61 years by family units to health insurance plans that differed in the amount of patient cost sharing required. The plans ranged from free care to major deductible plans with 95 percent cost sharing up to a maximum of $1,000 per family per year. Participants received lump-sum payments at the beginning of the study to

compensate them for their expected out-of-pocket costs if they were in cost-sharing plans. Families were studied for a three- to five-year period. Low income individuals were over sampled in the study. Both HMO and fee-for-service plans were included.

Varying the cost-sharing rate induced a substantial change in the use of health care services. The per-person expenditure on the 95 percent plan was about 69 percent of that on the free-care plan; adjustment for underfiling raises this figure to about 75 percent. This amount of cost sharing reduced expenditures about 25-30 percent relative to a plan in which care was free. Cost sharing markedly decreased use of all types of services among all types of people. Although the impact of cost sharing in the experiment was reduced for the poor, decreases in expenditure were similar among the poor and the nonpoor. This similarity reflected a greater reduction in ambulatory care use due to cost sharing among the poor and a smaller response of inpatient use, i.e., the effect of cost sharing was greater on outpatient care than for hospitalization.

Results show that the 40 percent higher use of services on the free-care plan had little or no measurable effect on health status for the average adult. However, health among the sick poor was adversely affected. The additional care received by the free-care group had beneficial effects on blood pressure levels for the poor with high blood pressure, with an associated gain in predicted mortality for this group. However, a one-time screening examination achieved most of the gain in blood pressure that free care achieved. There were modest gains in correctable vision, also concentrated among the poor, and gains in periodontal health. Caries were more likely to be filled among those on the free plan.

The RAND results suggest the possibility of a beneficial effect of free care for anemia among poor children and indicate a favorable effect on caries in the deciduous teeth of preschool children. Otherwise, the substantial increase in services induced by free care did not manifest itself in measurable improved heath outcomes for children.

In more recent research on the effects of cost-sharing on utilization of medical care, Eichner (1998), in a study of employed workers of a Fortune 500 firm, found a one percent increase in out-of-pocket cost produced a 0.62 percent fall in expenditures among employees and a 0.57 percent fall in family claims.

Unfortunately, the decrease in utilization of health services caused by cost sharing is not selectively targeted towards those services that inappropriately drive up health care costs. Lurie et al. (1987) used insurance claims from enrollees in the Rand Health Insurance Experiment to determine the amount of selected components of preventive care received. Utilization of preventive services in general were found to be far below recommended levels. Cost sharing was associated with receipt of even less preventive care; 49 percent of children on cost sharing plans received preventive care of any type compared to 60 percent on the free plan. For adults, women on the free plan received more preventive care of several kinds, and those aged 45-65 received more Pap smears, than those on cost-sharing plans. Even with free care, most enrollees did not receive recommended levels of preventive care. The authors concluded that free care alone, while significant, is not a sufficient incentive to providing recommended levels of preventive care. Other researchers have also found negative effects of different forms of cost-sharing on the utilization of recommended clinical preventive services (Solanki, Schauffler, & Miller, 2000).

Low cost sharing reduces care for minor symptoms; however, high co-payments reduce care for both minor and serious symptoms. In a study of the effects of cost sharing on medical care use for acute symptoms and on health status among chronically ill adults, data from the Medical Outcomes Study were used to compare utilization rates of physician care for minor and serious symptoms including 6- and 12- month follow-up of physical and mental health status among individuals at

different levels of cost sharing (Wong, Andersen, Sherbourne, Hays, & Shapiro, 2001). In comparison with a no-co-pay group, the low- and high-co-pay groups were less likely to have sought care for minor symptoms, but only the high-co-pay group had a lower rate of seeking care for serious symptoms. Follow-up physical and mental health status scores were similar among the three co-pay groups. In this chronically ill population, high cost sharing reduced the use of care for both minor and serious symptoms; however, the effect of low cost sharing was limited to a reduction in care for minor symptoms.

Among members of an HMO, the introduction of a small co-payment for the use of the emergency department was associated with a decline of about 15 percent in the use of that department, mostly among patients with conditions considered likely not to present an emergency (Selby, Fireman, & Swain, 1996). However, the authors noted that the results should not be generalized to apply to low-income, publicly-insured groups where imposing a co-payment could lead to adverse effects because of diminished access to a usual source of urgent care.

Cost sharing for prescription drugs has been shown to negatively impact low income recipients. Increased cost-sharing for prescription drugs in elderly persons and welfare recipients was followed by reductions in use of essential drugs and was associated with higher rates of serious adverse events and emergency visits (Tamblyn et al., 2001). In low-income patients with chronic mental illness, limits on coverage for the costs of prescription drugs increased the use of acute mental health services and increased costs to the government for care (Soumerai, Ross-Degnan, Avorn, Mclaughlin, & Choodnovskiy, 1991).

Consumer sensitivity to cost can be used selectively to encourage cost-effective consumer behavior. A recent trend in health plans is a tiered approach to co-pays for prescription drugs. To combat rising prescription drug costs, plans are increasingly providing financial incentives to encourage use of generic drugs and certain categories of preferred brand-name drugs (Gabel et al., 2002).

COST-SHARING POLICIES IN PUBLIC PROGRAMS OF OTHER STATES

Given the concerns about effects of cost sharing on low income families' enrollment in health insurance programs and impacts of costs on use of health services, other factors have driven states' adoption of cost sharing in design of their programs. State policymakers have based cost sharing decisions mainly on the political environment, philosophic beliefs, and state-specific program objectives (O'Brien et al., 2000). Political realities in some states have dictated the creation of a separate, nonentitlement program with cost-sharing provisions intended to reduce crowd-out and instill a sense of "ownership" and "personal responsibility" in enrollees. Likewise, a number of states indicated that by instituting moderately priced co-payments and premiums, families would not view the program as "welfare" and would be more likely to enroll in the new program. Other reasons cited by state policymakers for instituting cost sharing had to do with avoiding substitution or crowd-out of private insurance.

A 2001 study by the National Academy of State Health Policy found that four of five separate State Children's Health Insurance Program (SCHIP) plans required cost-sharing (Oliver & King, 2002). All but ten of the 35 states with separate or combination SCHIP programs utilized either a premium or enrollment fee with the majority using a premium on a sliding scale starting at income levels greater than 150 percent of Federal Poverty Guideline (FPG). Federal law prohibits charging premiums for children in Medicaid or Medicaid expansion SCHIP programs (Idaho's CHIP is a Medicaid expansion and therefore, does not impose cost sharing). In SCHIP programs of the 50 states and District of Columbia, only seven charge a health insurance premium for children in families with incomes less than 150 percent of the FPG. Those premiums ranged from $4-15 per

month per child. For higher income families (those above 150% FPG), premiums ranged $5-25 per child per month or less than one percent.

All but 11 of the 35 states with separate SCHIP programs employed a co-pay for at least one service. For families with income 100-150 percent FPG, co-pays were in the range of $2-10 with most at $5 per visit. For families at 150-200 percent FPG, the range was $5-15. A summary of states' cost-sharing policies in SCHIP and Medicaid programs is provided in Appendix A.

Among the 16 states with Section 1115 Demonstration waivers who have expanded coverage to childless adults and/or parents, most do not charge premiums to adults or parents below the poverty line. For those charging a premium to families with income between 100-150 percent of FPG, premiums range from $10-20 per month; however, Hawaii charges $150 per month. For families between 150-200 percent FPG, premiums range $15-35 per parent per month. At least two states charge premiums as a percent of income on a sliding scale. Minnesota's premiums are on a sliding scale at 2.3-6.2 percent of family income for those 100-200 percent FPG and Wisconsin's premiums are 3 percent of annual income for those above 150 percent FPG. A few states begin premiums for families at 185 percent FPG or higher (Missouri, Rhode Island, Vermont) and at least two states, New York and Delaware) do not charge any premium. Co-pays range $5-10 per visit.

Alabama, Colorado, North Carolina, and Utah charge enrollment fees in lieu of premiums while Vermont and Texas do so for families with incomes above 185 and 150 percent FPG, respectively. Rhode Island offers families the option of co-payments or premiums.

IMPLICATIONS FROM THE LITERATURE FOR IDAHO'S PROPOSED PLANS

Idaho is among a minority of states that do not impose cost sharing in the State Children's Health Insurance Program (SCHIP). To expand coverage, policy makers may wish to revisit cost sharing. Assuming Idaho chooses to implement cost sharing, as most states have, the literature suggests policy makers should opt for low premiums, a higher deductible for inpatient care (except, perhaps, for young children), and co-payments targeting certain types of service (brand name versus generic prescriptions) and certain sites of care (e.g. emergency room versus physician office) to encourage a more cost-conscious use of resources. Preventive care should be exempted from cost sharing. Co-payments should be favored over coinsurance to reduce the financial exposure that coinsurance imposes on low-income families (Markus, Rosenbaum, & Roby, 1998).

At the time this research was undertaken, the HealthLink policy work group of the Idaho State Planning Grant was proposing a subsidized health insurance product with monthly premiums of $10 per adult with income below poverty level, $35 for those 100-150 percent of FPG, and $50 for those 150-200 percent FPG. Proposed co-pays per physician visit ranged from $5-$15 based on income. Estimating proposed HealthLink premium amounts as a percent of income reveals that low-income working individuals in Idaho would pay three to four percent of income and working couples would pay four to six percent of income on premiums (see Affordability Model worksheet in Appendix B).

To expand coverage to additional uninsured children, the original 1998 Idaho CHIP Task Force recommended a sliding-scale premium subsidy based on family income. If the current actual cost of $121 per child per month to cover children in CHIP were used to estimate premium, a family with income between 160-180 percent of FPG would pay $40 per month per child (3% of annual income for a 2-child family) while a family between 180-200 percent would pay $80 per month per child or 6 percent of annual income for a 2-child family.[1] At these levels, premiums would be higher than in

[1] SCHIP statute limits total cost sharing for families at 5% of annual income.

other states where premiums are less than $25 per child per month. In addition to the premiums, co-pays of $1-$5 per physician visit were also proposed. The proposed co-pay amounts are in line with practice in other states.

At these proposed premium levels, program participation would be estimated to range from approximately 35 to 60 percent for those with premiums at three percent of income. Program participation among the lower income families would be estimated to range from 15 percent to 45 percent for those with premiums in the range of 6 percent of income. Participation could range as high as 60 percent among families close to 200 percent FPG, but would most likely reflect crowd-out of private coverage as opposed to take up by the uninsured.

Table 1: **Estimated Monthly Premiums and Program Participation Rates among Low-Income Families**

Plan	Income as Percent of Poverty*		Monthly Premium	Premium as Percent of Annual Income	Participation Rate (%)
HealthLink					
	<100% FPG	Single adult	$10	3%	35-60
		Couple	$20	4%	26-50
	100-150% FPG	Single adult	$35	4%	26-50
		Couple	$70	6%	15-45
	150-200% FPG	Single adult	$50	4%	26-65
		Couple	$100	6%	15-60
CHIP Task Force					
	140-160% FPG	2 children	$0	0%	72-83
	160-180% FPG	2 children	$80	3%	35-72
	180-200% FPG	2 children	$160	6%	15-60

*Income at the midpoint of range used for calculations of premium as percent of annual income
Sources for participation rates (Holahan et al., 2000; Ku & Coughlin, 2000)

SCHIP statute defines excess cost sharing as exceeding five percent of annual income. Rosenbaum et al. (1999), in a study of the SCHIP five percent cost sharing limit commissioned by the Health Care Financing Administration, state that "while the definition of what constitutes excess cost sharing under the statute is high, as a practical matter, it would not take much to deter a low income family from enrollment. States that elevate their premiums and enrollment fees to this maximum figure risk failure on the part of families to enroll until a child is ill and in need of extensive care." As premiums increase as a percent of income, the risk of adverse selection (greater enrollment of persons in poorer-than-average health) also increases. Failure of states to account for adverse selection due to higher premium costs will result in greater than expected claims and higher costs of coverage.

STRUCTURED INTERVIEW RESEARCH

Qualitative research was undertaken during the summer of 2002 to determine the preferences of low-income uninsured for participating in the costs of health insurance and to assess whether findings from the research literature held true for Idaho families.

STUDY METHODS

STUDY SAMPLE

A total of 32 study participants were recruited via several methods, all of which involved distributing letters or memos to potential groups of participants and asking them to contact the interviewer if they wanted to participate. With one exception noted below, participants called a hotline and left a message with a contact phone number.

- At the WIC clinic at Southwest District Health, the receptionist distributed letters to clients as they came in for their appointments. Interested clients could stop by a side room after their appointments and participate in the survey in person. (Yield: 9 participants; 4 later excluded from data analysis due to translation difficulties or partial health insurance coverage)

- Adults accompanying children who attended the Boise School District's summer food program at Taft, Garfield, and Whitney elementary schools received memos during lunch and were able to call a hotline to sign up for a telephone interview. (Yield: 3 participants)

- Participants in the Homeward Bound program (a Neighborhood Housing Services program) received letters mailed from the agency office. (Yield: 4 participants)

- A randomly selected group of CHIP families received letters mailed from Region IV offices. (Yield: 8 participants)

- Clients of Work Force Essentials received memos directly from the office staff. (Yield: 2 participants)

- Clients of Terry Reilly Health Services and Family Practice Medical Center received letters from the receptionist or other staff who believed the person might qualify for the survey. (Yield: 5 participants)

- One participant received the memo from a friend and didn't know how the friend had gotten the memo.

Participants who did not currently have health insurance or Medicaid and whose income fell below 200 percent of the poverty level (based on guidelines published in the Federal Register on 2/14/2002) qualified for the survey. All who participated were offered a $20 gift certificate to Albertsons as a thank-you for participating in the 20-minute interviews. The participants are described more fully in the Table 2 below.

Table 2: **Profile of Participants** (n=28)

		Number	Percent
Age group	20-29	11	39%
	30-39	6	21%
	40-49	8	29%
	50+:	3	11%
Gender	Male	2	7%
	Female	26	93%
Children	None	5	18%
	One	9	32%
	Two	5	18%
	Three	5	18%
	Four	4	14%
Family size	One	1	4%
	Two	7	25%
	Three	8	29%
	Four	4	14%
	Five	4	14%
	Six	4	14%
Income as percent of poverty level	<100% (range: 55-96)	9	32%
	100-149% (100-140)	11	39%
	150%+ (150-276, with 2 above 185%)	8	29%
Respondents working outside home	Full-time	8	29%
	Part-time	11	39%
	No	9	32%
Respondents or spouse working for small businesses	<20 employees	14	50%
	20-50 employees	3	11%
Children insured (of participants with children):	No	4	17%
	Yes, CHIP/Medicaid	16	70%
	Yes, other	3	13%

INTERVIEW QUESTIONS

A preliminary set of questions was developed based on the Idaho State Planning Grant work groups' interests in examining payment method preferences, acceptable price points, and reactions to two health insurance plans under consideration. The questions were both open-ended and closed-ended and included background questions on the participants' age, gender, family size, combined income, employment status, employer's business size, and insurance coverage for the whole family.

Questions were then pre-tested with a person who fits the income category but has taken a second job simply to be able to purchase health insurance and therefore didn't qualify for the survey. Her feedback resulted in additional refinements to the survey. The final version of the questions appears in Appendix C.

The "Payment Methods" questions were structured to obtain opinions about each of five different payment methods. Individuals were asked to assume that the individual payment method being discussed was the only method being required of them and that they could identify what cost was acceptable for that payment method. They also assumed this was the only payment method required of them when identifying acceptable costs for policies for themselves and for their families. Participant responses should be viewed accordingly.

Although this worked well for obtaining opinions about the first four methods, the last (enrollment fees) became problematic. For most of the interviews, they assumed an annual enrollment fee would be all they were required to pay and, therefore, assumed it would need to be a substantial one-time payment for full-year coverage. Most participant opinions on enrollment fees, therefore, are not a reflection of true enrollment fees. The few opinions expressed about enrollment fees as they are typically implemented are included in the results section.

In the "Specific Plans and Payments" section, Plan B (hypothetical CHIP family plan) mentioned covering the "whole family." After the first few CHIP parents participated in the interviews, a confusion arose as to whether their response to the question about how much they would pay for Plan B should include payment to cover their spouse and themselves or to cover all members of their family, including their children who currently are covered under CHIP. At that point, the interviewer added a question to CHIP participants about how much they would pay for just their spouse and themselves to be covered under Plan B along with payment for the whole family to be covered.

DATA ANALYSIS

Qualitative research by definition does not lend itself to quantitative evaluation methodologies. Basic calculations on overall group characteristics and responses where opinions clearly differ, however, are useful. For these calculations, individual interview records were entered into an Excel spreadsheet, where records could be grouped by poverty level, family size, employer's business size, age, and number of parents in household. Poverty level groupings were: less than 100 percent FPG, 100-149 percent FPG, and 150 percent or above. Family size groupings were 1-2 members, 3-4 members, and 5-6 members. Age groupings were 20-29, 30-39, 40-49, and 50-59. The number of parents in household was separated into categories of 0, 1, and 2.

Opinions as a whole and as subgroups were examined for variations in responses, although the statistical significance of those differences was not explored due to small sample size. In some cases, subgroups were so small as to be practically meaningless. Data for those subgroups appears in the report, but caution in interpreting those figures is urged.

RESULTS

PAYMENT METHODS

Participants rated each payment method on a 1-5 scale, where 1 meant "love it" and 5 meant "no way." The group as a whole strongly favored co-pays as a method of payment (average rating: 2.1). It was particularly popular with lowest income respondents. Families of 1-2 members also found it more favorable than the other families. Deductibles, on the other hand, were least popular with the overall group (average rating: 3.5), and even less popular among the lowest income respondents (3.9).

Table 3: **Cost Sharing Methods by Preference Rank Order**

	Rank	Average Score
Co-pays	1	2.1
Premiums	2	2.6
Enrollment fee (lump sum)	3	3.1
Coinsurance	4	3.3
Deductibles	5	3.5

Premiums were rated an average of 2.6 overall, while the one-time (one lump sum) enrollment fee rated 3.1 and coinsurance rated 3.3. There was no real variation in opinion among income and family size groups for premiums. However, small families rated coinsurance 2.8, whereas families with 3-4 and 5-6 members rated it 3.4 and 3.5, respectively. Ratings for enrollment fees ranged from 2.9 by the highest income group to 3.4 by lowest income group.

Regardless of the payment method, the main reasons cited for rating an individual payment method positively or negatively primarily fell into two areas: stability of bills or payments relative to household cash flow, and sense of cost benefit between payments made and cost of services used. For example, in the event of an expensive medical service, the high cash output that deductibles and coinsurance require at one point in time would be difficult for many respondents to pay. Premiums, on the other hand, were seen as good by many due to the regular nature of the billing. Those with variable income, however, worried about covering insurance premiums during the lean months. Some of these respondents felt a lump-sum enrollment fee coinciding with a season when they had more income could work better than premiums spread evenly throughout the year. Several also mentioned that they didn't want to pay more to an insurance company than they used in health care services, even though several recognized the value of insurance in major medical situations. Several pointed out, "I'm never sick," and found it hard to put scarce money towards premiums when they weren't sure they would need health care.

When asked which of the payment methods they preferred, co-pay was mentioned 18 times, enrollment fees (one-time, lump sum payment) were mentioned 9 times, premiums and coinsurance 4 times each, and deductibles 2 times. Several of those who preferred enrollment fees also mentioned that they would need to have lots of lead time to save up the money or that it would be helpful to be able to pay that one-time amount over several months (in other words, a premium without calling it that).

When asked an open-ended question about their preferences if a combination of payment methods were to be used, opinions were more spread out. However, the top four choices all involved co-pay plus something else: co-pay with premium (mentioned 5 times), co-pay with deductible or co-pay with coinsurance (4 each), or co-pay with lump-sum enrollment fee (3 times). In fact, only 6 participants preferred a combination that did not include co-pay.

Participants also identified unacceptable payment methods and the reasons they were unacceptable. Lump-sum enrollment fee was mentioned 10 times, deductible was mentioned 8 times, coinsurance was mentioned 4 times, and premiums and co-pays were each mentioned 2 times. Seven respondents said that none were unacceptable. As above, the vast majority of reasons given for a method to be unacceptable dealt with fear of household cash flow difficulties coinciding with times when health care is needed, fear of large payments being required at one time, or the risk of paying more out to the insurance company than they use in health care services.

When asked what amount of money they would find acceptable to pay for health insurance for each type of payment, respondents assumed they would only pay for their policy via that one

payment method, as opposed to a more realistic combination of methods that most policies require. Also, some of the CHIP parent respondents assumed that covering their whole family meant only paying extra for themselves and their spouses. Other CHIP parents assumed they would pay for their whole family, including children. If all had assumed children were included in premiums, some of the answers might have been higher than those given.

Responses to the payment questions were examined for effects of poverty level (by payment for self-only and for family coverage), family size (by family coverage), age group of respondent (by self-only coverage), and number of parents in household (by family coverage). Results appear in five tables below.

Table 4: **Acceptable insurance costs if paying via one method only and for self only, by payment method and by poverty level.**

		Income as percent of federal poverty level			
		<100% (n=9)	**100-149%** (n=11)	**>150%** (n=8)	**Total** (n=28)
Premiums	Mean	$38	$37	$47	$40
	Median	$25	$30	$43	$30
	Range	$0-150	$10-60	$15-100	$0-150
Deductibles	Mean	$184	$223	$131	$183
	Median	$200	$200	$100	$200
	Range	$75-300	$100-500	$0-250	$0-500
Co-pays	Mean	$13	$14	$18	$15
	Median	$10	$10	$14	$10
	Range	$5-25	$0-40	$10-45	$0-45
Coinsurance	Mean	19%	13%	15%	16%
	Median	20%	20%	10%	20%
	Range	5-33%	0-20%	10-33%	0-33%
Enrollment fee (lump sum)	Mean	$267	$200	$115	$191
	Median	$250	$200	$100	$180
	Range	$100-500	$50-300	$20-300	$20-500

Interviewees indicated that on average they could pay $30 per month per person if paying for health insurance solely by premium (Table 4). They would be willing to pay a little more than twice that amount for full coverage of their family (Table 5). If the only method by which they were paying was co-pays, they could on average pay $10 per visit.

Table 5: **Acceptable insurance costs if paying via one method only and for whole family only, by payment method and by poverty level.**

		Income as Percent of Poverty			
		<100% (n=8)	**100-149%** (n=11)	**>150%** (n=7)	**Total** (n=26)
Premiums	Mean	$104	$82	$109	$96
	Median	$100	$50	$100	$70
	Range	$0-250	$30-350	$30-200	$0-350
Deductibles	Mean	$413	$480	$279	$404
	Median	$450	$450	$200	$400
	Range	$100-750	$100-1000	$0-500	$0-100
Co-pays	Mean	$24	$14	$24	$20
	Median	$18	$15	$24	$20
	Range	$10-50	$0-20	$10-45	$0-50
Coinsurance	Mean	21%	13%	19%	17%
	Median	20%	10%	20%	20%
	Range	7%-35%	0-20%	10-33%	0-35%
Enrollment fee (lump sum)	Mean	$588	$316	$239	$383
	Median	$500	$325	$200	$350
	Range	$100-1500	$100-500	$20-500	$20-1500

Premium amounts that families would be willing to pay varied by family size with larger families expressing a willingness to pay more than smaller families.

Table 6: **Acceptable insurance costs if paying via one method only and for whole family only, by payment method and by family size**.

		Family Size		
		1-2 (n=8, but only 5 responded)	**3-4** (n=12)	**5-6** (n=8)
Premiums	Mean	$58	$65	$161
	Median	$50	$50	$175
	Range	$30-120	$0-150	$30-350
Deductibles	Mean	$440	$379	$413
	Median	$500	$300	$400
	Range	$0-900	$100-1000	$300-500
Co-pays	Mean	$25	$18	$19
	Median	$20	$13	$20
	Range	$10-50	$0-50	$10-25
Coinsurance	Mean	19%	16%	18%
	Median	20%	10%	20%
	Range	10-33%	0-35%	10-20%
Enrollment fee (lump sum)	Mean	$394	$330	$456
	Median	$400	$325	$400
	Range	$20-1000	$100-500	$100-1500

Older uninsured interviewees were willing to pay more in premiums than younger uninsured (Table 7).

Table 7: **Acceptable insurance costs if paying via one method only and for self only, by payment method and by age group.**

		Age			
		20 - 29 (n=11)	**30 - 39** (n=6)	**40 - 49** (n=8)	**50 - 59** (n=3)
Premiums	Mean	$23	$33	$42	$62
	Median	$20	$30	$40	$60
	Range	$0-60	$10-50	$15-75	$25-100
Deductibles	Mean	$208	$225	$136	$167
	Median	$200	$175	$100	$200
	Range	$75-500	$100-500	$0-250	$100-200
Co-pays	Mean	$13	$14	$22	$13
	Median	$10	$15	$13	$10
	Range	$5-25	$5-20	$0-45	$10-20
Coinsurance	Mean	18%	14%	15%	17%
	Median	20%	15%	15%	20%
	Range	5-33%	5-20%	0-33%	10-20%
Enrollment fee (lump sum)	Mean	$264	$175	$99	$200
	Median	$200	$150	$75	$200
	Range	$100-500	$100-300	$20-240	$100-300

Childless adults appear willing to pay more in premiums, deductibles, and co-pays than parents with children in the home; however, this most likely represents an older age group, as well (Table 8).

Table 8: **Acceptable insurance costs if paying via one method only and for whole family only, by payment method and by number of parents in household.**

		Number of Parents		
		0* (n=3)	**1** (n=5)	**2** (n=17)
Premiums	Mean	$87	$64	$107
	Median	$70	$50	$60
	Range	$70-120	$30-100	$0-350
Deductibles	Mean	$533	$380	$385
	Median	$500	$300	$400
	Range	$200-900	$0-750	$100-1000
Co-pays	Mean	$31	$18	$18
	Median	$24	$10	$20
	Range	$20-50	$0-50	$5-45
Coinsurance	Mean	21%	16%	17%
	Median	20%	15%	20%
	Range	10%-33%	0-35%	7-33%
Enrollment fee (lump sum)	Mean	$517	$356	$368
	Median	$500	$400	$300
	Range	$50-1000	$20-500	$100-1500

*adult-only households where both adults need coverage

SPECIFIC PLANS

Plan A (the Health Link model) was described and participants were asked if they would purchase a plan like that. Ten (36%) said yes, another 8 (29%) said maybe, and 10 (36%) said no. Of the 18 saying no or maybe, their main reasons were lack of vision/dental care coverage (mentioned 9 times), overall cost of the plan (4 times), and concern about the $25 thousand maximum the plan offered (2 times).

Twenty participants responded to the question about how much they would pay for this plan. Three (15%) were only able to pay $20-30 per month. Nine (45%) would pay $35, seven (35%) would pay $40-50, and one (5%) would pay $75 per month.

The 18 participants who said "yes" or "maybe" they would buy a plan like this identified the most they would find acceptable to pay for Plan A. Responses appear in Table 9, below.

Table 9: **Acceptable Per Person Cost Sharing for HealthLink Plan (Plan A)**

		Income as Percent of Poverty		
		<100% (n=7)	**100-149%** (n=7)	**≥150%** (n=4)
Premiums	Mean	$37	$39	$53
	Median	$35	$35	$50
	Range	$20-50	$35-50	$35-75
Co-pays	Mean	$9	$7	$10
	Median	$10	$10	$10
	Range	$5-10	$0-10	$10

Plan B (the hypothetical CHIP family plan) was universally popular (25 respondents, or 90%, said they would buy this plan.) The only one who would not buy the plan wanted nursing home coverage. Two others did not respond because they had no children and either no spouse or the spouse was already covered by insurance.

Participant responses to the question of the most they would pay for coverage on Plan B (CHIP family plan), grouped by income level, appears in Table 10, below.

Table 10: **Acceptable Per Family Cost Sharing for CHIP Family Plan (Plan B)**

		Income as Percent of Poverty		
		<100% (n=8)	**100-149%** (n=11)	**≥150%** (n=6)
Premiums	Mean	$55	$54	$78
	Median	$50	$50	$80
	Range	$35-100	$30-150	$30-125
Co-pays	Mean	$11	$6	$10
	Median	$10	$5	$10
	Range	$0-20	$0-10	$5-20

Because this plan covers whole families, responses to the question about how much a participant would pay for coverage on this plan was also examined by family size. Table 11, below, shows the amount participants would find acceptable to pay for Plan B, by family size, for the 25 participants who responded to the question.

Table 11: **Acceptable Per Family Cost Sharing for CHIP Family Plan (Plan B)**

		Family Size		
		1 - 2 (n=5)	**3 - 4** (n=12)	**5 - 6** (n=8)
Premiums	Mean	$46	$48	$87
	Median	$50	$50	$88
	Range	$30-60	$30-100	$45-150
Co-pays	Mean	$6	$8	$9
	Median	$5	$8	$10
	Range	$0-10	$0-20	$5-10

Within family size groupings, poverty level appeared related to size of acceptable payment among the larger families (5 or 6 members), but this trend was not seen among the smaller families.

When asked whether it would make a difference if a state agency, a private insurance company, or their employer administered the plan, families with at least one parent working for a small business (<20 employees) showed a stronger preference for a state agency (5 of 15 responses, or 33%) than did families working for businesses with more than 20 employees (1 of 14 responses, or 7%). Conversely, families working for larger businesses (>20 employees) showed a stronger preference for an employer-administered program (5 of 14, or 36%) than did families working for small businesses (2 of 15, or 13%). Overwhelmingly, however, 40-50 percent of respondents in each group had no preference whatsoever. Private insurance companies were favored by just one respondent in each group (7%).

DISCUSSION AND INTERPRETATION

STUDY LIMITATIONS

There are a number of limitations that must be acknowledged with this research. First, because this research required participants to take the initiative to volunteer, those who chose to participate might be different in some important ways from non-participants. For example, participants may be more aware of the importance of insurance and the expense of medical care than those who did not volunteer.

Second, respondents largely were female and primarily mothers. Since women and children use health care services more frequently than men, responses probably should not be generalized to men.

Third, the qualitative nature of the interviews and the small sample size require caution in interpreting numeric information, especially when the sample is broken into subgroups for comparisons. In these situations, medians may be more reliable measures than means.

Fourth, the format of the questions may have biased the responses in some instances. For example, the questions on Plan A and Plan B described the plan and their proposed costs before asking for opinions. A different set of responses might have been gained had the participants been asked simply what they would find acceptable to pay for the plans.

Fifth, because participants were asked to assume each payment method was the only one required, using those responses to craft a more realistic insurance plan that incorporates more than one payment method will require care.

In general, participants seemed to appreciate the importance of health insurance and were willing to pay for it. Even so, specific payment methods were sometimes confusing, requiring the interviewer to give extensive examples before participants seemed to understand. Deductibles and coinsurance were among the most confusing, as several participants' responses indicated. For example, six participants said they would pay a higher percentage of all costs on a whole family plan than they would on a single adult plan, even though this clearly would require more money to be paid out altogether. One such participant, at 66 percent of poverty level, said she would pay 20 percent of all bills for herself and would increase that to 35 percent for her whole family.

Preferences for payment methods seemed clearly to depend on whether or not a method would result in sudden large payments or bills and whether or not it would be cost effective to respondents personally. These two concerns seem to be the main reason that co-pays and premiums were the two most popular payment methods as individual methods, although not all agreed. Several who said they would like the lump-sum enrollment fee liked it because once they came up with the cash they'd be covered for the whole year without worries. Coming up with the cash, however, would be difficult and several said they would need to plan, or make payments on the total amount due. A few respondents who did not care for co-pays and premiums were concerned that inability to pay on the spot or make a monthly payment one month would result in not receiving health care when needed.

Many opinions were expressed about which payment methods were most cost effective and "fair." Some disliked methods such as premiums, because you pay but might never need health care. Others disliked deductibles, where you pay a large amount at the beginning and may never see any benefit of your insurance plan if the year runs out and you haven't used more than your deductible's value. Several disliked policies that require you to pay via more than one method at all, including one who felt like companies were just "scalping" their clients. The few respondents who addressed enrollment fees as they typically occur said they didn't like them at all, didn't understand them, or felt companies were just looking for more ways to make money.

In looking at specific plans, Plan A (the HealthLink model) would likely be more popular if it included vision and dental. Plan B (the hypothetical CHIP family plan) was a runaway favorite, and it appears most people would be willing to pay more than a $30 premium, especially those with larger families. Several respondents said they would buy this plan "in a heartbeat" and wanted to know when it would become available. One such participant mentioned that the cost of including herself and four children on her husband's insurance plan through his employer would cost $600—more than their monthly rent. Another said that paying for the insurance available through her employer, at $140 per month, would eliminate groceries from her budget.

Cost figures that appear in Table 10 and Table 11 indicate that costs proposed in the HealthLink model and the hypothetical CHIP family plan are considered reasonable by participants, particularly if HealthLink included dental and vision. Individuals in the highest income group and in the largest families would pay even more than the proposed cost of $30 per month for the CHIP family plan. Those with income greater than 150 percent would pay a median of $80 per month, and those with families of 5-6 members would pay a median of $88. For HealthLink those with income 150 percent or above said a median of $50 was acceptable for the plan as described.

Interestingly, earlier in the interview, when asked about acceptable premiums in general for themselves, participants in the lowest and middle income groups said a median of $25 and $30 per month, respectively, would work, while respondents in the highest income group said a median of $43 per month would be acceptable. When stating acceptable premiums for their whole families, participants in the middle income group cited a median of $50 per month, while participants in the lowest and highest groups cited $100. Participants with 5-6 family members stated a median of $175 as acceptable for a whole family, compared with $50 for families with four or fewer members. (Keep

in mind that participants stated these amounts assuming that this premium was the only payment required of participants. Also, the sample size is quite limited.)

Data from the payment questions on deductibles and lump-sum enrollment fees might best be interpreted as a maximum amount of money a respondent might be able to come up with at one time, again with the caveat that this was the only payment required for health insurance coverage. For individuals, this amount ranged from a median of $100-250, while for whole families it ranged from $200-500. For both individual and whole family coverage, the highest income group identified the lowest median deductible and enrollment fee amount, while the lowest income group identified the highest medians for those two figures.

Interestingly, within family size groupings the participants' responses did not appear to correspond to income levels at all, although small sample sizes do not permit examination of this question with any statistical grounding. A respondent's age group, however, did appear related to the amount a person would be willing to pay, at least for premiums. Perhaps older respondents are willing to pay higher premiums because they have had more experience with their own or others' health care needs and expenses. The number of parents in the household appeared to indicate that those without children were willing to pay more for each of the individual payment methods. However, the number of those participants is so small that it is difficult to know if that would bear out if there were more participants in this category.

Finally, when asked at the end if they had anything else they wanted to add, almost 40 percent of respondents emphasized how important they thought this problem was. Some said there were many people like themselves, who fall through the cracks. Others wanted to know when they might be able to participate in a plan like the ones described. Most, however, simply were glad someone one was trying to do something to improve the situation.

SUMMARY

The increasing cost of health care will continue to thwart efforts to expand coverage for low-income, uninsured Idahoans. As policies are being developed to expand coverage to the currently uninsured, increasing health care costs, and in particular, higher beneficiary cost sharing, will erode current coverage as more workers lose or choose to disenroll from private health insurance.

For most nonelderly Idahoans, employer contributions significantly reduce the cost of coverage. However, many low-income families do not have access to employer-sponsored insurance or are not eligible for such coverage.

Cost is the primary factor in consumer decisions to participate in health insurance. Health insurance take-up rates demonstrate the extreme price sensitivity among low-income, uninsured persons. When coverage is free, 72-83 percent of the uninsured would be expected to participate; however, even with modest cost sharing (1-2 percent of income), participation rates drop off to around 50 percent. At cost sharing levels exceeding five percent of a family's annual income, projected participation rates are low enough that adverse selection would seriously threaten the viability of the plans offered and the program would not be very effective or efficient in terms of cost per newly covered person.

Cost sharing strongly influences consumer utilization of health care. Consumers buy less medical care when faced with higher prices. For the general population, this decreased utilization does not appear to have a negative effect on health, overall. However, for special populations, including the

poor and children, cost sharing can have some negative effects on health and policies must be carefully crafted to avoid such impacts.

Consumer price sensitivity can be used to encourage cost-effective use of health services. By attaching a higher co-pay to brand-name drugs, use of equally effective generic drugs can be encouraged. Likewise, a higher co-pay for nonemergent emergency room use will discourage ER use in lieu of available primary care in a physician's office. To promote use of cost-effective preventive health services, co-pays on these types of visits should be greatly reduced or avoided altogether.

Low-income, uninsured Idahoans express a willingness to pay for health insurance and health care costs; and feel that, in fact, they should help pay for care. Their ability to pay, however, is limited by concerns about also being able to pay for other basic needs such as food and housing. Families expressed an ability to pay modest co-payments of no more than $5-10 per visit and monthly premiums of no more than three percent of a family's annual income for family coverage and four percent of annual income for adult-only coverage.

The findings from these 28 qualitative research participants are similar to the results of two previously conducted qualitative studies of low-income, uninsured Idahoans views of premium affordability (Center for Health Policy, 2001). A monthly premium of $30-$50 was identified as affordable in both previous studies.

Idaho is among a minority of states not implementing some form of cost sharing in its CHIP plan. Lessons gleaned from the policies of other states and the research literature, as well as the specified preferences expressed by low-income, uninsured families in Idaho, support the use of modest co-payments and premiums for the purchase of subsidized health insurance and health care.

Health insurance is viewed as very important to the families interviewed. Without it, they report worry that an illness or serious injury will render them unable to provide for their children and cause them to become bankrupt. By the time they pay for rent, food, and transportation, there is not enough money left to pay for health insurance at its full cost. They are eager, however, to purchase coverage if an affordable product were made available.

REFERENCES

Branscome, J. M., & Brown, E. (2001). *MEPS Chartbook #7: state differences in job-related health insurance, 1998* (No. 01-0036). Rockville, MD: Agency for Healthcare Research and Quality.

Bureau of Vital Records and Health Statistics. (2001). *Idaho behavioral risk factors: results from the 2000 behavioral risk factor surveillance system*. Boise: Idaho Department of Health and Welfare, Division of Health, Bureau of Vital Records and Health Statistics.

Center for Health Policy. (2001). *Idaho state planning grant on the uninsured: data and policy work group findings*. Boise: Boise State University, Center for Health Policy.

Center for Health Services Research and Policy. (1998). *More small firms offer health insurance but fewer employees enroll* (Data Bulletin No. 10).

Cooper, P. F., & Schone, B. S. (1997). More offers, fewer takers for employment-based health insurance: 1987 and 1996. *Health Affairs, 16*(6), 142-147.

Duchon, L., Schoen, C., Doty, M. M., Davis, K., Strumpf, E., & Bruegman, S. (2001). *Security matters: how instability in health insurance puts U.S. workers at risk* (Report #512). New York: The Commonwealth Fund: Task Force on the Future of Health Insurance.

Eichner, M. J. (1998). The demand for medical care: what people pay does matter. *The Changing Market for Health Insurance, 88*(2), 117 - 121.

Feder, J., & Levitt, L. (1998). *Choices under the new state child health insurance program: what factors shape cost and coverage?* Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

Ferry, D. H., Garrett, B., Glied, S., Greenman, E. D., & Nichols, L. M. (2002). Health insurance expansions for working families: a comparison of targeting strategies. *Health Affairs, 21*(4), 246 - 254.

Gabel, J., Levitt, L., Holve, E., Pickreign, J., Whitmore, H., Dhont, K., Hawkins, S., & Rowland, D. (2002). Job-based health benefits in 2002: some important trends. *Health Affairs, 21*(5), 143-151.

Gabel, J. R., Levitt, L., Pickreign, J., Whitmore, H., Holve, E., Rowland, D., Dhont, K., & Hawkins, S. (2001). Job-based health insurance in 2001: inflation hits double digits, managed care retreats. *Health Affairs, 20*(5), 180 - 186.

Garrett, B., Nichols, L. M., & Greenman, E. K. (2001). *Workers without health insurance: who are they and how can policy reach them?* Washington, DC: The Urban Institute.

Glied, S., Callahan, C., Mays, J., & Edwards, J. N. (2002). *Bare-bones health plans: are they worth the money* (Issue Brief #518). New York: The Commonwealth Fund.

Heffler, S., smith, S., Greg Won, Clemens, M. K., Keehan, S., & Zezza, M. (2002). Health spending projections for 2001-2011: the latest outlook. *Health Affairs, 21*(2), 207 - 218.

Holahan, J., Uccello, C., Feder, J., & Kim, J. (2000). Children's health insurance: the difference policy choices make. *Inquiry, 37*(1), 7 - 22.

Kaiser Commission on Medicaid and the Uninsured. (2002). *The uninsured: a primer* (Report # 4050). Washington, D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Ku, L., & Coughlin, T. A. (2000). Sliding-scale premium health insurance programs: four states' experiences. *Inquiry, 36*(4), 471-480.

Lee, J. S., & Tollen, L. (2002). How low can you go? The impact of reduced benefits and increased cost sharing. *Health Affairs, 21*(3), 229 - 241.

Long, S. H., & Marquis, M. S. (2001). Low-wage workers and health insurance coverage: Can policymakers target them through their employers? *Inquiry, 38*(3), 331-337.

Lurie, N., Manning, W., Peterson, C., Goldberg, G., Phelps, C., & Lillard, L. (1987). Preventive care: do we practice what we preach? *American Journal of Public Health, 77*(7), 801-804.

Markus, A., Rosenbaum, S., & Roby, D. (1998). *CHIP, health insurance premiums and cost -sharing: lessons from the literature*. Washington, D.C.: The George Washington University.

Merlis, M. (2002). *Family out-of pocket spending for heath services: a continuing source of financial insecurity*. New York: The Commonwealth Fund.

Newhouse, J. P., & group, T. I. E. (1993). *Free for all? Lessons from the RAND health insurance experiment*. Cambridge: Harvard University Press.

O'Brien, M. J., Archdeacon, M., Barrett, M., Crow, S., Janicki, S., Rousseau, D., & Williams, C. (2000). *State experiences with cost-sharing mechanisms in children's health insurance expansions* (Report 385). New York: The Commonwealth Fund.

Oliver, L. N., & King, M. P. (2002). *SCHIP: money matters*. Denver: National Conference of State Legislators.

Rosenbaum, S., Markus, A., & Roby, D. (1999). *An analysis of implementation issues relating to CHIP cost-sharing provisions for certain targeted low income children* (Report). Washington, D. C.: The George Washington University Medical Center School of Public Health and Health Services, Center for Health Services Research and Policy.

Selby, J. V., Fireman, B. H., & Swain, B. E. (1996). Effect of a copayment on use of the emergency department in a health maintenance organization. *The New England Journal of Medicine, 334*(10), 635-642.

Solanki, G., Schauffler, H. H., & Miller, L. S. (2000). The direct and indirect effects of cost-sharing on the use of preventive services. *Health Services Research, 34*(6), 1331 - 1351.

Soumerai, S., Ross-Degnan, D., Avorn, J., Mclaughlin, T., & Choodnovskiy, I. (1991). Effects of Medicaid drug-payment limits on admission to hospitals and nursing homes. *The New England Journal of Medicine, 331*(10), 650-655.

Tamblyn, R., Laprise, R., Hanley, J., Abrahamowiez, M., Scott, S., Mayo, N., Jurley, J., Grad, R., Latimer, E., Perrcault, R., McLeod, P., Haung, A., Larochelle, P., & Mallet, L. (2001). Adverse events associated with prescription drug cost-sharing among poor and elderly persons. *JAMA, 285*(4), 421 - 429.

Thorpe, K. E., & Florence, C. S. (1997). Why are workers uninsured? Employer-sponsored health insurance in 1997. *Health Affairs, 18*(2), 213 - 218.

Wong, M., Andersen, R., Sherbourne, C., Hays, R., & Shapiro, M. (2001). Effects of cost sharing on care seeking and health status: results from the medical outcomes study. *American Journal of Public Health, 91*(11), 1889-1894.

Appendix A: State Cost-Sharing Policies

	SCHIP Programs						Medicaid Programs		Medicaid 1115 Waivers				
	Type of SCHIP Program as of 7/15/2002	Program Name	Upper Eligibility	Premiums	Co-Pays	Maximum Out-of-Pocket Expense	Premiums	Co-pays*	Program Name	Eligible Population	Premiums	Co-pays or Deductibles	OOP Limit
ALABAMA	Combination	ALL Kids	200% FPL	<150% = None 150%-200% = $50 annually up to $150 /family	<150% = none 150%-200% = $5 per hospital stay, office visit, none-emergent ER visit $3 brand-name Rx $1 generic Rx	150%-200% = $150 /family /year $500 copayment limit							
ALASKA	Expansion	Denali KidCare	200% FPL	None									
ARIZONA	Separate	KidsCare	200% FPL incl parents	150%-174%= $10/child per month; or $15/2+ kids/mo; or $20/family/mo 175%-200%= $15/child per month; or $20/2+ kids/mo; or $25/family/mo	$5 per nonemergency ER visit	No more than 5% of annual family income			Healthy Arizona	Adults under age 65 <=100% FPL	None	$1 visit $5 nonemergen OR or ER	
ARKANSAS	Expansion	ARKids First	200% FPL	None	0%-100% (ARKids A) = None 101%-200% (ARKids B) = $5 per Rx drug, $10 per office visit, 20% of the Medicaid-allowed amount for durable medical equipment, 20% of the Medicaid per diem cost of the day of an inpatient stay	No more than 5% of annual family income			ARKids First	Uninsured children under age 19 <=200% FPL			
CALIFORNIA	Combination	Healthy Families	250% FPL incl parents	*Community provider plan ($3/mo discount):* 100%-149% = $4/child per month; or $8/2+ children 150%-200% = Maximum payment, $18/month *State-designed plan:* 100%-149% = $7/child per month; or $14/2+children/mo; or $10/parent/mo 150%-200% = $9/child per month; or $18/2 children/mo; or $27/3+ children/mo; or $20/parent	$5 per service adult dental copay same as state employee	$250 per year If family prepays three months, the fourth month is free		$1 office visit $5 nonemergent ER $1 Rx					
COLORADO	Separate	Child Health Plan Plus (CHP+)	185% FPL	151%-185%=$25 annual enrollment fee per child; $35 maximum annual enrollment fee per family	101%-150% = $2 office visit; $1 per Rx; $5 ER service 151%-185% = $5 office visit; $3 per generic Rx; $5 per brand name Rx; $15 ER service 101%-185% = $10 nonemergent ER visit			$2 office visit $15 hospital stay $.75 generic Rx $3 name brand Rx					
CONNECTICUT	Combination	HUSKY	300% FPL	185%-235% = None 236%-300% = $30/child/mo; or $50/family/mo >300% = $137-$200/mo depending on plan selected	$5 office visit; $3 generic Rx; $6 brand-name Rx; $25 nonemergent ER visit. For mental health conditions with limitec coverage: Up to 10 visits = 100% covered 11-20 visits = $25 copayment 21-30 visits = lesser of a $50 copayment or 50% coinsurance	185%-235%=$650 limit 236%-300%=$1,250 limit Greater than 300%= No limit						
DELAWARE	Separate	Healthy Children	200% FPL	101%-133% = $10/family/mo 134%-166% = $15/family/mo 167%-200% = $25/family/mo	$10 nonemergent ER visit				Diamond State Health Plan	Adults under age 65 <=100% FPL		None	
DISTRICT OF COLUMBIA	Expansion	DC Healthy Families	200% FPL	Medicaid expansion plan; no cost sharing provisions					Beneficiaries will be added to the existing Medicaid managed care 1915(b) waiver program, the District of Columbia Managed Care Program	Childless adults age 50-64 up to 50% FPL			
FLORIDA	Combination	KidCare	200% FPL	101%-200% = $15/family/mo Above 200% = full premium	$3 office visit, behavioral health outpatient visit, prescribed medicine, therapy services; $10 nonemergent ER visit and emergency transportation								
GEORGIA	Separate	PeachCare for Kids	235% FPL	Birth-age 5 = None Ages 6-18 = $7.50/child/mo $15/family/mo	None	$180/family per year on cost sharing							
HAWAII	Expansion	New program	200% FPL	Medicaid expansion plan; no cost sharing provisions					Hawaii QUEST	AFDC-related eligibles, all General Assistance eligibles, and the State Health Insurance Program population <100% FPL	> 100% FPL. premiums $150.00/mo/adult, $61.80/month/child. Pregnant women and infants up to 185 percent FPL, and children under 6 years of age up to 133 percent FPL, are exempt from premiums. In addition, .	Copayments are imposed on all adults who are covered under the program expansion	
IDAHO	Expansion	(Idaho) CHIP	150% FPL	Medicaid expansion plan; no cost sharing provisions									

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	Type of SCHIP Program as of 7/15/2002	Program Name	Upper Eligibility	Premiums	Co-Pays	Maximum Out-of-Pocket Expense	Premiums	Co-pays*	Program Name	Eligible Population	Premiums	Co-pays or Deductibles	OOP Limit
ILLINOIS	Combination	KidCare	185% FPL	KidCare Assist (Below 133%) = None KidCare Share (133%-150%) = None KidCare Premium (150%-185%) = $15/child/mo; or $25/2 children/mo; o $30/3 or more children/mo	KidCare Assist = None KidCre Share = $2 office visit or Rx KidCare Premium = $5 office visit; $3 generic Rx; $5 brand Rx; $25/nonemergent ER visit	$100 per year on copayments		$2-$3 hospital day					
INDIANA	Combination	Hoosier Healthwise	200% FPL	100%-150% = None 150%-175% = $11/child/mo; or $16.50/2 or more children/mo; or $31.50/child/quarter; or $47.25/2 or more children quarterly; or $120/child/year; or $180/2 or more children/year 175%-200% = $16.5/child/mo; $24.75/2 or more children/mo or $47.25/child quaterly; or $71/2 or more children quarterly; or $180/child/year; or $270/2 or more children/year	$3 generic Rx; $10 brand Rx; $10 amulance transport; $20 nonemergent ER visit			$0.50 generic Rx $1-$3 name brand Rx $3 nonemergent ER				
IOWA	Combination	Hawk-I	200% FPL	<150% = None 150%-200% = $10/child/mo; $20/family/mo	$25 per nonemergency ER visit								
KANSAS	Separate	HealthWave	200% FPL	Up to 150% = None 151%-175% = $10/family/mo 176%-200% = $15/family/month	None	Not to exceed 1% of total family income per year							
KENTUCKY	Combination	KCHIP	200% FPL	None									
LOUISIANA	Expansion	LA CHIP	150% FPL	Medicaid expansion plan; no cost sharing provisions									
MAINE	Combination	Cub Care	200% FPL	Up to 150% = None 151%-160% = $5/child/mo; or $10/family/mo 161%-170% = $10/child/mo; or $15/family/mo 171%-185% = $15/child/mo; or $30/family/mo	None	151%-160%=.4%-.6% of family income 161%-170%=.7%-1.1% of family income 171%-185%=1%-1.6% of family income							
MARYLAND	Combination	Maryland Children's Health Program	300% FPL	200%-250% = $450/family/year. ($38/family/mo) 251%-300% = $562/family/year. ($47/family/mo)	None								
MASSACHUSETTS	Combination	MassHealth	200% FPL	<150% = None 151%-200% = $10/child/mo or $30/family/mo	$.50 Rx; $3 nonemerget ER visit				MassHealth	Children, families and disabled <=150% FPL; Long-term unemployed (>12 months) childless adults to <=133% FPL	Cost-sharing requirements vary across the MassHealth components, however requirements for premiums and copayments are nominal. Where cost-sharing is required, it is on a sliding-scale based on income		
MICHIGAN	Combination	MIChild	200% FPL	Up to 150% = None 151%-200% = $5 per famliy per month	None								
MINNESOTA	Expansion	MinnesotaCare	275% FPL (age 2-19) 280% FPL (age 0-2) Parents <200%	100%-199% = Based on sliding scale from 2.3% to 6.2% of gross income 275%-280% = Full cost	None				MinnesotaCare	Parents <200% FPL; children under age 19, <=275% FPL	Mdcd = None Expansion = 2.3% - 6.2% of fam income on a sliding scale basis.	Mdcd = None Expansion = $3 Rx $25 eyeglasses 100%-175% FPL 50% copay for nonpreventive dental	
MISSISSIPPI	Combination	(Mississippi) CHIP	200% FPL	None	<150% = None 151%-175% = $5 outpatient visit; $15 ER visit 176%-200% = $5 outpatient visit; $15 ER visit	151%-175%=$800 per family per year 176%-200%=$950 per family per year							

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	SCHIP Programs Type of SCHIP Program as of 7/15/2002	Program Name	Upper Eligibility	Premiums	Co-Pays	Maximum Out-of-Pocket Expense	Medicaid Programs Premiums	Medicaid Programs Co-pays*	Medicaid 1115 Waivers Program Name	Eligible Population	Premiums	Co-pays or Deductibles	OOP Limit
MISSOURI	Expansion	MC+ For Kids	300% FPL	Medicaid expansion plan; no cost sharing provisions					Missouri Managed Care Plus (MC+)	Adults transitioning off welfare who would not otherwise be insured or Medicaid eligible <=300% FPL; Uninsured custodial parents <=100% FPL; Uninsured non-custodial parents <=125% FPL; Uninsured non-custodial parents actively participating in Missouri's Fair Share program <=100% FPL	226%-300% FPL pay up to $80	<185% FPL = no cost sharing 185%-225% FPL $5 visit 226%-300% FPL $10 visit & $9 Rx +$2 Rx dispensing fee	
MONTANA	Separate	(Montana) CHIP	150% FPL	None	101%-150% = $25 inpatient stay; $5 ER or outpatient visit; $3 office visit; $3 generic Rx; $5 brand Rx	$215 per year							
NEBRASKA	Expansion	Kids Connection	185% FPL	Medicaid expansion plan; no cost sharing provisions				$2 visit $1 Rx $3 dental					
NEVADA	Separate	Nevada Check Up	200% FPL	Quarterly premium based on family size and annual income *Family of 2* = Up to $16,000: $10 per quarter/$20 enrollment fee; $16,001-$18,500: $20 per quarter/ $40 enrollment fee; $18,501-$21,000: $50 per quarter/$50 enrollment fee *Family of 3* = Up to $20,000: $10 per quater/ $20 enrollment fee; $20,001-$23,250: $20 per quater/ $40 enrollment fee; $23,251-$26,500: $50 per quarter/ $50 enrollment fee *Family of 4* = Up to $24,000: $10 per quarter/$20 enrollment fee; $24,001-$28,000: $20 per quarter/ $40 enrollment fee: $28,001-$32,800: $20 per quarter/ $40 enrollment fee; $32,801-$37,500: $50 per quarter/ $50 enrollment fee	Up to 150% = None 151%-200% = $5 Rx; $5 dental visit; $10 pair of eyeglasses; $10 pair of hearing aids							
NEW HAMPSHIRE	Combination	Healthy Kids	300% FPL	185%-250% = $20/child/mo 250%-300% = $40/child/mo	$5 office visit; $5 generic Rx; $10 brand Rx; $25 nonemergent ER visit; $5 substance abuse office visit	No more than 5% of annual family income. $100 per family per month		$0.50 generic Rx $1 brand name Rx					
NEW JERSEY	Combination	NJ KidCare	350% FPL incl parents <200% FPL	Up to 150% = None 151%-200% = $15/family/mo 201%-250% = $30/family/mo 251%-300% = $60/family/mo 301%-350% = $100/family/mo	151%-200% = $5 office visit; $1 Rx; $5 brand Rx ; $35 ER visit; $5 eye exam 201%-350% = $5 office visit; $10 off-hours office visits and nurse midwifery; $5 generic Rx; $10 brand Rx; $25 outpatent mental health visit; $5 outpatient detoxification; $35 ER visit	No more than 5% of annual family income. $100 per family per month							
NEW MEXICO	Expansion	New Mexikids	235% FPL	None	185%-235% = $25 inpatient hospital stay; $15 ER visit; $5 office visit; $5 missed appointment; $2 Rx; $25 inpatient mental health stay; $5 outpatient mental health; $25 substance abuse treatment; $5 hearing, dental, vision, immunization and therapeutic service				New Mexico Medicaid Section 1115 Demonstration	All Medicaid eligible children in families with income between 186% - 235% FPL		186%-235% FPL: $5 visit $5 outpatient services (clinic, therapy) $15 urgent care/ER visit $25 inpatient hospital admission $15 outpatient hospital services $2 Rx $5 dental visit $5 missed appointment Not to exceed the following % of annual income: 186%-200% - 3% 201%-215% - 4% 216%-235% - 5%	

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	SCHIP Programs						Medicaid Programs		Medicaid 1115 Waivers				
	Type of SCHIP Program as of 7/15/2002	Program Name	Upper Eligibility	Premiums	Co-Pays	Maximum Out-of-Pocket Expense	Premiums	Co-pays*	Program Name	Eligible Population	Premiums	Co-pays or Deductibles	OOP Limit
NEW YORK	Combination	Child Health Plus	250% FPL	Up to 160% = None 160%-222% = $9/child/mo; or $27/family/mo 223%-250% = $15/childmo; or $45/family/mo	None	No more than 5% of annual family income			Family Health Plus	Parents up to 150% FPL; Individuals without children up to 100% FPL	None		
NORTH CAROLINA	Separate	NC Health Choice for Children	200% FPL	Up to 149% = None 150%-200% = $50/child/year enrollment fee; $100/family/year	$5 office visit; $5 outpatient hospital visit; $6 Rx; $20 nonemergent ER visit			$3 visit $1 generic Rx $4 name brand Rx $3 dental visit					
NORTH DAKOTA	Combination	Healthy Steps	140% FPL	None	<140% = $2 Rx; $5 ER visit; $50 hospital admit, psychiatric hospital or substance abuse inpatient facilities; $50 deductible for first day of inpatient substance abuse treatment			$2 visit $2 dental visit $50 hospital admission					
OHIO	Expansion	Healthy Start	200% FPL	Medicaid expansion plan; no cost sharing provisions									
OKLAHOMA	Expansion	SoonerCare	185% FPL	Medicaid expansion plan; no cost sharing provisions				$1 service $1-$2 Rx					
OREGON	Separate	Oregon Health Plan	170% FPL		None				Oregon Health Plan (OHP)	Uninsured under age 65, <100% FPL	Oregon implemented a sliding scale of premiums on adult, non-pregnant, expansion eligibles, beginning 12/1/95. The State now waives past due premium amounts for individuals at the zero income level or those who meet certain objective criteria (such as homelessness)		
PENNSYLVANIA	Separate	PA CHIP	235% FPL	<200% = None *State-funded subsidized program* 200%-235% = Families must pay half of premium cost	None			$1 Rx $3 hospital day up to $21/adm $0.50 - $3 nonemergent ER					
RHODE ISLAND	Expansion	RIte Care	250% FPL	Families have choice of paying premium or copayment 185%-300% Age 0-12 months = $12.34-$12.46 Age 1-5 years = $1.94-$1.96 Age 6-14 years = $1.57-$1.58 Males age 15-18 years = $2.48-$2.51 Females age 15-44 years = $4.01-	$5 office visit; $25 hospital admission; $15 outpatient surgery; $2 Rx; $35 nonemergent ER visit; rates differ for family planning services and for pregnant women	No more than 5% of annual family income			RIte Care	Children up to age 18 <=250% FPL Parents to 185% FPL	185%-250% FPL offered a choice of cost-sharing arrangements: 1) pay a fixed monthly premium payment (based on a percentage of the actual capitation rate charged by the plan), with no additional charge at the point of service delivery; or 2) pay their share through copayments imposed at the point of service delivery. $35 non-emergent ER transportation services		
SOUTH CAROLINA	Expansion	Partners for Healthy Children	150% FPL	Medicaid expansion plan; no cost sharing provisions				$3 Rx					
SOUTH DAKOTA	Combination	(South Dakota) CHIP	200% FPL		None			No co-pay for PCP $2 referral Dr $2 Dr home visit $2 Rx $3 dental visit $2 hospital					
TENNESSEE	Expansion	TennCare for Children	400% FPL		None				TennCare	Uninsured Medicaid eligible; Uninsurables; Persons not eligible, either directly or as a dependent, for an employer-sponsored or government-sponsored health plans as of 6/1/1994.	>100% FPL are required to pay premiums on a graduated fee schedule , deductibles, and copayments based on income. Premiums include individual premiums and family premiums.Cost-sharing expenditures are limited by annual out-of-pocket maximums of $1,250 per individual/family, excluding premium payments.To encourage use of preventive services, no deductible or copayment is required for such services.	100%-199% = $250/individual; $500/family deductibles; Copayments are up to 10 percent of costs, based on a graduated scale (other than mandatory Medicaid eligibles) >=200% = 10% of cost of service	
TEXAS	Combination	TexCare Partnership	200% FPL	100%-150% = $15 enrollment fee/family/year 150%-185% = $15/family/mo 186%-200% = $18/family/mo	100%-150% = $2 office visit; $5 ER visit; $1-$2 Rx 151%-200% = $5 office visit; $25 ER visit; $5 generic and $10 brand Rx 186%-200% (coinsurance payment) = 5% for HMO and PPO in-network services; 15% for PPO out-of-network services where no copayment is required; $100 annual deductible/family/inpatient hospital stay	100%-150% = $100/family/year No more than 5% of annual family income Coinsurance capped at $250/family/year							

Appendix A: State Cost-Sharing Policies

	SCHIP Programs Type of SCHIP Program as of 7/15/2002	Program Name	Upper Eligibility	Premiums	Co-Pays	Maximum Out-of-Pocket Expense	Medicaid Programs Premiums	Medicaid Programs Co-pays*	Medicaid 1115 Waivers Program Name	Eligible Population	Premiums	Co-pays or Deductibles	OOP Limit
UTAH	Separate	(Utah) CHIP	200% FPL	None	101%-150% = $10 ER visit; $5 hospital or outpaitent visit; $2 Rx. 151%-200% = $30 ER visit and 10% coinsurance for lab and x-ray services above $50; $10 hospital or outpatient visit and 10% coinsurance; $4 Rx on approved list or generic brand and 50% coinsurance for drugs outside formulary 10% coinsurance for first 10 days of inpatient mental health services and 50% coinsurance for last 20 days; 20% coinsurance for dental filling sand 50% coinsurance for outpatient mental health services	101%-150%=$500 per family 151%-200%=$800 per family		$3 visits $2 Rx $100 coinsurance for hopsital admission $6 nonemergent ER	Primary Care Network	Adults age 19-64 who have not had health care coverage for >= 6 months, whose employer pays < 50% of health care benefit, and whose annual income < 150% FPL	$25 annual enrollment fee	$5 visits $5 generic Rx; 24% coinsurance for name-brand $30 nonemergent ER No copay on preventive dental; 10% coinsurance on restorative dental	Out-of-pocket max $1,-000/client/yr
VERMONT	Separate	Dr. Dynasaur	300% FPL	225%-300% = $50/family/mo	<150% = $2-$15 inpatient admission 151%-200% = $5-$25 inpatient admission No copayments for premium assistance plan enrollees	Up to 150%=$180 per family per year 151%-200%=$350 per family per year			Vermont Health Access Plan (VHAP)	Uninsured <=150% and uninsured children between 225%-300% FPL	50%-185% = Enrollment fee $10-$25/adult not otherwise eligible for Medicaid coverage/ 6-month 185%-225% = $10/mo 225%-300% = $12/mo 225%-300% CHIP = $25/mo Categorically needy = none	Expansion eligibles = Cost sharing up to an annual out-of-pocket max of $750 for a single person and $1,500 for families $1 Rx under $30, $2 Rx of $30 or more is charged to low-income Medicare beneficiaries receiving the pharmacy-only supplemental benefit	
VIRGINIA	Separate	Family Access to Medical Insurance Security Plan (FAMIS)	200% FPL		None								
WASHINGTON	Separate	(Washington) CHIP	250% FPL	200%-250% FPL = $10/child/mo; or $30/family/mo	$5 office visit; $5 brand Rx; $25 nonemergent ER vixit	$300/child/year; or $900/family/year				<200% FPL Basic Health for adults Waiver req:Mdcd & SCHIP parents < 250% FPL; Possibly childless adults	<100% FPL = None BH: $20-$30/adult/mo Waiver req: >100% FPL = "reasonable premiums"	BH: $10 visit $100 hosp adm $3-$7 generic Rx; 50% coinsurance for name-brand Rx Waiver req: $5 brand-name Rx $10 nonemergent ER	5% of annual income limit
WEST VIRGINIA	Separate	WV CHIP	200% FPL	None	150%-200% = $15 office visit, $25 inpatient admission, $25 outpatient procedure, $35 nonemergent ER visit, $5 generic Rx, $10 brand Rx	$250/child/year $750/family/year		$0.50 - $3 Rx					
WISCONSIN	Expansion	BadgerCare	185% FPL	150%-200% = 3% of annual income	None			$0.50 - $3 visit $0.50-$1 Rx up to $5/mo $0.50 - $3 dental visit $3 hospital day up to $75 $3 outpatient visit	BadgerCare	Uninsured children and parents <=185%; Reenrollment up to 200% FPL	>150% = 3 percent of family income	None	
WYOMING	Separate	Kid Care	133% FPL	None	<133% = None 134%-150% = $15 inpatient service; $5 outpatient service; $2 generic Rx; $4 brand name Rx; $10 nonemergent ER visit	134%-150% = $200/family/year							

Exceptions to SCHIP cost-sharing:

1. Preventive services including well-baby and well-child health care and immunizations.
2. American Indian or Alaskan Native children are exempt.
2. Routine preventive dental services.

Exceptions to Medicaid cost-sharing:

1. Any service for which the State payment is $10 or less.
2. Any family planning service.
3. Any services provided to a person age 18 or under (some cases 21 or older)
4. Any woman receiving perinatal care.
5. Any person who is an inpatient in a health facility.
6. Any children under 21 living in boarding homes or institutions for foster care.
7. Drugs dispensed in an emergency.
8. Managed Care enrollees.
9. Emergency Services
10. Individuals who are receiving waiver services.
11. Individuals who receive assistance under the State Disability Program
12. Nutritional Therapy and nutrition supplements if under age 20

Appendix B: Affordability Model

Premiums as Percent of Annual Income

Income Category Relative to Poverty Guideline (2002 HHS Poverty Guideline)	Annual Income*						
	Single	Couple	Family (2 adults, 2 children)	Single	Couple	Family (2 adults, 2 children)	
<100%	$ 4,430	$ 5,970	$ 9,050				
100-150%	$ 11,075	$ 14,925	$ 22,625				
151-200%	$ 15,505	$ 20,895	$ 31,675				
	Monthly Premium			Premium as % of Annual Income			Selected Co-Payments
Average Monthly Worker Premium, All Plans, Western Region, 2001[1]							
$44,300 Idaho median family income (2001)	$ 24	$ 149	$ 149	1%	4%	4%	
HealthLink Model							
<100%	$ 10	$ 20		3%	4%		$5 PCP visit, $20 hospital day, $50 ER unless admitted, $10 generic Rx, $25 name-brand Rx
100-150%	$ 35	$ 70		4%	6%		$10 PCP visit, $40 hospital day, $75 ER unless admitted, $10 generic Rx, $25 name-brand Rx
151-200%	$ 50	$ 100		4%	6%		$15 PCP visit, $75 hospital day, $100 ER unless admitted, $10 generic Rx, $25 name-brand Rx
CHIP Task Force Model (child only coverage; premium based on $121 avg. Medicaid cost/child)							
<100%			$ -				
100-160%			$ -				
160-180%			$ 80			3%	$1-$5 service
180-200%			$ 160			6%	$1-$5 service
							Premiums + co-pays would exceed 5% of annual income
Maximum Cost Sharing Interviewees Were Willing To Pay:							
<100%	$ 35	$ 70	$ 50	9%	14%	7%	$10 physician visit
100-150%	$ 35	$ 70	$ 50	4%	6%	3%	$5-10 physician visit
151-200%	$ 50	$ 100	$ 80	4%	6%	3%	$10 physician visit

[1] Kaiser/HRET Survey of Employer Sponsored Health Benefits: 2001.

* Income at the midpoint of range used for calculations

APPENDIX C: INTERVIEW QUESTIONS

BACKGROUND QUESTIONS:

1. Age:
2. Sex: Female Male
3. # Family members (#kids and partner/spouse)
4. Average annual or monthly household income
5. Do you currently have health insurance for yourself?
6. If no, what is the main reason?
7. Do you work outside the home full-time or part-time (up to 50%)?
8. Do you or your spouse/partner work for a business with fewer than 50 employees? [if yes, go to 9-----if no, go to 10]
9. Fewer than 20 employees?
10. Does your employer or your partner/spouse's employer offer health insurance?
11. Is it possible to include your whole family on that insurance plan?
12. Do you currently have health insurance for your kids?
13. If no, what is the main reason?
14. Does your spouse/partner currently have health insurance?
15. If not, what is the main reason?

PAYMENT METHODS

"There are several different ways of paying for health care coverage: I'll ask you about 5 different kinds. Assume the plan has specific services it will cover and that it will not cover everything."

Premium: "you pay a certain amount each month for access to health care services covered on the plan."

16. On a scale of 1-5 (1=love it, 3=neutral, 5=no way) what's your opinion about premiums as a method of payment overall?
17. What is your main reason for rating it that way?

18. How much would you pay per month for health insurance for yourself? [if kids are NOT covered, ask also how much would pay per month for insurance for whole family]

Deductible: "you pay the first "x" amount of services you use each calendar year, the plan covers the rest"

19. On a scale of 1-5 (1=Love it, 3=neutral, 5=no way) what's your opinion about deductibles as a method of payment overall?

20. What's your main reason for rating it that way?

21. How much of a deductible would you pay for health insurance for yourself? [if kids are NOT covered, ask also how much of a deductible would pay for insurance for whole family]

Co-pay: "You pay "x" amount each time you use a service"

22. On a scale of 1-5 (1=Love it, 3=neutral, 5=no way) what's your opinion about co-pay as a method of payment overall?

23. What's your main reason for rating it that way?

24. How much of a co-pay would you pay for each doctor visit/health care service for yourself? [if kids are NOT covered, ask also how much of a co-pay would pay for each doctor visit/health care service for whole family]

Co-insurance: "you pay a set percentage of all bills, the plan pays the other set percentage (ex: 80/20—plan pays 80%, you pay 20%)"

25. On a scale of 1-5 (1=Love it, 3=neutral, 5=no way) what's your opinion about co-insurance as a method of payment overall?

26. What's your main reason for rating it that way?

27. What percentage of health service bills would you pay towards overall health insurance? [if kids are NOT covered, ask also what percentage of health service bills would pay towards insurance for whole family]

Enrollment fees: "once-a-year payment"

28. On a scale of 1-5 (1=Love it, 3=neutral, 5=no way) what's your opinion about enrollment fees as a method of payment overall?

29. What's your main reason for rating it that way?

30. How much of an enrollment fees would you pay for health insurance for yourself? [if kids are NOT covered, ask also how much of an enrollment fee would you pay for insurance for whole family]

Overall payment methods questions:

31. Of these five payment methods, which do you prefer? [however many]

32. If a few were combined, which would you prefer to see combined?

33. Are any completely unacceptable?

34. If so, what is the main reason?

SPECIFIC PLANS AND PAYMENTS:

"There are two different insurance plans being considered by the state right now. I'll describe each one and ask specific questions about each.

Plan A: Covers basic adult services—doctor visits, hospital visits, lab/x-ray, mental health services, prescription drugs, and nursing home care. Each year it would pay out no more than $25,000. No vision and dental. Proposed cost: $35/month plus $10 co-pay for office visits.

35. Would you buy a plan like this for yourself?

36. If no, why not?

37. What is the most you would pay for a plan like this?

**If dependent children in home, ask about Plan B. Otherwise, skip to #41

Plan B: Covers the same basic services, plus vision and dental. No nursing home care. Covers whole family. Proposed cost: $30/month/family plus $5 co-pay for office visits.

38. Would you buy a plan like this for your family?

39. If no, why not?

40. What is the most you would pay for this kind of plan?

41. What difference would it make to you if the plan were administered by a state agency, a private insurance company, or through your employer?

42. Anything else you would like to add?