



Program Design Snapshot: State Buy-In Programs for Children

Description

A child buy-in program allows families with incomes in excess of a state's Medicaid/SCHIP eligibility levels to purchase insurance for their children through the public plan. Generally a buy-in program requires families to pay what the state pays for the coverage and, in some instances, the program's administrative costs.

Buy-in programs are designed to address coverage needs among more moderate-income children whose families do not have access to affordable private coverage. Buy-in programs can offer children the same comprehensive set of benefits offered through the state programs. Many of these programs are new and enrollment in buy-in programs, even the more established ones, has been relatively low. Buy-in programs have the potential to play an important role in reaching universal coverage for children, but only if it is coupled with strategies to make the premiums affordable for families.

Where States Stand¹

Child buy-in programs have existed since before the implementation of SCHIP, and at least eight states have operated a program for ten years or more (Connecticut, Florida, Maine, Minnesota, New Hampshire, New York, North Carolina, and Wisconsin). In addition, a new wave of states has implemented child buy-in programs, including Illinois, New Jersey, Pennsylvania, and Tennessee, and other states are planning or interested in doing the same.

Buy-in programs do not use federal Medicaid and SCHIP funds and do not operate under federal Medicaid or SCHIP rules. As a result, states have significant flexibility in how they operate a buy-in program, including the benefits offered and cost-sharing requirements. Generally, however, child buy-in programs mirror a state's SCHIP and/or Medicaid program by offering the same benefits package. This allows a state to implement a single outreach message that health coverage is available to all children, minimizes family confusion about program differences (especially when transferring from SCHIP when a family's income increases), and saves on administrative costs associated with having a separate application and administrative process. Additional program elements include:

- **Income Eligibility:** Most states allow families with incomes above their Medicaid/SCHIP program levels, with no upper income cap, to enroll in the buy-in program. A few states, however, have limited eligibility. New Hampshire has set income eligibility from 300 percent to 400 percent of the federal poverty level (FPL). At least three states, Maine, Minnesota, and North Carolina, limit eligibility to children who were enrolled in the state Medicaid/SCHIP program but no longer qualify due to increases in family income.
- **Administration:** Most states' child buy-in programs operate under the same administrative structure as the SCHIP program, utilizing the same vendors

(some even the same contracts) for the buy-in population. Similarly, state staff that perform administrative functions for the SCHIP program, play the same role for the buy-in, although without federal financial support. Families applying for the buy-in primarily do so through the same application for Medicaid and SCHIP (although some states, such as New Hampshire and New Jersey, utilize a separate application).

- **Flexibility:** Since buy-in programs receive no federal funding, states have flexibility in designing the programs, such as establishing different renewal procedures and allowing immigrant children to apply. For example, as with a regular insurance product, some states (Maine, New York, North Carolina, and New Hampshire) have no annual renewal requirements for families. A family stays enrolled in the program as long as they continue to pay premiums or unless they request a new eligibility assessment if they believe their child is eligible for Medicaid or SCHIP.
- **Premium Levels:** Monthly premium costs for child buy-in programs vary considerably from state-to-state and are largely dependent on a state's health care market and how the buy-in program is structured. As a whole, however, premiums for buy-in programs are substantially higher than Medicaid/SCHIP premiums and represent a large share of family income.² Buy-in programs have the potential to offer families a lower premium level than what is available in the private market because of administrative efficiencies and the size and composition of the risk pool (some states group the buy-in population with other publicly covered children which increases the size of the risk pool and

tends to reduce premiums for the buy-in population). However, how buy-in program premiums compare to coverage on the individual market will differ by state and any assessment must include a comparative review of program benefits and cost-sharing requirements.

- **Enrollment/Time Limit:** No state has a limit on the number of enrollees in its program. Florida's buy-in program had a cap of 10 percent of its SCHIP (MediKids and Healthy Kids) enrollment, however, in 2008 the state eliminated the cap.³ Generally, states do not limit the amount of time a child can stay enrolled in the buy-in program (with the exceptions of Maine and North Carolina which target children transitioning off SCHIP/Medicaid and have a maximum limit of 18 months and 12 months respectively). Unlike SCHIP, there is usually no premium grace period for buy-in programs if the state is not providing any direct subsidies. As such, if a family does not pay a monthly premium, the child or children are immediately disenrolled from the program.

Issues to Consider

Program Impact: To date, enrollment in child buy-in programs has been relatively small. According to 2005 data from six state child buy-in programs, enrollment as a percent of the SCHIP population ranged from less than one percent in Connecticut to up to 10 percent in Florida.⁴ In addition, analysis by the Urban Institute shows that enrollment in buy-in programs is low compared to the size of the targeted uninsured population, ranging from eight to 11 percent of eligible children in selected states.⁵

There could be a number of reasons for low enrollment in buy-in programs, including

program design and the extent to which the programs are marketed. In addition, it is likely that the premium levels (especially if similar coverage is available on the individual market at a comparable cost) may deter enrollment. Additional research is needed on this topic but cost-sharing experiences in Medicaid/SCHIP programs provide some insight: studies consistently show that higher premium requirements in Medicaid/SCHIP can depress enrollment.⁶

Thus, if the goal of the buy-in program is to provide coverage to all uninsured children, a state will want to consider using state dollars to directly subsidize the premium and/or administrative costs for families within the lower income bands. For example, Connecticut and Minnesota use state funds to pay administrative costs and Illinois has integrated a premium sliding-scale approach into its All Kids program. Under Illinois' program, Medicaid and SCHIP cover children up to 200 percent of the FPL, while a buy-in program is offered for all other uninsured children. Those with family income between 200 to 400 percent of the FPL receive a state-funded subsidy to lower the premium amount from \$15 to \$70 per child per month, depending on income. Those with family income above 400 percent of the FPL pay the buy-in program's premium costs to the state, which range from \$100 to \$300 per child per month.⁷

Conversely, a state could implement a Medicaid/SCHIP expansion as an alternative to a buy-in program, especially for children with lower family incomes. As of October 2008, 10 states have implemented Medicaid/SCHIP expansions to children with family income up to 300 percent of the FPL and three states provide coverage to children with family income above to 300 percent of the FPL. Many more states have enacted legislation and are planning expansions.⁸ (See

<http://ccf.georgetown.edu/index/medicaid-and-schip-programs> for Medicaid/SCHIP eligibility levels by states.)

Adverse Selection: Adverse selection occurs when children enrolling in a program have health care costs greater than those expected for the broader population of children. Adverse selection tends to occur in any voluntary insurance program and is dependent on a number of factors, including the premium structure and the availability of guaranteed issue in the individual market. There is very limited research on the extent of adverse selection in child buy-in programs and it clearly requires more study. One of the few studies available is a 2005 report of Florida's buy-in program (which is available to children with family income above 200 percent of the FPL). The report showed that Florida's buy-in population's costs were roughly twice as expensive, on average, than the subsidized SCHIP population.⁹ However, since the targeted populations are different, it is unclear to what extent this is evidence of adverse selection. For a further discussion on the factors affecting adverse selection see: *State Buy-In Programs: Prospects and Challenges* by The Urban Institute (http://www.urban.org/health_policy/url.cfm?ID=411795).

While a buy-in program may experience some adverse selection, they also have the potential to meet an important policy objective—to provide an insurance option to children with high health care needs. A state implementing a buy-in program will want to consider how to mitigate the effect of adverse selection to make the program sustainable, and ultimately how much adverse selection it can tolerate.

One way in which a state can address adverse selection is to ensure that the premium costs are not too high. The number and type of participants who are likely to enroll in

coverage is largely a function of the premium amount. As premium levels increase, healthier people are more likely to drop coverage, while a sicker population would be willing to pay more.¹⁰ Thus states will want to consider setting the premium level as low as possible, potentially through state subsidies, to create a large enough pool of enrollees to limit the risk of adverse selection.

Another option is for states to implement the Family Opportunity Act (FOA). In February 2006, as part of the Deficit Reduction Act, Congress provided states with a new buy-in program option for children.¹¹ The FOA allows states to offer families with income below 300 percent of the FPL the opportunity to buy into Medicaid on a sliding scale if their child has a disability.¹² Since the benefits in Medicaid are more generous and premiums are subsidized with federal and state dollars, families with disabled children would more likely choose enrollment in the Medicaid buy-in program.

The Welcome Mat Effect: Buy-in programs have the potential to positively effect enrollment of children who are eligible for Medicaid and SCHIP but uninsured. Data indicates that “putting out the welcome mat” by offering affordable coverage options to uninsured children at higher income levels can have a powerful effect on the enrollment of already-eligible uninsured children.¹³ Pennsylvania and Illinois implemented their buy-in programs as part of a greater “all kids” coverage strategy and subsequently experienced large enrollment gains from the eligible but uninsured population. In Illinois, 68 percent of new enrollments from November 2005 to June 2008 were previously eligible but not enrolled.¹⁴ In Pennsylvania, 59 percent of new enrollments from February 2007 to June 2008 were previously eligible but not enrolled.¹⁵

Achieving this success however requires that a state adequately market the buy-in program and implement it within the context of a “cover all kids” message. For more information see *Putting Out the Welcome Mat: Implications for Coverage Expansions for Already-Eligible Children* (<http://ccf.georgetown.edu/index/strategy-center>).

Crowd-Out: Because enrollment levels have been so low to date, crowd out has only been a minor concern to states.¹⁶ As with SCHIP, some child buy-in programs require “waiting periods,” i.e. a child must have had no health insurance, with exceptions, at the time of enrollment for a specified period of time, ranging from three months up to 12 months in Illinois and Florida. However, any policy that leaves children uninsured for a period of time should be considered in the context of the health consequences and financial costs associated with no access to health care during the waiting period. See *Program Design Snapshot: Public Coverage Waiting Periods for Children* (<http://ccf.georgetown.edu/index/strategy-center>).

Conclusion

Child buy-in programs offer states another option for providing health coverage to children with moderate family incomes, and as a result, increasing coverage to those with lower family incomes. Enrollment in the programs, however, has been limited to date, due in part to the high premiums that families must pay. Only a few states have decreased premiums through the use of state subsidies, but the effectiveness of buy-in programs as a universal coverage option may not be achieved without such assistance.

For More Information

- *State Buy-In Programs: Prospects and Challenges*, The Urban Institute, 2008
http://www.urban.org/health_policy/url.cfm?ID=411795.
- *SCHIP Buy-in Programs*, National Academy for State Health Policy, 2006
http://www.nashp.org/Files/SCHIP_Buy-in_programs_2006.pdf
- *Full-Cost Buy-Ins: An Overview of State Experience*, State Coverage Initiatives, 2001
<http://www.statecoverage.net/pdf/issuebrief801.pdf>
- *Full-Cost Buy-In Options for Optimizing Coverage through NJ FamilyCare*, State of New Jersey in collaboration with Rutgers Center for State Health Policy, 2006
<http://www.cshp.rutgers.edu/DOWNLOADS/6160.PDF>
- *State Children's Health Insurance Program (SCHIP) Buy-in Programs*, Report of the Department of Medical Assistance Services to the Governor and the General Assembly of Virginia, 2006
http://www.dmas.virginia.gov/downloads/studies_reports/2006-HD48_SCHIP.pdf

Endnotes

¹ Information on the state programs was gathered through research documents, conversations and state program Web sites. Resources used include: C. Pernice and D. Bergman, "[SCHIP Buy-in Programs](#)," National Academy for State Health Policy (May 2006); M. Birnbaum, "[Full-Cost Buy-Ins: An Overview of State Experience](#)," State Coverage Initiatives (August 2001); J. Zhou, "[SCHIP Full-Cost Buy-In Programs](#)," The University of Texas at Austin (May 2002); State of New Jersey and Rutgers Center for State Health Policy, "[Full-Cost Buy-In Options for Optimizing Coverage through NJ FamilyCare](#)," (April 2006); and Report of the Department of Medical Assistance Services to the Governor and the General Assembly of Virginia, "[State Children's Health Insurance Program \(SCHIP\) Buy-in Programs](#)," (2006).

² G. Kenney, L. Blumberg, and J. Pelletier, "[State Buy-In Programs: Prospects and Challenges](#)," The Urban Institute (November 2008).

³ [S. 2534](#), 2008 Regular Session (Florida, 2008).

⁴ *op. cit.* (1), Report of the Department of Medical Assistance Services to the Governor and the General Assembly of Virginia, 2006. Maine also had less than one percent enrollment as a percent of the SCHIP population in its buy-in program but the state limits enrollment to previous SCHIP enrollees.

⁵ *op. cit.* (2).

⁶ S. Artiga and 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 and V. Wachino, "[The Effect of Increased Cost Sharing in Medicaid: A Summary of Research Findings](#)," Center on Budget and Policy Priorities (July 7, 2005).

⁷ State of Illinois, All Kids Web Site, <http://www.allkids.com> and email communication with John Bouman, President, Sargent Shriver National Center on Poverty Law, September 15, 2008.

⁸ 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). Updates by Georgetown University of Center for Children and Families. Note that in an August 17th letter to health officials, the Centers for Medicare and Medicaid Services established new restrictions on states planning to use federal funds to cover children with family income above 250 percent of the FPL. See Centers for Medicare and Medicaid Services, State Health Official Letter, [SHO #07-001](#)

(August 17, 2007). Data and analyses from state officials, research organizations, and policy experts raise significant questions about the basis for and the potential adverse effects of the directives, as well as the process by which CMS issued the policy. See J. Guyer, M. Odeh and C. Mann, "[Out of Touch: A Status Report on CMS's August 17th Directive](#)," Georgetown University Center for Children and Families (May 2008).

⁹ Ross Actuarial, "Actuarial Analysis of Full Pay Enrollees in the Florida Healthy Kids Program," Florida Healthy Kids Corporation (October 6, 2005).

¹⁰ L. Ku & T. Coughlin, "[Sliding-Scale Premium Health Insurance Programs: Four States' Experiences](#)," *Inquiry*, 36: 471-480 (Winter 1999-2000).; and G. Kenney, *et al.*, "[Effects of Premium Increases on Enrollment in SCHIP](#)," *Inquiry*, 43: 378-392 (Winter 2006/2007).

¹¹ Section 6062 of the Deficit Reduction Act of 2005 ([Public Law No. 109-171](#)).

¹² The option is being phased in: in 2008, it is available for children under age 12 but by 2009 it is available for all children under age 19. Parents who are offered employer group health insurance where the employer pays 50% of the annual premium must elect coverage if they want to buy into Medicaid. Medicaid then would pay for services that are not covered by the private health plan but are covered under Medicaid. In these cases, a state must reduce its premium by an amount that reasonably reflects the contribution the family has paid for the private coverage. For more information on the new option see Catalyst Center, "[Frequently Asked Questions about the Family Opportunity Act's Medicaid Buy-In Option](#)," (February 2007).

¹³ L. Arjun and J. Guyer, "[Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children](#)," Georgetown University Center for Children and Families (September 2008).

¹⁴ Data received from the Illinois Department of Healthcare and Family Services, May 2008.

¹⁵ Email communication from George L. Hoover, Deputy Commissioner, CHIP and AdultBasic Programs, Pennsylvania Department of Insurance, June 28, 2008.

¹⁶ *op. cit.* (1).

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