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Cost Sharing for Children and Families in Medicaid and CHIP

Framing the Issue

Cost sharing is an established part of health insurance in this country, but it is imperative to use it judiciously in Medicaid and CHIP to avoid deterring low-income children and families from using needed health care services. While some families served by these programs are able to pay premiums or make copayments, others, especially those at lower-income levels or with extensive health care needs, may find that such fees make it difficult for them to access needed care. The research on cost sharing is clear that premiums and cost sharing charges will decrease enrollment and use of services among low-income families, but cannot definitively answer the question of "What is an appropriate premium level?" or "How much cost sharing is acceptable?" As a result, policymakers must carefully consider the tradeoffs and their competing policy goals when setting premium and cost sharing levels in Medicaid and CHIP.

Definitions

Cost sharing is a common feature in both private insurance plans and public insurance programs. While primarily a financing mechanism, cost sharing can also be used to affect the extent to which people enroll in or use services. There are three main types of cost sharing:

- **Premiums or enrollment fees** are payments that families must pay periodically (e.g., monthly, quarterly, or annually) to enroll in and continue to receive health care coverage.
- **Deductibles** are a specific dollar amount that a family must pay out-of-pocket before the insurance plan begins to cover services.
- **Copayments and coinsurance charges** are charges that beneficiaries pay when they receive a service. A *copayment* is a dollar amount that someone must pay when using a specific service. *Coinsurance* is similar to a copayment, but is expressed as a percent of the cost of the service received (rather than as a flat dollar amount).

Along with cost sharing charges, families may face other out-of-pocket costs for health care if they need services that are not included in their benefit packages. As a result, their total out-of-pocket costs can sometimes significantly exceed the amount that they spend on premiums and other cost-sharing charges.

Legislative/Regulatory Authority

Within federal standards, states have discretion to impose limited cost sharing on children and families in Medicaid and CHIP.

Medicaid. Since Medicaid was originally designed largely for people with very limited incomes or serious health care conditions, it historically has sharply limited cost sharing. As a result of new federal standards adopted in 2005 (through the Deficit Reduction Act), states now have somewhat more flexibility to impose cost sharing and premiums on Medicaid beneficiaries, especially those who

are not deeply impoverished.[1] The detailed rules now governing state flexibility to impose cost sharing on children and families in Medicaid are outlined in Table 1. In general, they are designed to allow for only minimal cost sharing at the lowest income levels, but somewhat more if states expand coverage further up the income scale. For example, states cannot impose any cost sharing on children below 150 percent of the federal poverty level except in a narrow range of circumstances (e.g., using an emergency room for a non-emergency and for certain medications). Even at more moderate-income levels, federal rules also exempt some special services, such as preventive care for children, from any cost sharing.

CHIP. Created in 1997, the CHIP program allows states to expand Medicaid, create a separate CHIP program, or use a combination of both. Cost sharing rules in CHIP-funded Medicaid expansions are the same as those in Medicaid, whereas, as shown in Table 1, states have more flexibility to impose cost sharing in separate CHIP programs.

The CHIP law enacted in 2009 also requires states to provide a 30-day premium payment grace period under CHIP (for new coverage periods beginning on or after January 4, 2009) before terminating a child's coverage and to provide a notice to families within seven days of the possible termination and their right to appeal.

Where States Stand

Due to the federal standards largely precluding it and states' sensitivity to the negative impact of cost sharing, most parents and children in public programs with income below 150 percent of the federal poverty level are not subject to significant cost sharing. The only states imposing premiums on children below 150 percent of the federal poverty level are Alabama, Arizona, California, Delaware, Florida, Georgia, Idaho, Nevada, Rhode Island, and Utah, and they can do so only because they operate separate CHIP programs (or have received federal waivers to do so for their Medicaid population). The use of cost sharing varies far more across states when it comes to children with family income above 150 percent of the federal poverty level. According to a January 2009 survey of Medicaid and CHIP programs, 24 states charge premiums at 151 percent of the federal poverty level and 24 states charge premiums at 200 percent of the federal poverty level.[2]

Low-income families also sometimes pay a cost when using services, usually in the form of copayments. As of January 2009, 19 states require copayments for a non-preventive physician visit for a child with family income at or above 200 percent of the federal poverty level (ranging from $5 to $20), and 24 states require prescription drug copayments for children at this income level.[3]

(View http://ccf.georgetown.edu/index/medicaid-and-schip-programs for up-to-date information on premiums for children in Medicaid/CHIP by state.)

Research on Cost Sharing

The body of research on cost sharing is extensive and has been summarized in detail by the Kaiser Commission on Medicaid and the Uninsured (KCMU) and by the Center on Budget and Policy Priorities (CBPP).[4] It indicates that cost sharing in Medicaid and CHIP can depress enrollment and reduce utilization, at times increasing the number of uninsured. Furthermore, unaffordable cost sharing places financial burdens on families and providers, despite the stated willingness of families to pay a reasonable share of costs. These themes are elaborated on in more detail below.

1. Premiums in Medicaid and CHIP can reduce enrollment. Research shows that premiums in Medicaid and CHIP can depress enrollment if the financial burden is too great in light of families' income and other expenses. This occurs both because fewer families will apply and more families will disenroll if premiums are too high. For example:

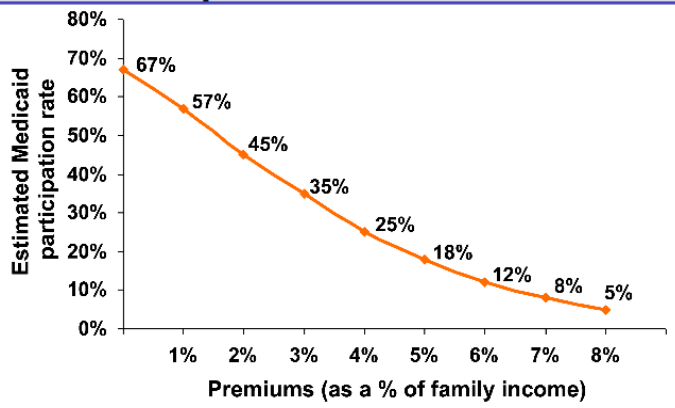
- An Urban Institute study of Medicaid expansions during the 1990's estimated declines in enrollment of 16 percent when participants are charged premiums that equal one percent of family income, enrollment declines of about 49 percent if premiums equal three percent of family income and enrollment declines of about 74 percent if premiums are set at five percent of family income.[5] In other words, even small premiums discourage participation, with higher premiums resulting in even less participation (Figure 1).

- New or increased premiums have been shown to reduce enrollment or increase/hasten disenrollment in CHIP programs in Arizona, Florida, Kansas, Kentucky, Maryland, Missouri, New Hampshire, New Jersey, Rhode Island, and Vermont.6 A Florida study, for example, found that a $5 premium increase reduced CHIP enrollment length by more than half, with lower-income children more severely impacted than higher-income children.7 Another study of children in rural Arizona estimated that a $10 increase in monthly CHIP premiums would cause 10 percent of enrolled children to lose coverage.[8]

2. Even relatively small premium changes can lead to disenrollment. Among low-income families, even modest-sounding changes in premiums can have a notable impact on enrollment. For example, in January 2003, New Hampshire increased premiums from $20 to $25 for children with income between 185-250 percent of the federal poverty level and from $40 to $45 for children with income between 251-300 percent of the federal poverty level. A study of the impact of the premium change found that the CHIP caseload dropped and then resumed growing three to five months after the premium increase, although at a slower pace than before the increase.[9] Overall, the study authors estimate that the implied effect was a 4 percent reduction in monthly caseload. Disenrollment occurred particularly among children with incomes between 251 percent and 300 percent of the federal poverty level.

Figure 1

Fewer Low-Income Uninsured Families Participate as Premiums Rise



Sources: Based on data from L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry*, 36: 471-480 (Winter 1999-2000); see also L. Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities (May 7, 2003).

3. Cost sharing can reduce use of services. The seminal work on the topic of how copayments and coinsurance affect use of services comes from the classic RAND Health Insurance Experiment (HIE).10 In the HIE, which ended in 1982, families were randomly assigned to either a free health plan or a health plan which required varying levels of cost sharing. The analyses of the HIA conclude that:

- Cost sharing reduces the use of both needed and unneeded health services, primarily because patients sometimes do not initiate care when faced with a cost-sharing charge;
- Cost sharing reduces the use of both effective and less-effective care, suggesting cost sharing has little impact on the appropriateness or quality of care sought; and
- Cost sharing seems to have little effect on health, however, the most vulnerable (i.e., the poorest and sickest) participants in the experiment had improved health outcomes under the free plan.

In sum, the HIE indicates that cost sharing is a somewhat blunt instrument for changing people's use of health care services – it will reduce the use of necessary and unnecessary care, and its impact is greatest on those with the fewest resources. In general, these same themes have been reaffirmed and echoed by more recent research on the topic. The KCMU and CBPP reviews of the literature on cost sharing in public programs for low-income families found that service-related cost sharing in Medicaid and CHIP, even when modest, can reduce utilization, result in unmet need, cause financial stress, and burden providers.[11]

4. Cost sharing has significant implications for providers and safety net institutions. Due to their low incomes, some Medicaid/CHIP enrollees may be unable to afford cost sharing, and providers often bear the burden by providing care without being able to collect the patient cost sharing. For example, Oklahoma Medicaid providers in one survey reported that only 29 percent of the time do Medicaid beneficiaries pay cost-sharing charges.[12] Safety net institutions, such as public hospitals and community health clinics can end up being affected when cost sharing results in the loss of Medicaid/CHIP coverage. For example, research has confirmed that when children lose public coverage they are likely to become uninsured, and as a result, some care shifts from ambulatory care settings to more costly emergency department and hospital inpatient settings.[13]

5. Medicaid and CHIP enrollees are not averse to reasonable cost sharing requirements and practices. Many Medicaid and CHIP beneficiaries are prepared to pay a share of their health care costs. For example, a survey of potential Medicaid enrollees in Oklahoma found that 68 percent felt that a modest monthly premium was reasonable, 67 percent felt that $5 - $20 copayments were acceptable, and 53 percent thought that total annual out-of-pocket health expenses of 1-2 percent of family income was reasonable.[14] A focus group with parents of current and former CHIP enrollees also found that most do not mind paying premiums when they are reasonable and affordable, although sometimes the process of paying premiums can be problematic.[15] Focus group participants noted their appreciation of the balance between coverage and cost sharing. For example, participants would not necessarily want lower premiums if it meant higher copayments or less comprehensive benefits.

Strategies

Some strategies for developing cost sharing and premium policies consistent with the goals of CHIP and Medicaid in providing coverage and necessary services to children and parents in low-income families include:

1. Ensure that premium and cost sharing charges are affordable. In making cost sharing decisions, it is critical to match premiums and other cost sharing charges to the amount that families can afford to pay. With the wide variation in the cost of living across states, state-specific studies on the amount of income available to low-income families to finance health care expenses after paying for other essentials, such as food and housing, should be taken into account when establishing cost sharing policies.

2. Eliminate or minimize cost sharing for the lowest-income families. The evidence is overwhelming that low-income families are more sensitive to cost sharing charges than their more moderate-income counterparts. In light of this, it is critical not to impose any cost sharing charges on the lowest-income families or, at a minimum, ensure that they are very modest. Most states already do this; for example, only ten states with separate state CHIP programs charge any premiums for children below 150 percent of the federal poverty level.

3. Protect children and parents with extensive medical needs from excessive cost sharing charges. For children and parents with extensive medical needs, even modest-sounding cost sharing charges can add up quickly. For example, a $5 charge for an office visit may be affordable for the low-income family with a child who sees the pediatrician once or twice a year, but an enormous problem for a family with a child with a disability who requires multiple medical appointments each week. In response, some states have established monthly caps on the dollar amount that families can be required to pay in cost sharing charges, effectively preventing cost sharing charges from accumulating and imposing an excessive burden on those with particularly extensive medical need. For example, Minnesota imposes a small charge ($3 per prescription) on parents filling prescriptions, but only for the first four prescriptions that they fill in a given month, and some mental health drugs are exempt from the copayment.

4. Monitor the impact of cost sharing and make changes as needed. Given that there is no "correct" answer as to what level of premiums and service-related cost sharing charges are appropriate for low-income families and children, it is important to consider establishing a mechanism to monitor the impact of a state's cost sharing policies and to modify them if appropriate. Virginia, for example, discontinued CHIP premiums and Florida rescinded a premium increase after seeing the potential effects on enrollment. Specifically, Virginia imposed a $15 per child per month premium for children between 150-200 percent of the federal poverty level; the state spent $1.39 in administrative costs to collect every $1 in premiums and some 6,000 children were at risk of losing coverage for failure to pay the premium.[16] In the face of this significant cost and potential loss of coverage, the state permanently eliminated the premiums in April 2002 and cancelled the coverage terminations. Florida increased its KidCare premium by $5 in July 2003 but rescinded the increase for children with income below 150 percent of the federal poverty level in October 2004 after enrollment length decreased by 63 percent for children with income 101-150 percent of the federal poverty level.[17] A number of other states have sponsored studies to evaluate the impact of premium changes, which can be used to document if the impact of cost sharing

changes are greater than expected and pave the way for modifications.

5. Exempt critical services from cost sharing charges for cost-effectiveness reasons. Federal rules already prohibit states from imposing cost sharing charges on certain services, such as preventive care for children. States, however, may want to follow the growing trend among some employers of exempting a wider array of services from the usual cost sharing charges when it is cost-effective to do so. For example, in order to link cost sharing to value,18 CHIP and Medicaid programs could exempt copayments for physician visits and medications needed to control asthma, diabetes, mental illness, and other conditions that lead to higher costs and complications if not managed well. The emerging evidence is that doing so can help people to better manage chronic conditions, potentially reducing long-term costs associated with complications. For example, one recent study found that a large employer's decision to reduce copayments for five chronic medication classes (e.g., diabetes) in the context of a disease management program lead to markedly better compliance with medication regimes.[19]

6. Create easy, family-friendly ways to make cost sharing payments. Most states accept premium payments through the mail, but a number of states are providing families with other options to make premium payments, such as on-line, at drug or grocery stores, or through automatic deductions from checking accounts.[20] These options are likely to gain in popularity and make it administratively easier for families to keep up with premium payments. Some states, such as Alabama and North Carolina, allow families to pay a single, relatively modest annual enrollment fee, eliminating the need for monthly payments. (Note, however, that an annual enrollment fee likely needs to be set well below the annualized cost of monthly premiums because many low-income families will find it difficult to come up with a single, large payment).

It also is important to give families that miss premium payments an easy way to "cure" the non-payment and to re-enroll their children in the program. The CHIP law enacted in 2009 requires states to provide at least a 30-day premium payment grace period before terminating a child's coverage. Georgia's experience with a three-month "lock out" policy for families that failed to make a monthly CHIP premium payment highlights the risks of failing to do so. Within eight months of adopting its lock out policy, 80,000 children were locked out of PeachCare, almost 60 percent of whom had family incomes below 150 percent of the federal poverty level.[21]

Conclusion

Given rising health care costs and the budget difficulties facing states, it is likely that Medicaid and CHIP programs will continue to experiment with changes to their premium and cost sharing policies in the years ahead. In doing so, states will need to continue to balance the challenge that cost sharing poses to low-income families with the need to keep Medicaid and CHIP costs under control. By keeping charges minimal, especially for the lowest-income families and those with extensive health care needs, and by setting up mechanisms to monitor and modify cost sharing policies as needed, states should be able to do so.

Primary Resources

Research on Cost Sharing in CHIP and Medicaid:

- L. Ku & V. Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005).
- S. Artiga & M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured (May 2005).
- J. Hudman & M. O'Malley, "Health Insurance Premiums and Cost-Sharing: Findings from the Research on Low-Income Populations," Kaiser Commission on Medicaid and the Uninsured (March 2003).
- Government Accountability Office, "Medicaid and SCHIP: States' Premium and Cost Sharing Requirements for Beneficiaries," (March 2004).

Descriptions of Federal Medicaid and CHIP Cost Sharing Rules:

- E. Herz, "Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)," Congressional Research Service (January 25, 2007).
- J. Solomon, "Cost-Sharing and Premiums in Medicaid: What Rules Apply?," Center on Budget and Policy Priorities (February 28, 2007).
- State Medicaid Director Letters from the Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, (June 16, 2006 and August 15, 2007)
- J. Guyer, C. Mann, & J. Alker, "The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families," Center for Children and Families (March 2006).

Table 1: Federal Cost Sharing Rules for Children in Medicaid and CHIP

	MEDICAID			CHIP		
	Mandatory Children[a]	**Other Children 100-150% FPL**	**Other Children >150% FPL**	**Children <100% FPL**	**Children 100-150% FPL**	**Children >150% FPL**
AGGREGATE CAP	5% of family income	5% of family income	5% of family income	5% of family income	5% of family income	5% of family income
PREMIUMS	Not allowed	Not allowed	Allowed (no upper limit)	Up to $19 per month depending on family size and income	Up to $19 per month depending on family size and income	Allowed (no upper limit)
DEDUCTIBLES	Not allowed	Up to $2.10 per month	Up to $2.10 per month	Up to $2.10 per month	Up to $3.15 per month	Allowed (no upper limit)
COPAYMENTS/ COINSURANCE[b]						
Preventive services	Not allowed	Not allowed	Not allowed	Not allowed	Not allowed	Not allowed
Outpatient services (including managed care services)	Not allowed	Up to 10% of payment	Up to 20% of payment	Up to $3.40 or 5% of payment	Up to $5.50 or 5% of payment	Allowed (no upper limit)
Institutional services	Not allowed	Up to 50% of payment for first day of care or 10% of payment	Up to 50% of payment for first day of care or 20% of payment	Up to 50% of payment for first day of care	Up to 50% of payment for first day of care	Allowed (no upper limit)
Emergency services	Not allowed	Not allowed	Not allowed	Not allowed	Up to $5.50 in hospital setting; 5% of payment in clinic or non-hospital setting	Allowed (no upper limit)
Non-emergency use of ER[c]	Up to $3.40 or 5% of payment	Up to $6.80 or 5% of payment	Allowed (no upper limit)	Up to $3.40 or 5% of payment	Up to $10	Allowed (no upper limit)
Prescription drugs	Up to $3.40 or 5% of payment for non-preferred drugs	Up to $3.40 or 5% of payment	Up to $3.40 or 5% of payment; or up to 20% of payment for non-preferred drugs	Up to $3.40 or 5% of payment	Up to $5.50 or 5% of payment	Allowed (no upper limit)

[a] Mandatory children include children under age six with family income below 133% FPL and children ages six to 17 with family income below 100% of the FPL. (For purposes of the cost sharing and premium provisions of the Medicaid law, 18-year olds are treated as adults.) The rules that apply to mandatory children also apply to children (without regard to age) for whom Title IV foster care or adoption assistance is being provided.

[b] If their families cannot pay the copayment or coinsurance charge, children in this group still must be provided with the service or prescription drug.

[c] Federal law allows states to impose cost sharing for non-emergency use of an ER only if a beneficiary has been provided with an appropriate referral to an alternative provider, such as a community clinic or doctor's office.

Table 2: Federal Cost Sharing Rules for Parents[a] in Medicaid

	Parents <100% FPL	Parents 100-150% FPL	Parents >150%FPL
AGGREGATE CAP	5% of family income	5% of family income	5% of family income
PREMIUMS	Not allowed	Not allowed	Allowed (no upper limit)
DEDUCTIBLES	Up to $2.10 per month	Up to $2.10 per month	Up to $2.10 per month
COPAYMENTS/ COINSURANCE[b]			
Preventive services[c]	Up to $3.40 or 5% of payment	Up to $3.40 or 10% of payment	Up to $3.40 or 20% of payment
Outpatient services (including managed care services)	Up to $3.40 or 5% of payment	Up to $3.40 or 10% of payment	Up to $3.40 or 20% of payment
Institutional services	Up to 50% of payment for first day of care	Up to 50% of payment for first day of care or 10% of total cost of stay	Up to 50% of payment for first day of care or 20% of total cost of stay
Emergency services	Not allowed	Not allowed	Not allowed
Non-emergency use of ER[d]	Up to $3.40 or 5% of payment	Up to $6.80 or 5% of payment	Allowed (no upper limit)
Prescription drugs	Up to $3.40 or 5% of payment	Up to $3.40 or 5% of payment	Up to $3.40 or 5% of payment; or up to 20% of payment for non-preferred drugs

[a] Pregnant women and institutionalized individuals are exempt from almost all Medicaid cost sharing.
[b] If they cannot pay the copayment or coinsurance charge, adults in this group still must be provided with the service or prescription drug.
[c] Copayments and coinsurance are not allowed for family planning services.
[d] Federal law allows states to impose cost sharing for non-emergency use of an ER only if a beneficiary has been provided with an appropriate referral to an alternative provider, such as a community clinic or doctor's office.

Endnotes

[1] See E. Herz, "Medicaid Cost-Sharing Under the Deficit Reduction Act of 2005 (DRA)," Congressional Research Service (January 25, 2007); and J. Guyer, C. Mann, & J. Alker, "The Deficit Reduction Act: A Review of Key Medicaid Provisions Affecting Children and Families," Center for Children and Families (March 2006).
[2] D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured, (January 2009); updated by the Center for Children and Families.
[3] *Ibid.*
[4] S. Artiga & M. O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured (May 2005); and L. Ku & V. Wachino, "The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings," Center on Budget and Policy Priorities (July 7, 2005).
[5] L. Ku, "Charging the Poor More for Health Care: Cost-Sharing in Medicaid," Center on Budget and Policy Priorities (May 7, 2003); and L. Ku & T. Coughlin, "Sliding-Scale Premium Health Insurance Programs: Four States' Experiences," *Inquiry,* 36: 471-480 (Winter 1999-2000).
[6] See G. Kenney, *et al.,* "Assessing Potential Enrollment and Budgetary Effects of SCHP Premiums: Findings from Arizona and Kentucky," *Health Services Research*, 42: 2354-2372 (August 2007); B. Shenkman, "Healthy Kids Program Changes in State Fiscal Year 2003-2004: Associations with Enrollee Case-Mix, Health Care Expenditures, and Disenrollment; Tab O, Impact on Cost Sharing," A Report to the Healthy Kids Corporation (November 2004); G. Kenney, *et al.*, "Effects of Premium Increases on Enrollment in SCHIP," *Inquiry*, 43: 378-392 (Winter 2006/2007); J. Marton, "The Impact of the Introduction of Premiums into a SCHIP Program," *Journal of Policy Analysis and Management*, 26: 237-255 (March 2007); Maryland Department of Health and Mental Hygiene, "Maryland Children's Health Program: Assessment of the Impact of Premiums, Final Report," (April 2004); J. Ferber, "Measuring the Decline in Children's Participation in the Missouri Medicaid Program: An Update," Legal Services of Eastern Missouri (September 2006); J. Miller, *et al.*, "Demographics of Disenrollment from SCHIP: Evidence from NJ KidCare," *Journal of Health Care for the Poor and Underserved*, 15: 113-126 (February 2004); RI Medicaid Research and Evaluation, "Results of Rite Care Premium Follow-Up Survey #2," (July 2004); and S. Kappel, "Effects of Medicaid Premiums on Program Enrollment: Preliminary Analysis," Vermont Joint Fiscal Office, (April 8, 2004).
[7] J. Boylston Herndon, *et al.*, "The Effect of Premium Changes on SCHIP Enrollment Duration," *Health Services Research*, 43: 458-477 (September 2007).
[8] T. Johnson, M. Rimsza, & W. Johnson, "The Effects of Cost-Shifting in the State Children's Health insurance Program," *American Journal of Public Health*, 96: 709-715 (April 2006).
[9] *Op. cit.* (6), Kenney, *et al*. 2006/2007.
[10] See RAND, "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," (2006).
[11] *Op. cit.* (4).
[12] Health Care Not Welfare Project, "Appropriate Rate Structure for Services Rendered and Estimated Percent of Co-Pays Collected Under the Medicaid Program," Submitted to the Oklahoma Health Care Authority (January 31, 2004).
[13] M. Rimsza, R. Butler, & W. Johnson, "Impact of Medicaid Disenrollment on Health Care Use and Cost," *Pediatrics*, 119: e1026-e1032 (May 2007).
[14] Health Care Not Welfare Project, "Beneficiary Attitudes Towards Paying Enrollment Fees, Copayments, and Premiums to Obtain Health Insurance Coverage Under an Expanded Medicaid Program," Submitted to the Oklahoma Health Care Authority (January 31, 2004).
[15] S. Kannel & C. Pernice, "What Families Think about Cost-Sharing Policies in SCHIP," National Academy for State Health Policy, (October 2005).
[16] Virginia Department of Medical Assistance Services memo, (May 15, 2002); see also, L. Summer & C. Mann, "Instability of Public Health Insurance Coverage for Children and Their Families: Causes, Consequences, and Remedies," The Commonwealth Fund (June 2006).
[17] *Op. cit.* (6), Shenkman, 2004 and *Op. cit.* (7).
[18] For example, see R. Braithwaite & A. Rosen, "Linking Cost Sharing to Value: An Unrivaled Yet Urealized Public Health Opportunity," *Annals of Internal Medicine*, 146: 602-605 (April 2007).

[19] M. Chernew, *et al.*, "Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment," *Health Affairs*, 27: 103-112 (2008).
[20] See N. Kaye, C. Pernice, & A. Cullen, "Charting SCHIP III: An Analysis of the Third Comprehensive Survey of State Children's Health Insurance Programs," National Academy for State Health Policy, (September 2006).
[21] A. Essig & T. Sweeney, "PeachCare Lockout: Who Suffers?," Georgia Budget and Policy Institute (May 2005).

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