OPPAGA
OFFICE OF PROGRAM POLICY ANALYSIS & GOVERNMENT ACCOUNTABILITY

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Legislature Has Several Options for Florida's KidCare Family Premiums

at a glance

Florida's KidCare Program provides health insurance to uninsured, low-income children and requires cost sharing for some enrollees. Enrollees in the MediKids, Children's Medical Services Network, and Healthy Kids components pay premiums of $15 or $20 per month, depending on family income.

As directed by law, this report examines options for changing the family premium for Florida's KidCare Program. In setting family premiums for the KidCare Program, the Legislature should consider tradeoffs between the goals of reducing state costs by raising premium amounts and serving the maximum number of children within budgetary constraints.

If the Legislature wants to reduce the state costs of the KidCare Program, it could consider increasing family premiums for Fiscal Year 2005-06. However, research suggests that raising family premiums would reduce the number of children participating in the program.

Scope

Chapter 2004-1, *Laws of Florida,* directed OPPAGA to perform a study to determine the appropriate family premium for Florida's State Children's Health Insurance Program (SCHIP)—Florida KidCare—and review family premiums collected by other states. We were assisted in performing analyses for this review by the University of Florida's Institute of Child Health Policy.

Background

In 1997, the United States Congress created the State Children's Health Insurance Program (SCHIP) under Title XXI of the Social Security Act. [1] This program was intended to assist state efforts to initiate and expand the provision of health insurance to uninsured, low-income children. To implement SCHIP, states could create a separate child health insurance program, expand their Medicaid program, or use both approaches in combination. Florida chose to implement a combination program in 1998 under the Florida KidCare Act. [2]

Florida KidCare Program

Florida KidCare is an umbrella program that provides health insurance coverage under both Title XIX (Medicaid) and Title XXI (SCHIP). The program includes several components.

- *Children's Medicaid* for children ages 0-18 whose family income is up to 185% of the federal poverty level depending on family size ($34,873 for a family of four). [3] This component is Title XIX-funded and family

[1] U.S. Public Law 105-33.

[2] Section 409.812, *F.S.*

[3] Dollar figures based on 2004 federal poverty levels for a family of four. For information on federal poverty levels by other family sizes, please see Appendix A.

contributions for services are not required. This component is administered by the Agency for Health Care Administration.

- *Children's Medicaid for Children Under One* for children ages 0-1 whose family income is from 186% to 200% of the federal poverty level ($34,873 - $37,700 for a family of four) and are not eligible for Medicaid. This component, which is a Medicaid expansion program, is Title XXI-funded and family contributions for services are not required. This component is administered by the Agency for Health Care Administration.
- *MediKids* for children ages 1-5 whose family income is between 134% and 200% of the federal poverty level ($25,071 - $37,700 for a family of four) and are not Medicaid eligible. This component uses Medicaid providers, but is Title XXI-funded. MediKids enrollees are required to pay a monthly premium. It is administered by the Agency for Health Care Administration.
- *Children's Medical Services Network* (CMSN) for children ages 0-19 with special health care needs whose family income is up to 200% of the federal poverty level ($37,700 for a family of four). This component is funded by Title XXI, but also has a Title XIX-funded (Medicaid) component and a state-funded safety net component. The network also includes a behavioral health program. CMSN Title XXI enrollees are required to pay a monthly premium. This component is administered by the Department of Health.
- *Healthy Kids* for children ages 5-18 up to 200% of the federal poverty level ($37,700 for a family of four). This component is Title XXI-funded. Healthy Kids enrollees are required to pay a monthly premium and co-payments for some services.

  In addition, a limited number of children who have family incomes over 200% of poverty are enrolled in the component's unsubsidized Full Pay category in which the family pays the entire cost of the premium, including administrative costs, or are enrolled in the subsidized Non-Title XXI for children who are legal aliens with family incomes up to 200% of the federal poverty level. This component is administered by the Florida Healthy Kids Corporation.

Program component enrollments. In November 2004, 1,544,712 children were enrolled in the Florida KidCare Program (see Exhibit 1). The majority of these children (1.2 million) were enrolled in Title XIX components with the remaining 319,125 enrolled in Title XXI components. The Title XXI component with the highest enrollment was Healthy Kids, with 277,070 enrollees.

Exhibit 1
Total Enrollment in Florida KidCare Was Over 1.5 Million in November 2004

KidCare Program Component	Enrollment
Title XXI	
Children's Medicaid for Children Under 1	1,271
MediKids	31,130
Children's Medical Services Network	9,654
Healthy Kids	277,070
Total Title XXI - All Programs	319,125
Healthy Kids Non-Title XXI and Full Pay	21,782
Total Title XIX - Children's Medicaid	1,203,805
Total Florida KidCare Enrollment	1,544,712

Source: Florida Agency for Health Care Administration.

Program funding

Federal and state funding. Florida KidCare is financed by a combination of federal and state funds, as well as family contributions. Federal funds come from two sources: the State Children's Health Insurance Program (SCHIP), which requires a 29% state match, and Medicaid, which requires a 41% state match. Florida finances its state match through general revenue and tobacco settlement dollars. The Legislature appropriated a total of $130,052,674 from state funds to match $277,082,136 in federal funds for the non-Medicaid components of KidCare in Fiscal Year 2004-05.

Family contributions. Florida also uses money collected from family contributions to offset program costs. Federal SCHIP regulations grant states the authority to require families to pay a share of the cost of their children's coverage. Under these regulations, states may

charge families fees for enrolling a child in the program, premiums (payments for insurance coverage for a given period of time that may vary by income or family size), and co-payments (out-of-pocket payments for part of the cost of service each time it is rendered).

However, the regulations also cap the amount that can be charged for certain children. Cost sharing for children in families with incomes at or below 150% of the federal poverty level must follow regulations on cost sharing for adults in Medicaid. This means that families can be charged premiums between only $15 and $19 a month based on family size. For children above 150% of federal poverty level, states can impose cost-sharing requirements on a sliding scale not to exceed 5% of the family's income. In addition, states are prohibited from requiring any cost sharing on preventive services regardless of income.

Florida's KidCare Program requires cost sharing for some enrollees. The program charges premiums to enrollees in the MediKids, Children's Medical Services Network, and Healthy Kids components. The program has a two-tiered family premium. Families with incomes under 150% of the federal poverty level pay a premium of $15 per month and families between 151% and 200% of the federal poverty level pay $20 per month. As shown in Exhibit 2, family contributions totaled $50,983,711 in Fiscal Year 2003-04, or 11% of total program expenditures.

Exhibit 2
Family Contributions Accounted for an Average of 11% of KidCare Expenditures in Fiscal Year 2003-04

Title XXI Program Component	Family Contribution	Total Expenditures	Family Contribution as % of Total Expenditures
MediKids	$ 3,651,450	$ 35,866,576	10%
Children's Medical Services Network	847,435	55,618,165	2%
Healthy Kids	46,484,826	376,977,904	12%
Total	$50,983,711	$468,462,645	11%

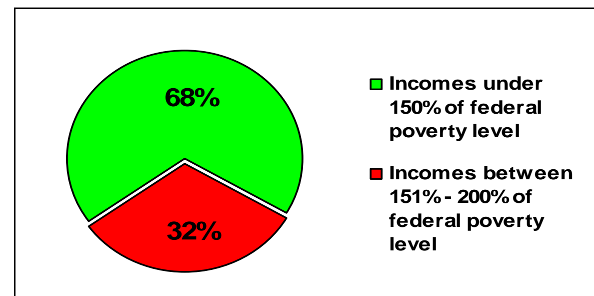
Source: Florida Agency for Health Care Administration, Healthy Kids Corporation, and Florida Department of Health.

Florida does not charge an enrollment fee to participate in the program. Only two states, North Carolina and Colorado, currently charge enrollment fees ($50 and $25, respectively). However, these states do not charge family premiums.

Florida only requires co-payments for Healthy Kids enrollees. Co-payment amounts range between $5 and $10 for some services and prescriptions. From January 2003 to December 2003 enrollees spent an average of $13.92 on co-payments. [4]

Program enrollee family incomes. Most of the families with children enrolled in the MediKids, Children's Medical Services Network, and Healthy Kids components had incomes under 150% of the federal poverty level in 2003 (see Exhibit 3).

Exhibit 3
Most KidCare Enrollees Had Incomes Under 150% of the Federal Poverty Level ($28,275) from November 2003 to October 2004[1]



[1] Includes Healthy Kids, Children's Medical Services, and MediKids enrollees. Enrollees with family income above 200% federal poverty are not included. Federal poverty level based on family of four.

Source: University of Florida Institute for Child Health Policy.

Recent efforts to address increasing program enrollments and costs

The 2004 Florida Legislature made several changes to the KidCare Program to slow projected increases in expenditures resulting from growing enrollment. [5] These changes, which primarily dealt with program enrollment and eligibility requirements, included

[4] The average annual co-payment does not adjust for the number of months the family was enrolled in the program.

[5] Section 409.814, *F.S.*

- eliminating continuous enrollment and replacing it with no more than two 30-day open enrollment periods per fiscal year;
- requiring proof of family income to verify eligibility for the program;
- requiring a statement from applicants verifying that their employers do not sponsor health benefit plans for employees or that the enrollees are eligible for coverage in such plans; if a potential enrollee is eligible but not covered in an employer-sponsored plan, the applicant must provide a statement of the cost to enroll the potential enrollee in the plan; if the cost to enroll the child in an employer–sponsored plan does not exceed 5% of the family's gross income, the child is not eligible for the KidCare Program; and
- providing disenrollment procedures on a last-in, first-out basis based on a determination of insufficient funds. [6]

Florida also has made changes to its cost-sharing requirements. In 2003, Florida raised its monthly premium amount from $15 to $20 for families earning between 150% and 200% of the federal poverty level. Florida also increased the copayments for pharmacy and medical office visits from $3 to $5 for Healthy Kids enrollees.

Many other states have recently taken similar actions in an effort to control SCHIP costs. These actions include placing controls on eligibility and enrollment, changing benefits, and increasing cost-sharing requirements. As shown in Exhibit 4, the most frequently used approach is increasing cost-sharing requirements by increasing premiums or co-payments (20 states).

[6] Children enrolled in the Children's Medical Services Network are exempt from this requirement.

Exhibit 4
Many States Have Recently Made Program Changes to Help Control SCHIP Program Costs

			Increased Cost Sharing	
State	Controls on Eligibility or Enrollment	Changes in Benefits	Premiums	Co-Payments
Alabama	X		X	X
Arkansas	X			
Arizona			X	
Colorado	X			
Connecticut			X	
Florida	X	X	X	
Georgia			X	
Kansas			X	
Kentucky			X	
Maryland	X		X	
Massachusetts			X	
Nebraska		X		
Nevada			X	
New Hampshire			X	X
New Jersey			X	
North Carolina				X
Texas		X	X	X
Vermont			X	
Wisconsin			X	
Wyoming		X		X
Total	5	4	15	5

Source: *The Child Health Program Impact Series*, Fact Sheet Number 4, Maternal & Child Health Policy Research Center, April 2004.

Findings

Chapter 2004-1, *Laws of Florida*, directed OPPAGA to determine an appropriate family premium for Florida's KidCare Program. Consequently, this report focuses on those program components that require cost sharing for families: Healthy Kids, MediKids, and the Children's Medical Services Network. Our analysis concluded that

- Florida's family premiums are close to median premiums charged by other states; and
- Florida has several options for changing family premiums; however, increasing premiums may reduce programs enrollments.

Florida's family premiums are close to median premiums charged by other states

Many states, including Florida, have incorporated family premiums into their SCHIP programs. Currently, 29 states charge premiums to some or all of their SCHIP enrollees (see Appendix B).

States view family premiums as being beneficial for two major reasons. First, premiums are viewed as promoting individual responsibility and providing a bridge to private health insurance in which families typically pay premiums. Second, premiums reduce the public costs of the program since the enrollees offset some state costs. For example, in Florida, funds from premium contributions are used to pay health plans for their services.

Other states' SCHIP premium amounts vary. As shown in Appendix B, the amount of SCHIP premiums charged to families varies widely among states, ranging from $5 to $500. The majority of the states (24) charged premiums on a monthly basis, with two states (Alabama and Wyoming) charging annually, and two states (Nevada and Utah) charging quarterly. Almost every state varied the premium amounts according to an enrollee's family income level, with the highest premiums being charged to families with the highest income levels.

States also vary on whether premiums are paid per child or per family. Fourteen states, including Florida, charged premiums on a per family basis, while 15 states charged premiums on a per child basis. However, the states that charged premiums on a per child basis capped the total amount of premiums charged to a family. For example, in New York, premiums for families between 134% and 185% of the federal poverty level were $9 per child per month with a cap of $27 per family per month.

We surveyed 17 states with combination SCHIP programs similar to Florida's and found that they used various methods to set their premiums, as shown in the examples below. [7]

- Two states (Idaho and Iowa) used focus groups or public forums to help determine the amounts.
- Two states (Maryland and Rhode Island) calculated family premiums based on a formula that established the premium at a specified percentage of family income. Maryland set the premium amounts at 2% of income for a family of two at 200% and 250% of the federal poverty level.
- New Jersey increased premiums annually based on changes in the Consumer Price Index.

None of the states we surveyed reported using actuarial analyses to establish premiums. [8]

Surveyed states also varied in the percentage of family income going toward cost-sharing payments, such as premiums and co-payments, although most states did not report this data. Of the states that provide this information, California reported the lowest percentage of family income allocated to cost sharing, (an average of 1.2%) while Rhode Island reported the highest percentage (5%). Delaware, New Hampshire, and New York reported that the percentage of family income going toward cost-sharing payments in their states was below 3%, while Maine reported that families with two or more children in the highest income tier (185%-200% of the federal poverty level) paid 3.4%.

Florida's family premium is close to the median of premiums charged by other states' SCHIP programs. To make reasonable comparisons among states, we estimated the premiums for a family with two children enrolled in a SCHIP program in Florida and other states (see Exhibit 5). Florida's $15 a month premium for a family with an income between 100% and 150% of the federal poverty level is at the median premium amount for seven states that charge premiums to such families. [9] Florida's $20 a month premium for a

[7] We received completed surveys from Arkansas, California, Delaware, Idaho, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, New Hampshire, New Jersey, New York, North Dakota, Rhode Island, South Dakota, and Virginia.

[8] An actuarial analysis sets premium rates based on statistical studies and determines the amounts of money required to assure the payment of benefits.

[9] Sixteen of the 29 states we reviewed do not charge families between 100% and 150% of the federal poverty level a premium or they do not cover these families in their SCHIP program. The poverty classifications of six other states are not comparable with Florida's.

family with an income over 150% of the federal poverty level is slightly below the median premium amount of $20.31 for 20 states. [10]

Exhibit 5
Florida's KidCare Premiums Are Moderate Compared to Other State SCHIP Programs

Family Income (% of Federal Poverty Level)	State	Estimated Monthly Family Premium [1]
100% - 150%	Utah	$ 4.33
	Alabama	8.33
	California	14.00
	Arizona	15.00
	Florida	**15.00**
	Georgia	15.00
	Texas	15.00
151% - 200%	Michigan	$ 5.00
	Utah	8.33
	Idaho	15.00
	Alabama	16.67
	New Jersey	17.00
	Nevada [2]	17.50
	California	18.00
	Florida	**20.00**
	Iowa	20.00
	Kentucky	20.00
	Indiana [2]	20.63
	Texas [2]	22.50
	Massachusetts	24.00
	Illinois	25.00
	Kansas [2]	25.00
	Maine [2]	25.00
	Arizona [2]	30.00
	Georgia [2]	44.00
	Rhode Island [2]	69.00
	Wisconsin	$50.00 - $500.00

[1] Based on a family with two enrolled children.
[2] For states with multiple poverty groups within 100% - 150% and 151% - 200% OPPAGA calculated the monthly premium by using an average of the rates charged across the groups.

Source: National Academy of State Health Policy.

Florida has several options for family premiums

We assessed four options the Legislature may wish to consider in setting the family premium for the KidCare Program. These options maintain the state's current two-tiered premium structure (one premium for families with incomes from 100% and 150% of the federal poverty level and a higher premium for families with incomes above 150% of this level). The options also maintain the state's current policy of charging co-payments for certain services provided to Healthy Kids enrollees.

In developing these options, we considered the family premiums charged by other states with SCHIP programs and the maximum premium allowed by federal law. [11]

Option 1 - Maintain the state's current family premium. This option would not change the current program requirements. As noted previously, Florida's family premiums are close to the median premiums charged by other states.

Option 2 - Increase the family premium for families with incomes above 150% of the federal poverty level from $20 to $25. This option would raise Florida's premium ranking from below the median to the top third of the states we examined, as the new premium level would be higher than 63% of these states. This option does not raise the premium for families with incomes up to 150% of the federal poverty level because most states we reviewed that charge premiums to such families charge the same amount as Florida.

Option 3 - Increase the family premium for families with incomes above 150% of the federal poverty level from $20 to $30. This option would raise Florida's premium ranking from below the median to the top fifth of the states we examined, as Florida's premium would be higher than that charged by 79% of these states' SCHIP programs. As with Option 2, this option does not raise the

[10] Five of the 29 states we reviewed do not charge a premium for families between 150% and 200% of the federal poverty level or they do not cover these families in their SCHIP program. The poverty classifications of four other states are not comparable with Florida's classification.

[11] We did not assess the option of instituting an enrollment fee because this fee would be subject to the same federal cap on total family contributions, would only serve to offset premium levels, and would require a separate administrative process that would likely increase costs.

premium for families with incomes up to 150% of the federal poverty level.

Option 4 - Increase the family premium to the maximum amounts allowed under federal law. This option would increase premiums from $15 to $16 per month for families with incomes up to 150% of federal poverty level and from $20 to $110 per month for families over 150% of the federal poverty level. [12] Two states (Rhode Island and Wisconsin) in our comparison charge the maximum amount.

Exhibit 6 shows the premium levels and the percentage of family income spent on family premiums and copayments for health care services under the four options.

Exhibit 6
Options for Kid Care Family Premiums

	Percent of Federal Poverty Level	Monthly Family Premium	% of Family Income[1]
Option 1	Up to 150%	$ 15	0.92%
	Above 150%	20	0.82%
Option 2	Up to 150%	15	0.92%
	Above 150%	25	1.02%
Option 3	Up to 150%	15	0.92%
	Above 150%	30	1.22%
Option 4	Up to 150%	16	1.00%
	Above 150%	110	4.50%

[1]Federal law allows for premiums and copayments for health care services up to 5% of the family's income. We selected 4.50% of a family's income for the premium to allow for copayments.

Source: OPPAGA analysis.

Higher family premiums would reduce state costs for KidCare. Increasing family premiums would enable the state to reduce general revenue appropriations to the program. To estimate the amount of state funding that would be reduced by increasing family premiums, we applied the premium amounts for the four options to the program's expenditures for Fiscal Year 2003-04.

As shown in Exhibit 7, we estimated that Options 2 and 3 would reduce state expenditures slightly ($1.9 million and $3.8 million, respectively) while Option 4 would reduce state expenditures by $35.8 million. [13] However, while increasing premium amounts reduces state expenditures, it also causes a reduction in federal matching funds which would be offset by the increased family contributions.

Exhibit 7
Higher Family Premiums Would Decrease State Expenditures for KidCare

Expenditures ($ millions)	Option 1	Option 2	Option 3	Option 4
State	$169.1	$167.2	$165.3	$133.3
Federal	248.4	245.7	243.1	198.7
Family	51.0	55.6	60.1	136.5
Total	$468.5	$468.5	$468.5	$468.5

Source: OPPAGA analysis of KidCare Program expenditures in Fiscal Year 2003-04.

Raising family premiums may cause decreases in program enrollment

An important factor the Legislature will need to consider in setting family premiums is that program enrollments appear to be highly sensitive to increases in family premiums. Research conducted on the Florida Healthy Kids Program by the Institute for Child Health Policy at the University of Florida suggests that

[12] States may charge premium amounts of $15 to $19 based on family size for families with incomes under 150% of poverty: $19 for families of two, $16 for families of four, $15 for families of five or more. Based on Florida's average family size of four for SCHIP components, we are using a premium amount of $16 for our calculations.

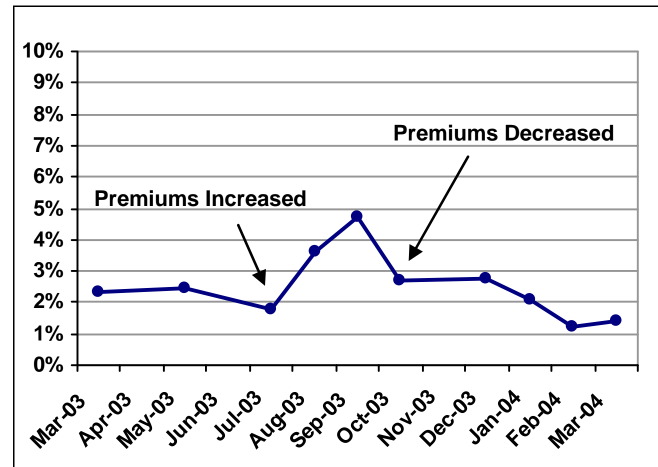
[13] It was not feasible for us to project total state costs under the premium options based on the KidCare Consensus Estimating Conference projections of program expenditures for Fiscal Year 2004-05. The conference's Fiscal Year 2005-2006 program expenditure projections totaled $122.9 million for Healthy Kids, MediKids, and CMSN compared to actual program expenditures of $468.5 million in Fiscal Year 2003-04. The conference's projection was lower because it assumed there would be no new enrollments in the program through June 2006. The estimating conference made this assumption as a result of a 2004 change in law that eliminated continuous enrollment and replaced it with no more than two 30-day open enrollment periods during a fiscal year. In the absence of prior experience with a restricted open enrollment period, the conference did not have sufficient information to estimate the new enrollments and expenditures. The conference agreed to use projections that did not consider new enrollments because it was unlikely that any increase in expenditures due to new enrollments would exhaust the state's allotment of federal funds. As options to increase premiums would likely affect enrollment in unknown ways, it was not feasible for us to project total costs.

increasing premiums would lead to a decrease in enrollment.

For example, the institute determined that children in the Healthy Kids Program were 24% more likely to disenroll after the state temporarily increased premiums in July 2003. [14] At that time, premiums for families participating in the Healthy Kids, MediKids, and Children's Medical Services Network programs were increased from $15 to $20 per month. The institute also determined that children in families with lower incomes were more likely to disenroll compared to children in families with higher incomes. Families with incomes at or below 150% of the federal poverty level were 36% more likely to disrenroll in the period following the premium change period compared to the pre-premium change period. Additionally, children in poorer health were significantly less likely to leave the program than healthy children. These children were 8% to 17% less likely to disenroll than healthy children. [15] Similar results occurred following the implementation of the Title XXI program in 1998 when changes were made to the Healthy Kids Program's premiums. [16]

Exhibit 8 shows the trend in program disenrollments before and after the premium change in July 2003. During the period from January through June 2003 (prior to the premium increase), the Healthy Kids Program experienced an approximate 2% disenrollment of children from the program each month. However, disenrollment increased after the premium change in July 2003 to 3.6% of children in August 2003 and 4.7% in September 2003. When premiums were subsequently reduced to $15 for families with incomes at or below 150% of the federal poverty level in October 2003, disenrollment gradually declined, slowing to a low of 1.4% in March 2004.

Exhibit 8
Disenrollment in the Healthy Kids Program Increased When Premiums Were Increased



Source: University of Florida Institute for Child Health Policy.

The disenrollment experienced in the Healthy Kids Program indicates that Florida families are sensitive to what may appear to be modest increases ($5 per family per month). The researchers found that a 1% increase in premiums is associated with about a 2% increase in disenrollment. Therefore, large premium increases such as those envisioned in option 4 could result in large increases in disenrollment, particularly for the lowest income families in the program.

Other states have experienced program disenrollment when they instituted or altered family premiums for their SCHIP Programs.

- When Maryland's SCHIP program started charging premiums for children with incomes between 185 and 200% of poverty, half (3,000 of 6,000) of the enrollees disenrolled from the program. [17]
- In Connecticut, 20% of the 14,000 children enrolled in the state's SCHIP program were slated to be disenrolled because their families did not pay new or increased premiums that were implemented in

[14] *The Analysis of the Impact of Cost-Sharing Changes: The Impact of a Premium Increase on Health Kids Disenrollment,* Institute for Child Health Policy, University of Florida, May 2004.

[15] *Healthy Kids Program Changes in State Fiscal Year 2003-2004 Associations with Enrollee Case-Mix, Health Care Expenditures, and Disenrollment,* Institute for Child Health Policy, University of Florida, November 2004.

[16] *Disenrollment and Re-enrollment Patterns in a Children's Health Insurance Program: The Impact of Program Eligibility and Benefits Package Changes,* Institute for Child Health Policy, University of Florida, August 2001.

[17] *Funding Health Coverage for Low-Income Children in Washington,* Center on Budget and Policy Priorities, November 2003.

February 2004. The Connecticut legislature subsequently repealed the new premiums and prevented disenrollments. [18]

- Colorado experienced similar disenrollment when its SCHIP program began charging premiums. The state initially required all families to pay premiums, including those with incomes between 100% and 150% of federal poverty level. However, nonpayment rates escalated over time and enrollment dropped. The state subsequently eliminated premium requirements and created an annual enrollment fee that did not apply to families with incomes under 150% of the federal poverty level. Some months later, enrollment growth rates returned to earlier levels. [19]

Recommendations

In setting family premiums for the KidCare Program, the Legislature should consider the tradeoffs between the goals of reducing state costs by raising premium amounts and serving the maximum number of children within budgetary constraints.

If the Legislature wants to reduce state costs for the KidCare Program, it could consider increasing family premiums for Fiscal Year 2005-06. Assuming that program expenditures in Fiscal Year 2005-06 were the same as in Fiscal Year 2003-04, increasing family premiums from $20 to $25 for a family with an income above 150% of the federal poverty level would reduce state costs by $1.9 million. Increasing this premium to $30 would reduce state costs by $3.8 million. If the family premium was raised to the maximum amount allowed by federal law ($16 and $110), it would reduce state costs by $35.8 million. However, while increasing premium amounts reduces state expenditures, it also causes a reduction in federal matching funds which would be offset by the increased family contributions.

In addition, research suggests that raising family premiums would likely reduce the number of children participating in the program. Research also suggests that families with lower incomes would be more likely to disenroll their children from the program than higher income families. Accordingly, the Legislature may choose to maintain the current KidCare premiums for Fiscal Year 2005-06 ($15 for families with incomes up to 150% of the federal poverty level and $20 for families with incomes above 150% of the federal poverty level).

[18] *The Impact of Recent Changes in Health Care Coverage for Low-Income People: A First Look at the Research Following Changes in Oregon's Medicaid Program,* Kaiser Commission on Medicaid and the Uninsured, June 2004.

[19] *Interim Evaluation Report: Congressionally Mandated Evaluation of the State Children's Health Insurance Program*, U.S. Department of Health and Human Services, February 2003.

Appendix A

2004 Federal Poverty Levels

Federal poverty levels are issued each year by the federal Department of Health and Human Services. The guidelines are used for administrative purposes such as determining financial eligibility for certain federal programs. The federal poverty levels are based on family size. Thus, a family of two with an income of $12,490 would be classified as at the poverty level, as would a family of six with an income of $25,210.

Percent of Poverty	Annual Income for a Family of					
	Two	Three	Four	Five	Six	Seven
100%	$12,490	$15,670	$18,850	$22,030	$25,210	$28,390
125%	15,613	19,588	23,563	27,538	31,513	35,488
130%	16,237	20,371	24,505	28,639	32,773	36,907
133%	16,612	20,841	25,071	29,300	33,529	37,759
140%	17,486	21,938	26,390	30,842	35,294	39,746
150%	18,735	23,505	28,275	33,045	37,815	42,585
170%	21,233	26,639	32,045	37,451	42,857	48,263
175%	21,858	27,423	32,988	38,553	44,118	49,683
185%	23,107	28,990	34,873	40,756	46,639	52,522
200%	24,980	31,340	37,700	44,060	50,420	56,780

Source: *Federal Register,* February 13, 2004: Volume 69(30), pp. 7336-7338.

Appendix B

State SCHIP Premiums

The following table details premiums required by SCHIP programs in 29 states by income level as of August 2004.

State	Percent of Federal Poverty Level	Premium (Amounts shown are monthly unless otherwise noted.)
Alabama	100% - 150%	$50 per member per year, $150 maximum
	151% - 200%	$100 per member per year, $300 maximum
Arizona	100% - 150%	$10 per member, $15 maximum
	150% - 175%	$15 per member, $25 maximum
	175% - 200%	$25 per member, $35 maximum
California	100% - 150%	$7 per member, $14 maximum
	150% - 250%	$9 per member, $27 maximum
Connecticut	235% - 300%	$30 per member, $50 maximum
Delaware	101% - 133%	$10 per family
	134% - 166%	$15 per family
	167% - 200%	$25 per family
Florida	100% - 150%	$15 per family
	151% - 200%	$20 per family
Georgia	100% - 150%	$10 per member, $15 maximum
	151% - 160%	$20 per member, $40 maximum
	161% - 170%	$22 per member, $44 maximum
	171% - 180%	$24 per member, $48 maximum
	181% - 190%	$26 per member, $52 maximum
	191% - 200%	$28 per member, $56 maximum
	201% - 210%	$29 per member, $58 maximum
	211% - 220%	$31 per member, $62 maximum
	221% - 230%	$33 per member, $66 maximum
	231% - 235%	$35 per member, $70 maximum
Idaho	150% - 185%	$15 per member
Illinois	150% - 200%	$15 per member, $25 for two, $30 for three or more
Indiana	150% - 175%	$11 per member, $16.50 maximum
	175% - 200%	$16.50 per member, $24.75 maximum
Iowa	150% - 200%	$10 per member, $20 maximum
Kansas	150% - 175%	$20 per family
	176% - 200%	$30 per family
Kentucky	150%-200%	$20 per family
Maine	150% - 160%	$5 per member, $10 maximum
	160% - 170%	$10 per member, $20 maximum
	170% - 185%	$15 per member, $30 maximum
	185% - 200%	$20 per member, $40 maximum
Maryland	200% - 250%	$41 per family
	250% - 300%	$52 per family
Massachusetts	133% - 150%	$12 per member, $15 maximum
	151% - 200%	$12 per member, $36 maximum
Michigan	150% - 200%	$5 per family
Missouri	185% - 225% 225% - 300%	Variable according to income and family size, $62 minimum, $252 maximum adjusted annually
Nevada	133% - 150%	$15 per family per quarter
	151% - 175%	$35 per family per quarter
	176% - 200%	$70 per family per quarter
New Hampshire	185% - 250%	$25 per member, $100 maximum
	250% - 300%	$45 per member, $135 maximum
New Jersey	151% - 200%	$17 per family
	201% - 250%	$34 per family
	251% - 300%	$68 per family
	301% - 350%	$113.50 per family
New York	134% - 185%	$9 per member, $27 maximum
	186% - 208%	$15 per member, $45 maximum
Rhode Island	150% - 185%	5% of family income, $61 per family
	185% - 200%	5% of family income, $77 per family
	200% - 250%	5% of family income, $92 per family
Texas	101% - 150%	$15 per family
	151% - 185%	$20 per family
	186% - 200%	$25 per family
Utah	101% - 150%	$13 per family per quarter
	151% - 200%	$25 per family per quarter
Vermont	225% - 300%	$70 per family
Washington	200% - 250%	$15 per member, $45 maximum
Wisconsin	150% - 200%	5% of family income $50 - $500 per family
Wyoming	100% - 185%	$200 per family per year

Source: National Academy of State Health Policy, August 2004.

The Florida Legislature

Office of Program Policy Analysis and Government Accountability

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