OVERVIEW

As states expand children’s coverage up the income scale, families are expected to contribute more to the cost of that coverage, but unaffordable premiums can place a significant financial burden on low-income families. In fact, research has shown that imposing or increasing premiums in Medicaid and SCHIP (known as Medi-Cal and Healthy Families in California) depresses enrollment and can increase the number of uninsured children with implications for their access to care. In light of this reality, policymakers need to weigh the policy objectives associated with new or increased premiums against the potential adverse consequences for children, families, and the health care delivery system.

KEY ISSUES RAISED BY PREMIUM INCREASES

1. Impact on Affordability

The purpose of SCHIP is to provide parents with an affordable coverage option for their uninsured children when they lack such an option through their jobs. To date, however, there is no clear consensus on what constitutes “affordable” coverage. Research in California and other states indicates that families under 300 percent of the federal poverty level (FPL) need significant assistance purchasing health insurance.¹ Based on concerns about affordability, almost half of all states do not charge any premiums in Medicaid/SCHIP for children with family income below 200 percent of the federal poverty level and virtually all states with coverage at more moderate income levels (i.e., up to 250 percent of the federal poverty level) charge premiums well below the levels allowed under federal law.² In California, the issue of affordability is particularly acute because of the state’s high cost of living (Figure 1). In effect, the high cost of living means that low and moderate-income families must spend a higher share of their incomes on essential items, such as housing, leaving fewer resources with which to pay health premiums.
2. Reductions in Enrollment

A large and consistent body of research indicates that increasing premiums in Medicaid and SCHIP will cause enrollment to decline. For example, in a study of Medicaid expansions during the 1990’s, a premium set at one percent of family income was estimated to reduce enrollment by 15 percent, with higher premiums resulting in fewer families enrolling. Other studies have found that many of the children who lose public coverage will become uninsured, with children between 100 percent and 200 percent of the FPL most at risk of joining the ranks of the uninsured in the face of a premium increase. Uninsurance can have a significant impact on children’s health and development since uninsured children are more likely to delay or forgo the medical care they need.

A number of state-specific studies have documented the impact of premium increases similar to those now under consideration in California. The studies, some of which are described below, consistently find that new or increased premiums in public programs reduce enrollment levels, especially for children in lower-income families.

- **Kentucky saw enrollment decline as a result of modest premiums for families between 151 percent and 200 percent of the FPL.** In December 2003, Kentucky imposed new premiums in SCHIP of $20 per family per month for children families with income from 151-200 percent of the FPL. As a result of the premium, children were enrolled for a shorter period of time, with the impact concentrated in the first three
months following the premium. Overall, enrollment for children subject to the premium declined by 18 percent after the premium.

- **Even relatively small premium changes led to enrollment declines in New Hampshire.** In January 2003, New Hampshire increased premiums from $20 to $25 for children with income between 185-250 percent of the FPL and from $40 to $45 for children with income between 251-300 percent of the FPL. A study of the changes found that the state’s SCHIP enrollment level dropped and then resumed growing three to five months after the premium increase, although at a slower pace than before the increase. Overall, the researchers estimate that the implied effect was a 4 percent reduction in monthly caseload and a 10 percent reduction in new monthly enrollment. The greatest negative impact on enrollment occurred particularly among children with incomes from 185 to 250 percent of the FPL.

3. **Greater discontinuity of coverage for children.** Some children cycle on and off public coverage because their family income fluctuates, their parents gain or lose access to employer-sponsored coverage, they face paperwork barriers to renewal, or for other reasons. One significant source of such “churning,” is that families can find it difficult during some months to meet premium requirements (e.g., a temporary job loss or unexpected car repair bill) or may have trouble navigating payment procedures. Especially if coupled with other policy changes known to increase churning, such as more frequent renewal periods, premium increases may lead to more children cycling on and off public programs and to more gaps in their access to care.

4. **Unintended, offsetting increases in spending on other areas.** As children lose Medicaid/SCHIP coverage due to premium increases, they tend to have few, if any, other affordable health insurance options and, as a result, are likely to become uninsured. The resulting increase in the number of uninsured children can cause offsetting increases in spending that offset some of the savings associated with reduced public coverage and add to inefficiencies in the health care delivery system.

- **Administrative costs.** The administrative costs associated with collecting premiums can be high and even consume much of the revenue a state raises by imposing premiums. Virginia, for example, terminated an initiative to impose premiums after finding that they were expensive to administer and led to thousands of children facing the prospect of losing coverage. Specifically, in October 2001, Virginia imposed a $15 per child per month SCHIP premium for children between 150 and 200 percent of the FPL. The state incurred $1.39 in administrative costs for every $1 in premiums collected from families and some 4,000 children were at risk of losing coverage for failure to pay the premium. In the face of potential coverage losses for children and the administrative burden on the state, Virginia eliminated the premiums and cancelled the pending coverage terminations in the spring of 2002.

- **Uncompensated care.** Research has shown that decreases in Medicaid/SCHIP enrollment are associated with increases in emergency department use among the uninsured, reflecting a shift from ambulatory care to more expensive settings. The
Institute of Medicine has found that uninsured children have less access to a regular source of primary care and as a result may use the health system less appropriately, which can potentially increase uncompensated and charity care in the community.

- **Adverse selection.** Premiums may induce healthier families to disenroll from Medicaid/SCHIP at higher rates, resulting in a phenomenon known as “adverse selection,” which can increase the per child cost of serving children left in the program. In July 2003, for example, Florida increased KidCare premiums from $15 to $20 per family per month, but rescinded the increase for families with incomes below 150 percent of the FPL by October 2004. After the relatively modest premium increase, there was a sharp decrease in the length of enrollment and a 36 percent increased chance of disenrollment among children between 101-150 percent of the FPL. In addition, children with chronic conditions or special health needs were eight to 17 percent less likely to disenroll than healthy children, suggesting that some adverse selection was occurring and possibly causing an increase in per capita program costs for the remaining children.

**CONCLUSION**

California is currently facing a significant budget deficit and many options are being considered to balance it, including increasing the premium amounts for children in Healthy Families. Current proposals will have consequences that may unintentionally have adverse effects for the Healthy Families program as a whole as well as for individual families and the health care delivery system. In light of this, these proposals require a serious debate that should carefully evaluate both what California families can afford and what the unintended consequences might be if more children become uninsured. Of particular importance is considering the implications for children with family income below 200 percent of the FPL given that they are most at risk of joining the ranks of the uninsured if faced with a premium increase.

**Other Key Resources**


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ii The maximum cost sharing allowed in SCHIP under federal law is five percent of family income. For more information on Medicaid/SCHIP premiums by state see D. Cohen Ross, A. Horn & C. Marks, “Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles,” Kaiser Commission on Medicaid and the Uninsured, (January 2008).


Virginia Department of Medical Assistance Services memo, (May 15, 2002).


Institute of Medicine, Health Insurance Is a Family Matter, (2002).
