

## **State Buy-In Programs: Prospects and Challenges**

**Genevieve Kenney, Linda Blumberg, and Jennifer Pelletier**

### **EXECUTIVE SUMMARY**

- SCHIP buy-in programs, available in a growing number of states, provide comprehensive health insurance options for children in families with incomes too high to qualify for government-supported plans. Through these programs, moderate- and higher-income parents can buy their children the same health care coverage offered through the state programs, but at a much higher premium than charged for lower-income children.
- Take-up rates in buy-in programs appear to be low relative to the size of the uninsured population to which they are targeted, ranging from 8 to 11 percent of eligible children in selected states. Enrollment in private nongroup coverage among the target income group tends to be substantially higher than enrollment in buy-in programs in the same state.
- While no definitive analysis is available on how much buy-in programs are “crowding out” private insurance, the low enrollment levels in buy-in programs suggest that they have had little impact on employer-sponsored insurance (ESI). In addition, since the buy-in populations largely pay for the full costs of their coverage, there is little displacement of private dollars with public dollars.
- Premiums in buy-in programs are substantially higher than premiums charged to children in the subsidized component of Medicaid/SCHIP. The high premiums likely contribute to the low take-up rates observed since they constitute a large share of income for families with moderate incomes (i.e., families with incomes between 200 and 400 percent of the federal poverty level) and since most families can reasonably expect their children to have spending levels substantially lower than the premium.
- By providing greater subsidies to moderate-income families, thereby raising the minimum income level for the unsubsidized buy-in, states will likely see greater enrollment in the buy-in program and greater reductions in uninsurance among children.
- Adverse selection is likely to occur in buy-in programs, especially in those where premiums are high relative to income, participation is voluntary, and the private nongroup insurance market does not have community rating and guaranteed issue of policies. The limited information available does suggest that there is adverse selection in buy-in programs, though more research is needed. However, to the extent that these programs are enrolling children with higher than average health needs, the buy-ins are likely providing high quality, comprehensive care, with low out-of-pocket cost sharing to which these children would not have had access otherwise.

- States may be able to limit adverse selection by requiring that children be uninsured for a specified period of time prior to enrolling. However, this approach will penalize children with private coverage that is more costly or less comprehensive than what is available through the buy-in program. Nongroup coverage, in particular, tends to have limited benefits and provides a lower insurance value for the dollar due to high administrative costs. Requiring such waiting periods also may have adverse health consequences for children.
- States could reduce premiums for buy-in programs by increasing out-of-pocket cost-sharing requirements. Such a change could increase take-up and reduce adverse selection. However, increasing cost sharing places a greater financial burden on those with high health care needs and may reduce some families' financial access to necessary care. In addition, administrative costs associated with the buy-in may rise as mechanisms for tracking payments must be implemented.
- One option being considered is to impose a mandate on parents to cover their children, which would likely be the most effective strategy for increasing take-up and reducing adverse selection in the buy-in. The impacts on the coverage of moderate- and higher-income uninsured children will likely depend on how the penalties for noncompliance compare with the premiums in the buy-in program. Moreover, before a mandate is implemented, it will be essential to consider the affordability of the buy-in premiums and cost sharing, particularly for moderate-income families.
- Buy-in programs can stimulate greater enrollment among children already eligible for Medicaid and SCHIP, but this will not occur automatically; it will likely require aggressive marketing and outreach.
- Many questions about buy-in programs remain unresolved. In particular, no information is publicly available on how enrollment and take-up in buy-in programs vary by income group, how the characteristics (e.g., demographic, health needs, etc.) and health care access of the children served by the buy-in differ from those in other insurance groups (i.e., children with non-group coverage, children with ESI, children with subsidized public coverage, and uninsured children), how buy-in programs affect and are affected by the nongroup market in a particular state, and what other policies are needed to maximize the positive spillover effects associated with offering a buy-in.

## State Buy-In Programs: Prospects and Challenges

Genevieve Kenney, Linda Blumberg, and Jennifer Pelletier

November 2008

A growing number of states are either proposing or have begun implementing policies aimed at achieving universal coverage for children (Pernice and Bergman 2006; Heberlein et al. 2008). These proposals often include a buy-in program whereby families whose incomes are too high to qualify for subsidized public coverage can buy their children into a comprehensive public insurance plan with low out-of-pocket cost sharing at an unsubsidized premium (Horner 2008).

Buy-in programs are designed to address current coverage shortfalls among moderate- and higher-income children whose families are not eligible for Medicaid or SCHIP but who cannot afford, or do not have access to, private coverage. Buy-in programs may also allow states to be more effective at marketing the available public coverage in their state, leading to a spillover effect of higher enrollment in the subsidized portion of their programs. Since around two-thirds of uninsured children are eligible for existing Medicaid/SCHIP coverage but are not yet enrolled (Hudson and Selden 2007; Holahan et al. 2007), combining a buy-in program with additional resources dedicated to program outreach and enrollment may have a very significant impact in reducing the number of uninsured children overall.

Addressing coverage gaps among higher-income children is, in and of itself, an important part of achieving universal coverage for children. As many as 1.3 million uninsured children have family incomes above 300 percent of the federal poverty level (FPL), and another 1.3 million uninsured children have incomes between 200 and 300 percent of the FPL; most of these children do not qualify for coverage under subsidized Medicaid or SCHIP. Many higher-income families with uninsured children lack affordable coverage options. Few higher-income uninsured children can be added to existing employer plans since their parents are unlikely to have coverage themselves. Only 24 percent of uninsured children with incomes between 200 and 400 percent of the FPL and 29 percent of those with incomes above 400 percent FPL live in families where at least one parent is covered under an employer plan. Just 15 and 21 percent, respectively, live in families where both parents are covered under an employer plan (Urban Institute tabulations of the 2007 Current Population Survey [CPS]). Therefore, most moderate- and higher-income

families wanting health insurance for their children would need to look to the nongroup insurance market for coverage. However, nongroup coverage may be prohibitively expensive for many families (Blumberg and Kenney 2007), the benefits may not include services such as dental or prescription drug coverage that are important for children (Pollitz and Sorian 2002), or nongroup policies may not be available at all for children who have significant health care needs (Pollitz et al. 2001).

At least 8 states have operated buy-in programs for 10 years or longer. For example, New York and Florida have buy-in programs that date back to 1991 and 1992, respectively. Other states, like North Carolina, Maine, and Connecticut began their buy-in programs when they implemented their SCHIP expansions. In recent years, states such as Illinois and Pennsylvania have launched buy-in programs as part of their strategy to reach universal coverage for all children, and additional states have either recently received approval to operate buy-in

programs or are developing proposals to do so (Heberlein et al. 2008).

This paper discusses the likely impacts of buy-in programs on coverage, both for the children eligible for the buy-ins and those who are already eligible for Medicaid or SCHIP but who are not yet enrolled. The brief draws on published reports, information from state web sites, discussions with state officials, and analyses of enrollment, premiums, and adverse selection, that is, the extent to which the children who enroll in the buy-in program have higher health care spending than the average for the target population (AcademyHealth 2004). The following section discusses take-up, crowd-out, affordability, adverse selection, and spillover effects.

### **Take-Up Rates and the Role of Premiums**

Enrollment in buy-in programs has been limited thus far, indicating that the programs have not made a large dent in the uninsurance problem among the higher-income children who qualify for them.

#### ***Take-up rates have been low in buy-in programs.***

While current enrollment information is not available for all the buy-in programs in operation, the experiences of four states (Connecticut, Florida, New York, and Pennsylvania) for which enrollment data are available suggest that enrollment in the buy-in programs comprises a small fraction of the target population (table 1). For example, as of 2005, New York had enrolled 12,262 children in its program, yet 99,161 children in the income group eligible for the buy-in remain uninsured, a take-up rate of 11 percent—the highest of the four states examined.<sup>1</sup> In the other three states examined, take-up rates ranged from 7.9 percent to 8.2 percent.<sup>2</sup> While the low take-up and enrollment in Pennsylvania may be partially explained by the fact that the program is very new, having been in place for just over a year, the other three programs have operated for over a decade.<sup>3</sup>

One explanation for these low take-up rates is that many families may not be aware of the buy-in option. Aggressive marketing of the buy-in program either on its own or as part of a comprehensive strategy to cover all children may be a prerequisite for achieving greater take up in the buy-in program (Hoover 2008). However, questions have been raised about how effective buy-in programs will be at attracting uninsured children in higher-income families (Belloff and Marquis 2006), even with high-visibility outreach. One concern is that it may be difficult to induce higher-income parents of uninsured children to enroll their children in the buy-in program since they have not already sought out insurance for their children, which may indicate that they place a low value on health insurance coverage.

#### ***High premiums in buy-in programs likely contribute to low take-up.***

While no research is available to assess the reasons for such low take-up in existing buy-in programs, it is also likely that the premiums that are being charged are deterring many families from enrolling their children. Premiums are likely to be a particularly important issue for moderate-income families, those with incomes between 200 and 400 percent of the FPL. There is an extensive literature that indicates that premium levels affect take-up of coverage (Herndon et al. 2006; Kenney et al. 2006/2007; Blumberg et al. 2004; Ku and Wachino 2005) and that families with lower incomes are more likely than families with higher incomes to be deterred from obtaining coverage when facing premiums. Given that half of all uninsured children with family incomes above 200 percent of the FPL have incomes between 200 and 300 percent of the FPL, many uninsured families eligible for the buy-in may find the premiums unaffordable relative to their income.<sup>4</sup> Premiums paid for children's coverage are, of course, only one part of a family's health care financing burden. When considering the affordability of the buy-in for families, it is important to factor in the costs of medical care (insurance and/or direct payments for services) for adults in the family that would be over and above the buy-in associated costs the family faces. The

costs incurred on behalf of the parents are likely to be considerably higher than those for the children. Indeed, a recent study found that even when there was no cost sharing for the children in the family, 12.7 percent of publicly-insured children would be in families that were spending more than 10 percent of their income on health care, and 5.9 percent were spending more than 20 percent of their income (Selden et al. forthcoming).

Table 2 shows the buy-in program premiums as a share of income for selected states. Because the premiums in the program are unsubsidized and do not vary with income, the financial burdens for families between 200 and 300 percent of the FPL to cover their children alone can be quite striking.<sup>5</sup> Even those families between 300 and 400 percent of the FPL would have to contribute significant shares of their income, especially if they have two or more children. For example, families in Florida with incomes at 201 percent of the FPL would need to contribute 5.5 percent, 8.7, and 10.8 percent of family income to cover one, two and three children, respectively. In contrast, a family at 600 percent of the FPL in Florida would contribute 1.8, 2.9, and 3.6 percent for one, two, and three children. As a consequence, unsubsidized coverage for those with modest incomes but still above the Medicaid/SCHIP income eligibility standards is likely to remain unaffordable for many.

***In most states, families experience a spike in premiums as they transition from subsidized to buy-in coverage.***

One of the fundamental decisions that likely affects take-up in buy-in programs and the overall impact of the public program in a given state is the income level at which subsidized coverage ends and unsubsidized buy-in coverage begins—that is, at what income level a buy-in program starts. The lower the income level at which families are required to pay full premiums for children’s coverage, the lower the take-up rates will be in the buy-in, other things equal. Many modest-income families will simply not consider these premiums affordable for their families given their budgets. In states where SCHIP eligibility

extends higher up the income scale, those expected to pay full premiums for coverage will be higher-income. In those cases, the share of uninsured children enrolling in buy-in programs can be expected to be higher, since full premiums are more affordable the higher the family’s income.

All the current buy-in programs begin at 200 percent of the FPL or higher (Pernice and Bergman 2006; Birnbaum 2001). While the lower-income threshold varies across states, most of the buy-in programs set their lower eligibility threshold at 250 or 300 percent of the FPL. The exceptions are Florida, North Carolina, and Maine. Florida has a buy-in program that offers coverage to children in families with incomes above 200 percent of the FPL. North Carolina and Maine only offer their buy-in programs to children who are disenrolling from subsidized SCHIP coverage because their income makes them no longer eligible. Thus these two states target families with incomes between 200 and 235 percent FPL (North Carolina) and above 200 percent of the FPL (Maine) (Pernice and Berman 2006). New York and Tennessee offer their buy-in programs to children with family incomes above 250 percent of the FPL, while Minnesota offers buy-in coverage to children disenrolling from subsidized coverage when their income exceeds 275 percent of the FPL. All the other states (Connecticut, New Hampshire, New Jersey, Pennsylvania, Ohio, and Wisconsin) have buy-in programs that begin at 300 percent of the FPL or higher. While it is not clear from the available data at what income level families are no longer subsidized in Illinois, Illinois allows families to buy their children into SCHIP coverage above 200 percent of the FPL,<sup>6</sup> with premiums that increase with family income up to 800 percent of the FPL, at which point the premium remains flat for all higher incomes.

Many states charge premiums in their subsidized Medicaid/SCHIP programs, especially for families with incomes above 200 percent of the FPL (Selden et al. forthcoming). However, those premiums tend to be much lower than the premiums that states charge in their buy-in programs. Table 3 shows the premium schedules for selected states in both their subsidized and

unsubsidized program components. In most states, there is a marked jump in the required premium contribution in the buy-in program compared to the subsidized program. For example, in Florida, a family with income at 200 percent of the FPL or below would be required to pay \$240 annually to enroll a child in SCHIP, whereas a family whose income was 201 percent of the FPL or higher would be required to pay \$1,536—over six times as much. Likewise, in Pennsylvania, a family with income at 300 percent of the FPL would pay \$768 on average for one child, whereas at 301 percent of the FPL, they would pay an average of \$1,932 annually, which is 2.5 times as much. In Connecticut, the premium in the buy-in program is 5.3 to 7.7 times higher than the subsidized premium at the cut off point.

New York's buy-in program, which underwent large changes this year when the state expanded subsidized coverage, had been charging \$180 annually for a family at 250 percent of the FPL to enroll a child in their SCHIP program, while it would cost between \$1197 and \$2153 for a family at 251 percent of the FPL in 2007. In 2008, New York expanded subsidized coverage to children between 250 and 400 percent of the FPL using state funds and offered a buy-in program to children above 400 percent of the FPL (New York State Executive Chamber 2008). Under the new plan, families between 250 and 400 percent of the FPL now face substantially lower premiums than they did previously—the premiums have been reduced by over a third on average. Families with incomes just above the new subsidy cut-off level experience the jump in premium prices: a family at 400 percent of the FPL in New York now pays \$480 per year to enroll a child in subsidized coverage while they would pay between \$1,268 and \$2,312 at 401 percent of the FPL to enroll in the buy-in program. It will be informative to assess how much the reduction in premiums for the families with incomes between 250 and 400 percent of the FPL induces greater participation and reduces adverse selection in New York's buy-in program.

The one exception to this pattern is Illinois, which has graduated premiums all the way up to 800 percent of the FPL. For example, families earning between 400 and 500 percent of the FPL

pay \$100 per month to enroll one child, while families earning between 500 and 600 percent of the FPL pay \$150 per month. Premiums continue to increase in \$50 increments as families climb the income scale to 700 percent and 800 percent of the FPL and then hit a maximum at \$300 per month for all families earning 800 percent of the FPL or more.<sup>7</sup> A graduated premium schedule such as Illinois has adopted makes much more sense for families' budgets, and might even reduce adverse selection by making the premiums more affordable. The higher the premium, the less likely parents are to enroll their healthy children, as they expect their children's health care needs to be lower than the premium charged. As premiums fall, the program becomes more attractive to those with healthier children, making the mix of enrollees look more like the population of children as a whole.

### **Adverse Selection and Crowd-Out**

Buy-in programs have the potential to replace private coverage (crowd-out) and to experience adverse selection. Evidence to date indicates that there has been little crowd-out in buy-in programs, but the risk of adverse selection is a greater concern.

#### *Low enrollment levels in buy-in programs suggest little impact on private coverage.*

Given the income groups that are targeted by buy-in programs, it is possible that buy-in programs will substitute for other private coverage.<sup>8</sup> Nationally, among children whose family incomes are above 300 percent of the FPL, 4 percent are uninsured, while a slightly higher percentage—5 percent—have nongroup coverage, and fully 88 percent have employer coverage (Urban Institute Tabulations of the 2006-2008 ASEC Supplement to the CPS). In order to reduce the likelihood that the buy-in will substitute for private coverage, buy-in programs limit enrollment by imposing waiting periods, particularly for children coming off of employer-sponsored insurance (ESI). In addition to explicit barriers aimed at discouraging families from dropping ESI, the favorable tax treatment of ESI and the employer's contributions

to dependent coverage may make it a much more affordable option for families compared to the buy-in, which would discourage parents from dropping private coverage even if they were willing to satisfy a waiting period. In addition, the buy-in program requires having children in different health plans from their parents, another feature that makes ESI more attractive.

The situation for children with nongroup coverage is quite different, where, depending on the structure of the nongroup market in the state and the premiums charged in the buy-in program, families may see the buy-in program as a better option than nongroup coverage. Interestingly, it appears that many more families have nongroup coverage in Connecticut, Florida, New York, and Pennsylvania than are enrolled in the buy-in programs in those states. The estimated number of children with nongroup coverage is over five times as high in each state as the number enrolled in the buy-in.<sup>9</sup>

***Adverse selection is likely to occur in voluntary buy-in programs.***

In addition to affecting take-up, the premium levels charged in buy-in programs also likely increase adverse selection, which occurs when children enrolling in the program have health care costs greater than those expected for the population of children targeted by the buy-in program. Adverse selection will tend to occur in any voluntary insurance program, including one where no premiums are charged, as is the case with the Medicaid program (Davidoff et al. 2000). Although enrollment in Medicaid is technically “free,” there are costs incurred by those choosing to enroll, including information gathering to enable application, filling out the application and submitting it, and any hassle involved with interactions with program officials throughout the process. As a consequence, those expecting to use the most services have the greatest incentives to incur the costs associated with the process. The higher the costs of enrollment (e.g., the higher premiums charged, or the more administrative hassles associated with enrollment), the greater the adverse selection that can be expected. Public programs may be able to address adverse selection

to an extent by keeping premiums low through subsidies to encourage participation by healthy children. But once nonsubsidized premiums are added to the other costs of enrollment, as in the case of buy-in programs, adverse selection is exacerbated. Adverse *retention* may also be an issue with buy-in programs since parents of children with high health care needs may be more likely to stay in the program and pay the unsubsidized premium year after year.

Adverse selection is more likely in programs that base premiums on the mean expected spending of the enrollees in the buy-in, but it will also likely occur in states that base their premiums on the combined experience of subsidized SCHIP enrollees and children in the buy-in program. Since health care spending for children is highly skewed (Liptak et al. 2006), the mean spending level will tend to be significantly higher than the median level, which could deter families with healthy children from enrolling in the buy-in program. For example, the mean spending level for children who are enrolled in Medicaid/SCHIP for a full year is more than five times as high as the median spending level in those programs (Kenney et al. 2008). The vast majority (84 percent) of the children in Medicaid/SCHIP had spending levels that were below the mean, and most of those had spending levels that were significantly lower than the mean. Similar patterns hold for the whole population of children.<sup>10</sup>

Not surprisingly, children in the top decile of spending are much more likely to be in fair or poor health or to have special health care needs compared to children with lower spending levels (Urban Institute tabulations of the Medical Expenditure Panel Survey from 2002 to 2005). Therefore, in a buy-in context, many families, particularly those whose children do not have chronic health problems, will expect their children to have low service use and may not be willing to pay premium levels that reflect average spending for enrolled children. Thus, it is likely that charging premiums that reflect average spending levels will deter parents with healthy children from enrolling their children in buy-in programs.

The premiums that are charged in buy-in programs do not vary with the health status or expected health care costs of the child – all

unsubsidized enrollees pay the same premium. In other words, the premiums are community rated. As a result, in any given year, lower cost enrollees pay more in premiums than the benefits that are paid out on their behalf, and higher cost enrollees pay less in premiums than the benefits they use. In this way, enrollees with above average costs are effectively subsidized by enrollees with below average costs, just as is the case under pure community rating in private health insurance markets. The larger the population of healthy children relative to high cost children, the smaller is the effective subsidy paid by each healthy child into the pool.

To the extent that the premiums charged to the buy-in group are based upon the health care spending experience of the buy-in group, as opposed to premiums that reflect the average costs of all children in the broader population, the premium for the community-rated product will tend to increase over time with adverse selection.<sup>11</sup> As the premiums increase, more families will determine that they are subsidizing the pool as opposed to being subsidized by it, and more of the healthier families in the pool will decide not to participate. Thus enrollment falls further over time, with only the highest cost and most risk-adverse finding it advantageous to remain in the program. Such an experience led to the dismantling of a buy-in program for adults in Washington State (Belloff and Marquis 2006).

While community rating may induce some adverse selection, it will also mean that the buy-in program can provide an insurance option to children with high health care needs who could not obtain nongroup coverage or could only obtain policies with limited benefits or very high cost sharing burdens. This potential benefit of buy-ins should be factored in when assessing the contribution that the buy-in program is making to the health and well-being of children. In addition, providing greater subsidies to moderate-income families, as was recently done in New York's program, could serve to both increase take-up and reduce adverse selection, while still providing coverage to these high-need children.

The risks of adverse selection also likely depend on the characteristics of the nongroup market in the state (Belloff and Marquis 2006).

Adverse selection is more likely in buy-in programs that operate in states with a nongroup market that does not have community-rating or guaranteed issue since chronically ill children do not have viable options in those nongroup markets and will be more likely to want to enroll in the buy-in program. Nongroup markets in states with pure community rating and guaranteed issue tend to enroll high cost individuals while those that allow insurers to select individuals based on risk have substantially healthier enrollees on average.

Of the four states examined in table 1, only New York has guaranteed issue and community rating in their nongroup market; the three other states, Connecticut, Florida, and Pennsylvania do not have either guaranteed issue or community rating (Kaiser Family Foundation 2008).<sup>12</sup> Thus, one might expect adverse selection to be lower in New York's buy-in program than in the buy-in programs in the other states. Nongroup coverage in these states includes look back periods for pre-existing conditions of 6 (New York) to 60 months (Pennsylvania) and permit coverage exclusions for 12 (Connecticut, New York, and Pennsylvania) to 24 months (Florida). Child-only policies are not available in the nongroup market in New York. In the three other states, it is possible to purchase a child-only policy, but nongroup coverage that is comparable to the buy-in in terms of benefits and cost sharing do not appear to be available—the available nongroup policies appear to offer fewer benefits and to include higher out-of-pocket cost sharing.

For example, in Connecticut, the nongroup child-only policy that most closely resembles what is available through the buy-in,<sup>13</sup> which would be available to a healthy five year old child, includes a premium of \$183 per month for a health maintenance organization (HMO) product, has no coinsurance or deductibles, but includes \$25 copayments on office visits, \$35 copayments on specialist visits, \$15 copayments on generic prescriptions, \$25 and \$40 copayments, respectively, for brand name and nonformulary prescriptions, a \$35 copayment for outpatient mental health care, a \$2000 deductible for inpatient mental health care, and no dental coverage. This compares to a premium ranging from \$158 to \$230 in Connecticut's buy-in

program with copayments of \$5 on office visits, \$3 generic prescriptions (\$6 brand name prescriptions), dental coverage (including preventive, diagnostic, and restorative services, oral surgery, and emergency care), and mental health benefits that include both inpatient (100 percent coverage) and outpatient (\$5 copayment) services.

In Pennsylvania, there is a Preferred Provider Organization (PPO) plan available in the nongroup market for a premium of \$187 per month with no overall deductible and no coinsurance. Office visits carry \$20 copayments; specialist visits have a \$40 copayment and generic prescriptions cost \$15; brand name and nonformulary prescriptions have a \$100 deductible, after which the copayments are \$25 and \$50, respectively; inpatient mental health care includes a \$200 per day copayment, and no dental care is covered. In contrast, Pennsylvania's buy-in program charges an average premium of \$161 per month with \$15 copayments for office visits, \$25 copayments for specialist visits (including outpatient mental health visits), \$10 for generic prescriptions, \$18 for brand name prescriptions, and coverage for dental and mental health care and substance abuse services. Preventive visits, including dental check-ups and cleanings, and inpatient mental health care are covered with no copayment.<sup>14</sup>

No information is available to assess access to providers in the buy-in program relative to the access that is afforded in the private market, which would likely affect a family's valuation of the buy-in and nongroup coverage. Moreover, some families may not be comparing child-only nongroup policies to what is available through the buy-in when deciding which coverage to take up for their children since they may have a nongroup policy that covers the whole family. However, in states where nongroup premiums are low, out-of-pocket cost sharing (in the form of deductibles, copayments, and coinsurance) is high and benefits are narrow relative to what is available in the buy-in program. Families whose children do not have any known major health problems may be more likely to purchase coverage in the nongroup market, while those whose children have high health care needs would likely be better served by

the buy-in program, leading to adverse selection in the buy-in.

Since higher-income families may place a higher value on insurance coverage as a way of protecting their assets and since uninsured children in higher-income families tend to have fewer health problems compared to uninsured children in lower-income families, adverse selection may be lower among the highest-income families targeted by the buy-in (Bloom et al. 2007). Many parents are presumably risk averse and would be willing to pay more than the expected value of the coverage to their child in a given year. In other words, they value the security that insurance provides for ensuring their children's access to necessary medical care as well as the protection of the family's assets if a child were to become seriously ill or injured. And while many families with healthy children would be willing to pay *something* for such protections against highly uncertain, low probability events, the empirical question is how much they are willing to pay for it. The access and insurance value that parents place on their children's coverage will surely be higher in families with more assets, in those where the child has known problems, and where the family has had negative experiences trying to obtain care through the safety net. But the greater the discrepancy between the premium and the expected value of the plan for a reasonably healthy child, even taking the asset and access protection value of the plan into account, adverse selection will be higher and take-up will be lower.

***Evidence from two states suggests that adverse selection is occurring.***

Information on the extent of adverse selection is available for just two states that have buy-in programs, Florida and Connecticut. Florida's buy-in program targets children in families with incomes above 200 percent of the FPL who must be uninsured at the time of enrollment and have had no ESI coverage in the prior 12 months. In 2005, enrollment in the buy-in program was around 20,000 (Pernice and Bergman 2006), making it the largest buy-in program in the nation.<sup>15</sup> To assess the extent of adverse selection

in Florida's buy-in program, total spending levels and spending patterns by service category were compared for children in the buy-in program and children in the subsidized component of the Healthy Kids Program, the state's version of SCHIP, over a three year period between 2002 and 2004 (Ross 2005). The analysis uses the ratio of the per member per month costs for the unsubsidized group relative to the subsidized group to estimate the extent of adverse selection, where a ratio greater than one would suggest that the unsubsidized group is higher risk than the subsidized group.<sup>16</sup> The ratio of per member per month costs for the unsubsidized compared to the subsidized group was clustered in the range of 1.5 to 2.0 across the different service categories and was 1.9 on average. These findings suggest that the children enrolled in the buy-in program were roughly twice as expensive, on average, as the children enrolled in subsidized coverage.

Connecticut's buy-in program dates back to 1998, covering children with incomes above 300 percent of the federal poverty level who are uninsured and have had no ESI coverage in the prior 2 months (exceptions are granted in the case where ESI was lost due circumstances beyond the family's control) (Belloff and Marquis 2006; Zhao 2001).<sup>17</sup> In 2008, enrollment in the buy-in program was around 1,000.<sup>18</sup> Until 2008, when the state changed its premium structure for buy-in enrollees, the premium charged to families in the buy-in program was based exclusively on the buy-in pool.

Analysis of program data from Connecticut on the unsubsidized and subsidized groups for 2005 through midyear 2007 indicates that per member per month costs were consistently higher over the three year period for the unsubsidized group than for the subsidized group (State of Connecticut 2008). Recent information on the rates negotiated with the plans for the buy-in and the subsidized groups suggests that the children in the buy-in cost about 1.4 times as much for the services that are covered under the plan as children in the subsidized component.<sup>19</sup>

## Policy Tools That Can Limit Adverse Selection

States have sought to limit adverse selection and displacement of other private coverage in their buy-in programs in order to avoid spiraling costs, keeping the program affordable for more moderate-income children.

### *States use lock-out and look-back waiting periods to limit adverse selection.*

One way of achieving this goal is by using lock-out periods to deter families from dropping out of the buy-in and reenrolling at times of high service need. In addition, some states, such as New Jersey, require that families enroll all children in the family in the buy-in program, which will prevent families from only enrolling children with chronic health care problems.<sup>20</sup> This could reduce adverse selection into the program since children with chronic health problems tend not to be concentrated in the same families (Urban Institute tabulations of the 2005 MEPS).

Buy-in programs commonly impose waiting periods on children with private coverage in an effort to lower the risks of adverse selection. New Jersey's buy-in program requires that children be uninsured for six months prior to enrolling (with exceptions for children who have had public coverage). In Connecticut and New Hampshire, children who have had ESI in the prior two or three months, respectively, are not eligible (though exceptions are made in the case where ESI was lost due to circumstances beyond the control of the family), and in Pennsylvania a waiting period of six months is applied for children who had group or nongroup coverage (exceptions are in particular instances such as parental loss of employment). It is thought that having these look-back periods will deter parents whose children have chronic health problems from dropping private coverage since they would be reluctant to let those children go without insurance for several months. However, in some states, such as Connecticut, the look-back period does not apply to nongroup coverage, which could

raise the risks of adverse selection. New York's buy-in program is an exception, imposing no waiting period for their buy-in program. Given that New York's nongroup market is heavily regulated, requiring guaranteed issue, pure community rating, and more comprehensive policies than the typical nongroup market, the risks of adverse selection in the buy-in program may be lower, possibly mitigating the effects of not having a waiting period. However, premiums for nongroup coverage in New York are very high due to the adverse selection in that market, making family coverage unaffordable for many families, and compromising its ability to meet the needs of some with high-cost illnesses.

Buy-in programs will be an attractive option for children with nongroup coverage in many states, as the levels of cost-sharing (deductibles, co-insurance, co-payments) can be quite high and the benefits much lower (e.g., no coverage or strict limits on prescription drugs, mental health care, and/or services related to pre-existing conditions) than what is available in the buy-in plans. So while denying enrollment to children who have nongroup coverage may reduce the amount of adverse selection in the buy-in program, it may also create significant barriers to needed care and substantial financial burdens for families with modest incomes. To the extent that states are willing to accept adverse selection in their buy-in programs, the buy-ins are in a position to provide high quality, comprehensive care, with low out-of-pocket cost sharing to children with health problems who would not have had access to such coverage otherwise. The central concern with adverse selection is that, without broader sharing of risk than simply within the buy-in population itself or without explicit subsidies to the buy-in, premiums in the program may be too high to attract a large enrollment.

***Mandating health insurance for children would reduce adverse selection, but states must consider the implications for family financial burdens.***

One of the newer buy-in programs—New Jersey's, which was just launched in January 2008—was coupled with a July 2008 mandate on

parents to cover children (New Jersey Office of the Governor 2008). The buy-in program is intended to be one potential source of coverage that parents can access to insure their children. While the mandate has not yet been enforced and the penalties for noncompliance have not been established or implemented, it will offer important insights about how mandates may affect enrollment and adverse selection in buy-in programs. Imposing a mandate on covering children raises issues, particularly related to the affordability of premiums for families. The New Jersey buy-in program begins at 350 percent of the FPL, which may mean that the buy-in premiums are affordable for the families in the target income group; however, it will be important for the state to monitor the potential economic hardship caused by the premiums for the families whose incomes are close to 350 percent of the FPL.

***Lowering premiums by broadening the risk pool or increasing out-of-pocket cost sharing should reduce adverse selection.***

Charging premiums based on a broader risk pool that includes subsidized children or even the full population of children should lower premiums, which in turn is likely to reduce adverse selection. However, doing so would imply some type of external subsidization of the buy-in program. In addition, current buy-in programs rely primarily on premiums to cover program costs, offering coverage with minimal cost sharing, which results in higher buy-in premiums. Most states have only modest cost sharing requirements, basing their cost sharing arrangements on the subsidized program. For example, New York's buy-in program has no out-of-pocket cost sharing requirements. As stated above, in Florida and Connecticut, buy-in enrollees face no deductibles or coinsurance and face copayments of just \$5 or less for most services and prescriptions. Pennsylvania's buy-in enrollees have slightly higher copayments, ranging from \$10 for generic prescriptions to \$25 for specialty visits and \$50 for ER visits. Buy-in enrollees in Pennsylvania do not face deductibles or coinsurance.

States should be able to bring down premium levels if they were to impose greater out-of-pocket cost sharing (California Healthcare Foundation 2008). States would want to balance the benefits of lower premium increases against the fact that co-payments and deductibles shift more of the financing burden to families with children who have the most health care needs. Increased cost-sharing would ideally be coupled with out-of-pocket maximums to clearly limit the out-of-pocket costs families would be required to bear, with the maximums including all deductibles, coinsurance, and copayments. Such maximums could also be set to increase with increasing income. However, it is not clear that states have the administrative structures already set up that would allow them to track coinsurance, copayments and spending relative to deductibles in order to implement out-of-pocket limits for children in these programs. States that use managed care organizations (MCOs) to administer their subsidized and unsubsidized programs would likely have an easier time implementing the various cost-sharing arrangements given that MCOs would only need to modify their existing administrative systems rather than create a system from scratch. Alternatively, as indicated above, states could bring down the premiums via subsidization or impose coverage mandates on higher-income families, both of which would reduce adverse selection and increase take-up.

### **Buy-In Programs Can Stimulate Medicaid/SCHIP Enrollment, but Not Automatically**

One important potential side benefit of buy-in programs is a positive spillover effect on enrollment in subsidized Medicaid and SCHIP coverage. Achieving positive spillover effects could have a more profound effect on overall coverage rates for children than would the direct buy-in program enrollment. This is the case because about two-thirds of all uninsured children are eligible for coverage under existing Medicaid and SCHIP programs, but are not yet enrolled (Hudson and Selden 2007; Holahan et al. 2007).

Both Illinois and Pennsylvania rolled out their buy-in programs as part of a broader “All Kids” strategy and reportedly experienced substantial enrollment gains in their traditional Medicaid and SCHIP programs following the adoption of the broader strategies (Arjun and Guyer 2008; Hoover 2008). The key appears to lie in messaging: outreach efforts in Illinois and Pennsylvania now proclaim that *no family makes too much money to qualify*, which encourages families of all income levels to inquire about coverage. Because the buy-in program is connected to traditional Medicaid and SCHIP, eligibility workers can ensure that families are enrolled in the program for which they qualify. Simply adding a buy-in program without publicizing it or without conveying a simple message about the availability of public coverage is unlikely to produce much of a pick-up in enrollment among the children who are already eligible for public programs. In addition, states that target their buy-in programs narrowly will be unlikely to experience large positive spillover effects.

### **Conclusion**

Buy-in programs have the potential to play an important role in reaching universal coverage among children by providing moderate- and higher-income families who do not have access to affordable private insurance with a comprehensive coverage option that is likely to be more affordable and more likely to meet their child’s health needs than what is available in the nongroup market. To date, however, enrollment in buy-in programs has been low relative to the size of the uninsured population targeted by the programs, even in those that have been in existence for years. Given the small levels of enrollment in the state buy-in programs, it appears that they have had no discernable effect on employer coverage.

Low take-up in buy-in programs is partially a function of the fact that premiums tend to be high relative to income, especially for families at the low end of the income range (between 200 and 400 percent of the FPL) that qualify for them. Moreover, since most families can reasonably expect their children to have spending levels that are substantially lower than the buy-in premium,

families may be reluctant to enroll healthy children, leading to adverse selection and keeping take-up levels low. While premiums may have deterred enrollment in buy-in programs, it is also not clear that higher-income families are even aware that they have an option of buying into the public program.

States can adopt a number of strategies aimed at increasing take-up among uninsured children. First and foremost, states should examine whether their buy-in is targeted at the right income level and in particular, whether subsidies need to be introduced for families with moderate incomes. With greater subsidies, premiums would be reduced, which should both increase take-up and reduce adverse selection. In addition, states can bring down premiums by increasing the cost sharing levels in the buy-in program, which to this point have been quite low, or by reducing the comprehensiveness of the coverage that is available. At the same time, however, substantial increases in out-of-pocket cost sharing requirements or efforts to narrow the benefit package could greatly increase spending burdens on families whose children have chronic health care problems or high health care needs. States may also be able to reduce premiums by broadening the risk pool on which the buy-in premiums are based.

Imposing a mandate on parents to cover their children should increase take-up in buy-in programs and also reduce adverse selection. However, the impacts on the coverage of higher-income uninsured children will likely depend on how the penalties for noncompliance compare to the premiums in the buy-in program. Moreover, before a mandate is implemented, it will be essential to consider the affordability of the buy-in premiums, particularly for moderate-income families.

Achieving higher take-up rates without a mandate will likely require greater subsidies,

especially for moderate-income families (i.e., those between 200 and 400 percent of the FPL). The changes made to New York's program this year should yield important information about the extent to which premium reductions lead to higher take-up and lower adverse selection among children with incomes between 250 and 400 percent of the FPL.

To the extent that states include buy-in programs as part of a universal coverage strategy, it may be essential that states actively market the availability of public coverage for all children in their states in order to maximize take-up. Otherwise, adding a buy-in program may not trigger positive spillover effects on Medicaid and SCHIP enrollment.

In addition, to the extent that the buy-in program does experience adverse selection, it is important to consider that in the context of the health insurance options that are available to families, particularly whether they have access to a nongroup market that is community rated and has guaranteed issue. In the states where high-quality, affordable nongroup coverage is not available to children with health problems, the buy-in program may be fulfilling a vital role.

Many questions about buy-in programs remain unresolved. In particular, no information is publicly available on how enrollment and take-up in buy-in programs varies by income group, how the characteristics (e.g., demographic, health needs, etc.) and health care access of the children served by the buy-in differ from those in other insurance groups (i.e., children with nongroup coverage, children with ESI, children with subsidized public coverage, and uninsured children), how buy-in programs affect and are affected by the nongroup market in a particular state, and what other policies are needed to maximize the positive spillover effects associated with offering a buy-in.

## References

- AcademyHealth. 2004. "Glossary of Terms Commonly Used in Health Care." Washington, DC: AcademyHealth. <http://www.statecoverage.net/pdf/glossary.pdf>.
- Arjun, L. and J. Guyer. 2008. "Putting Out the Welcome Mat: Implications of Coverage Expansions for Already-Eligible Children." Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute.
- Belloff, D. and S. Marquis. 2006. "Full-Cost Buy-In Options for Optimizing Coverage through NJ FamilyCare." State of New Jersey Department of Human Services and Rutgers Center for State Health Policy.
- Birnbaum, M. 2001. "Full-Cost Buy-Ins: An Overview of State Experience." State Coverage Initiatives Issue Brief. Washington, DC: Academy for Health Services Research and Health Policy.
- Bloom B, Cohen R.A. 2007. "Summary Health Statistics for U.S. Children: National Health Interview Survey, 2006." National Center for Health Statistics. *Vital Health Statistics* 10(234).
- Blumberg, L. and G. Kenney. 2007. "Can a Child Health Insurance Tax Credit Serve as an Effective Substitute for SCHIP Coverage?" Washington, DC: The Urban Institute.
- Blumberg, L. J., L.M. Nichols, and J.S. Banthin. 2004. "Worker Decisions to Purchase Health Insurance." *International Journal of Health Care Finance and Economics* 1(3-4): 305-26.
- Cantor, J., A. Monheit, S. Brownlee, and C. Schneider. 2007. "The Adequacy of Household Survey Data for Evaluating the Nongroup Health Insurance Market." *Health Services Research* 42(4): 1739-57.
- California Health Care Foundation. 2008. "Reference Guide: Benefits, Providers, and Costs." Oakland, CA: California Health Care Foundation. <http://www.healthcoverageguide.org/ReferenceGuide/BenefitsProvidersAndCosts/Cost-Sharing.aspx>.
- Davidoff, A. J., A. B. Garrett, D. M. Makuc, and M. Schirmer. 2000. "Medicaid-Eligible Children Who Don't Enroll: Health Status, Access to Care, and Implications for Medicaid Enrollment." *Inquiry* 37(2): 203-18.
- Heberlein, M., C. Mann, J. Guyer, and D. Horner. 2008. "States Moving Forward: Children's Health Coverage in 2007-2008." Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute.
- Herndon, J.B., B. Vogel, R. Bucciarelli, and E. Shenkman. 2008. "The Effect of Premium Changes on SCHIP Enrollment Duration." *Health Services Research* 43(2): 458-77.
- Holahan, J., A. Cook, and L. Dubay. 2007. "Characteristics of the Uninsured: Who Is Eligible for Public Coverage and Who Needs Help Affording Coverage?" Washington, DC: Kaiser Commission on Medicaid and the Uninsured.
- Horner, D. 2008. "Program Design Snapshot: State Buy-In Programs for Children." Center for Children and Families. Washington, DC: Georgetown University Health Policy Institute. <http://ccf.georgetown.edu/index/strategy-center>.

- Hoover, G. 2008. "Early Experiences and Lessons Learned in Working Toward Covering All Kids." Presented at the National Health Policy Forum on "Universal Coverage for Children: States Setting the Pace." Washington, D.C., September 19.
- Hudson, J., and T. Selden. 2007. "Children's Eligibility and Coverage: Recent Trends and a Look Ahead." *Health Affairs* 26(5): w618–29.
- Kaiser Family Foundation. 2008. "State Health Facts." <http://www.statehealthfacts.org>.
- Kenney, G., J. Hadley, and F. Blavin. 2006/2007. "Effects of Public Premiums on Children's Health Insurance Coverage: Evidence from 1999 to 2003." *Inquiry* 43(4): 345–61.
- Kenney, G., J. Ruhter, and T. Selden. 2008. "Medicaid/SCHIP Expenditures for Children: Implications for Program Design." Draft Manuscript.
- Ku, L., and V. Wachino. 2005. "The Effect of Increased Cost Sharing in Medicaid and SCHIP: A Summary of Research Findings." Washington, DC: Center on Budget and Policy Priorities.
- Liptak, G., L. Shone, P. Auinger, A. Dick, S. Ryan, and P. Szilagyi. 2006. "Short-Term Persistence of High Health Care Costs in a Nationally Representative Sample of Children." *Pediatrics* 2006(118): e1001–9.
- New Jersey Office of the Governor, Governor Jon Corzine. 2008. "Governor Signs Progressive FamilyCare Legislation." Press Release. July 7.
- New York State Executive Chamber. Governor Eliot Spitzer. 2008. "Budget Expands Health Care Access for New York's Children." Press Release. January 22.
- Pernice, C., and D. Bergman. 2006. "SCHIP Buy-in Programs." Washington, DC, and Portland, ME: National Academy for State Health Policy.
- Pollitz, K., and R. Sorian. 2002. "Ensuring Health Security: Is the Individual Market Ready for Prime Time?" *Health Affairs* web exclusive: w372-w376.
- Pollitz, K., R. Sorian, and K. Thomas. 2001. "How Accessible Is Individual Health Insurance for Consumers in Less-than-Perfect Health?" Washington, DC: Kaiser Family Foundation.
- Ross, T. 2005. "Actuarial Analysis of Full-Pay Enrollees in the Florida Healthy Kids Program." Prepared for the Florida Healthy Kids Corporation by Ross Health Actuarial. Hudson, WI.
- Selden, T., G. Kenney, M. Pantell, and J. Ruhter. 2008. "Cost Sharing Arrangements in Medicaid and SCHIP: Implications for Out-of-Pocket Spending Burdens." Draft Manuscript.
- State of Connecticut. Mercer Government Human Services Consulting. 2008. "HUSKY A and B Databook."
- Zhao, J. 2001. "SCHIP Full-Cost Buy-In Programs." Working Paper from the Policy Research Project on Expanding Health Care Coverage for the Uninsured. Austin: University of Texas at Austin.

**Table 1. Estimated Take-Up Rates in Buy-in Programs: Selected States**

	<b>Eligibility</b>	<b>Buy-in Enrollment</b>	<b>Uninsured Estimate<sup>1</sup></b>	<b>Take-Up Rate<sup>2</sup></b>
<b>Connecticut</b>	>300% FPL	1,041	11,692	8.18%
<b>Florida</b>	>200% FPL	20,401	238,387	7.88%
<b>New York<sup>3</sup></b>	>250% FPL	12,262	99,161	11.00%
<b>Pennsylvania<sup>4,5</sup></b>	>300% FPL	1,704	19,565	8.01%

Source: Uninsured numbers are based on Urban Institute tabulations of the 2006-2008 ASEC Supplement to the CPS; Enrollment figures are from Connecticut HUSKY website ([www.huskyhealth.com](http://www.huskyhealth.com)) October 2008 enrollment; Pernice and Bergman 2006 (NY and FL enrollment estimate from September 2005); Hoover, G. Presentation at the National Health Policy Forum, September 19, 2008 (PA enrollment estimate September 2008).

Note: FPL is the Federal Poverty Level, based on the Department of Health and Human Services guidelines for the year in which data was collected. In 2008, the federal poverty level for a family of 3 is \$17,600.

1 Due to small sample sizes in the CPS, these uninsured estimates have large standard errors (4,385 for Connecticut; 22,443 for Florida; 14,864 for New York; and 6,289 for Pennsylvania), which implies that the actual take-up rate in these programs may differ from the take-up rate calculated in the table.

2 The take-up rate is defined as the buy-in population divided by the buy-in population plus the estimated number of uninsured children in the income band covered by the buy-in program, which represents an upper bound on the take-up rate since it assumes that the buy-in programs are only covering children who would be uninsured otherwise.

3 New York changed its buy-in program in 2008 to provide subsidized coverage up to 400% FPL and full-cost coverage above 400% FPL. The table reflects New York's program as it existed before the changes.

4 Enrollment in Pennsylvania's buy-in program is still growing; between September and October 2008, the number of children enrolled in the buy-in rose by 70, an increase of about 4 percent, which is consistent with the increases observed for the prior three months.

5 A state survey in Pennsylvania yielded an estimate of 13,133 uninsured children over 300% FPL. Using this estimate rather than the CPS data raises the estimated take-up rate to 11.48%.

**Table 2. Premiums as Share of Income for Buy-in Programs in Selected States**

	1 child (%)	2 children (%)	3 children (%)
<b>Connecticut<sup>1</sup></b>			
301% FPL	6.7 to 9.8	10.7 to 15.6	13.3 to 19.4
400% FPL	3.4 to 4.9	5.4 to 7.8	6.7 to 9.8
500% FPL	2.7 to 3.9	4.3 to 6.3	5.4 to 7.8
600% FPL	2.3 to 3.3	3.6 to 5.2	4.5 to 6.5
<b>Florida</b>			
201% FPL	5.5	8.7	10.8
300% FPL	3.7	5.8	7.2
400% FPL	2.7	4.4	5.4
500% FPL	2.2	3.5	4.3
600% FPL	1.8	2.9	3.6
<b>Illinois</b>			
200% FPL	1.7	2.7	2.3
400% FPL	2.1	3.4	2.8
500% FPL	2.6	4.1	5.1
700% FPL	3.1	4.9	6.1
800% FPL	3.2	5.1	6.4
<b>New Hampshire<sup>2</sup></b>			
301% FPL	4.8	7.7	9.6
350% FPL	4.2	6.6	8.2
400% FPL	3.6	5.8	7.2
<b>New Jersey</b>			
351% FPL	3.3	5.3	6.6
400% FPL	2.9	4.7	5.8
500% FPL	2.3	3.7	4.7
600% FPL	2.0	3.1	3.9
<b>New York<sup>3</sup></b>			
251% FPL	3.4 to 6.1	5.4 to 9.7	6.7 to 12.1
300% FPL	2.9 to 5.1	4.5 to 8.2	5.6 to 10.2
400% FPL	2.1 to 3.8	3.4 to 6.1	4.2 to 7.6
500% FPL	1.7 to 3.1	2.7 to 4.9	3.4 to 6.1
600% FPL	1.4 to 2.6	2.3 to 4.1	2.8 to 5.1
<b>Pennsylvania<sup>4</sup></b>			
301% FPL	4.58	7.29	9.08
400% FPL	3.45	5.49	6.83
500% FPL	2.76	4.39	5.47
600% FPL	2.30	3.66	4.56

Sources: Current premiums as listed on states' websites and confirmed by eligibility staff. New York premium data from Pernice and Bergman 2006 (see note 3 below).

Notes: FPL is the Federal Poverty Level, based on the Department of Health and Human Services guidelines. In 2008, the federal poverty level for a family of 3 is \$17,600. Income levels correspond to those for one-parent families. Premiums in Connecticut, New York, and Pennsylvania vary by plan and county; the range of premiums is shown.

1 Connecticut renegotiated its buy-in premium in 2008. All buy-in enrollees now pay \$195 per child per month, or \$2220 per year.

2 New Hampshire caps eligibility for its buy-in program at 400% of the FPL.

3 New York changed its buy-in program in 2008 to provide subsidized coverage up to 400% FPL and full-cost coverage above 400% FPL. The table reflects New York's program as it existed before the changes. Under the new program, families earning 251% FPL now pay 0.68% of their income to enroll one child; families earning 300% FPL and 400% FPL now pay 0.57% and 0.86% of their income, respectively, to enroll one child.

4 The average cost of the buy-in premium across the 8 insurers offering plans in Pennsylvania is \$161 per child per month, or \$1932 per year. The range of premiums charged by the insurers is \$112.50-\$184.35 per child per month.

**Table 3. Premiums for Buy-in Programs and Subsidized Premiums in Selected States**

	Annual Premium Amount			Premium as Share of Family Income		
	1 child	2 children	3 children	1 child (%)	2 children (%)	3 children (%)
<b>Connecticut<sup>1</sup></b>						
300% FPL	\$360	\$600	\$600	0.9	1.1	0.9
<b>301% FPL</b>	<b>\$1,896 to \$2,760</b>	<b>\$3,792 to \$5,520</b>	<b>\$5,688 to \$8,280</b>	<b>6.7 to 9.8</b>	<b>10.7 to 15.6</b>	<b>13.3 to 19.4</b>
<b>Florida</b>						
200% FPL	\$240	\$480	\$720	0.9	1.4	1.7
<b>201% FPL</b>	<b>\$1,536</b>	<b>\$3,072</b>	<b>\$4,608</b>	<b>5.5</b>	<b>8.7</b>	<b>10.8</b>
<b>New Hampshire</b>						
300% FPL	\$540	\$1,080	\$1,620	1.3	2.0	2.5
<b>301% FPL</b>	<b>\$2,040</b>	<b>\$4,080</b>	<b>\$6,120</b>	<b>4.8</b>	<b>7.7</b>	<b>9.6</b>
<b>New Jersey</b>						
350% FPL	\$1,536	\$1,536	\$1,536	3.1	2.5	2.1
<b>351% FPL</b>	<b>\$1,644</b>	<b>\$3,288</b>	<b>\$4,932</b>	<b>3.3</b>	<b>5.3</b>	<b>6.6</b>
<b>New York<sup>2</sup></b>						
250% FPL	\$180	\$360	\$540	0.3	0.5	0.6
<b>251% FPL</b>	<b>\$1,197 to \$2,153</b>	<b>\$2,394 to \$4,306</b>	<b>\$3,591 to \$6,459</b>	<b>3.4 to 6.1</b>	<b>5.4 to 9.7</b>	<b>6.7 to 12.1</b>
<b>Pennsylvania<sup>3</sup></b>						
300% FPL	\$768	\$1,536	\$2,304	1.8	2.9	3.6
<b>301% FPL</b>	<b>\$1,932</b>	<b>\$3,864</b>	<b>\$5,796</b>	<b>4.6</b>	<b>7.3</b>	<b>9.1</b>

Sources: Current premiums as listed on states' websites and confirmed by eligibility staff. New York premium data from Pernice and Bergman 2006 (see note 2 below).

Notes: FPL is the Federal Poverty Level, based on the Department of Health and Human Services guidelines. In 2008, the federal poverty level for a family of 3 is \$17,600. Income levels correspond to those for one-parent families. Premiums in Connecticut, New York, and Pennsylvania vary by plan and county; the range of premiums is shown.

1 Connecticut renegotiated its buy-in premium in 2008. All buy-in enrollees now pay \$195 per child per month, or \$2220 per year.

2 New York changed its buy-in program in 2008 to provide subsidized coverage up to 400% FPL and full-cost coverage above 400% FPL. The table reflects New York's program as it existed before the changes. Under the new program, families up to 400% FPL pay subsidized premiums of up to \$480 per child per year, and families above 400% FPL may buy-in to the program for between \$1,268 and \$2,328 per child per year.

3 The average costs of the subsidized program in Pennsylvania is \$64 per child per month. The average cost of the buy-in premium across the 8 insurers offering plans in Pennsylvania is \$161 per child per month. The range of premiums charged by the insurers is \$112.50-\$184.35 per child per month.

## ENDNOTES

Genevieve Kenney, Ph.D. and Linda Blumberg, Ph.D. are Principal Research Associates and Jennifer Pelletier, B.A. is a Research Assistant at the Urban Institute Health Policy Center. This research was funded by the David and Lucile Packard Foundation. The authors appreciate the helpful comments, information, and suggestions of Judy Arnold, Tricia Brooks, Rose Ciarcia, George Hoover, Rose Naff, Lynn Thomas, Dawn Horner, Cindy Mann, Dina Belloff, Eugene Lewit, and participants at an October 2008 roundtable at the National Academy of State Health Policy Annual Health Policy Conference. The paper benefited from the excellent research assistance of Aimee Williams, Allison Cook, and Joel Ruhter. The views expressed are those of the authors and should not be attributed to the individuals listed above, to the David and Lucile Packard Foundation or to the Urban Institute, its sponsors, staff, or trustees.

1. Due to small sample sizes in the CPS, the uninsured estimates used here have large standard errors (4,385 for Connecticut; 22,443 for Florida; 14,864 for New York; and 6,289 for Pennsylvania), which implies that the actual take-up rate in these programs may differ from the take-up rate calculated in the table.
2. The take-up rates calculated here represent upper bounds as they assume that all of the children buying into the program would have been uninsured otherwise. The take-up rates that are reported here are defined as the buy-in population divided by the sum of the buy-in population and the estimated number of uninsured children in the income band covered by the buy-in program (based on 2006 to 2008 Current Population Survey data). For New York's buy-in program, the take-up rate is calculated as  $12,262/(12,262+99,161)=11.0$  percent.
3. Enrollment in Pennsylvania's buy-in program is still growing; between September and October 2008, the number of children enrolled in the buy-in rose by 70, an increase of about 4 percent, which is consistent with the increases observed for the prior three months. A state survey in Pennsylvania yielded an estimate of 13,133 uninsured children over 300 percent of the FPL. Using this estimate rather than the CPS data raises the estimated take-up rate to 11.48 percent.
4. Tabulation based on 2006 to 2008 ASEC Supplement to the CPS.
5. Illinois' program is an exception, charging premiums that increase incrementally as family income increases from 200 percent to 800 percent of the FPL, and remaining constant above 800 percent of the FPL. To our knowledge, Illinois is the only state that utilizes this type of premium structure in its program.
6. Illinois uses state funds to subsidize coverage to children above 200 percent of the FPL.
7. Illinois's premium schedule can be viewed on the AllKids web site at <http://www.allkids.com/income.html>
8. The extent of concern about crowd out in a particular state likely hinges on the extent to which the state is subsidizing premiums in the buy in, the value the state places on horizontal equity, and the role and functioning of the nongroup market in the state. Buy-in programs may also be politically contentious if they are viewed as introducing competition with existing nongroup insurers.
9. Urban Institute tabulations of the 2006 to 2008 ASEC Supplement to the CPS. It should be noted that questions have been raised about the validity of nongroup coverage estimates reported on household survey data (Cantor et al. 2007).
10. When the health care spending distribution for all children is considered, the mean spending level is over four times higher than the median level and 83 percent of all children have spending that is less than the mean. These estimates are based on Urban Institute tabulations of the Medical Expenditure Panel Survey from 2002 to 2005.
11. By basing the premiums on the blended pool of subsidized and unsubsidized children, the per member per month costs may increase for the subsidized group.
12. Nationally, only 2 states including New York have pure community rating, 5 have adjusted community rating, and 10 use rate bands. Six states including New York guarantee issue for all insurance products, and an additional 8 guarantee issue for some insurance products (Kaiser Family Foundation 2008).
13. Details on nongroup policies gathered from <http://www.ehealthinsurance.com> on 11/10/08 for a 5 year-old boy living in Hartford, CT, Philadelphia, PA, and Jacksonville, FL.
14. There is no comparable nongroup plan in Florida. The only plan with no deductible is a Point of Service Plan (POS) with a \$113 monthly premium and 35 percent coinsurance. Copayments are \$35 for office visits, \$45 for specialist visits, and \$15 for generic prescriptions. Brand name and nonformulary prescriptions are \$35 and \$50, respectively, after a \$500 deductible, and there is no mental health or dental coverage. Florida's buy-in program charges a \$128 monthly premium and \$5 copayments on office visits, specialist visits, outpatient mental health services, and generic prescriptions. The buy-in also provides full dental benefits up to \$800 per year.
15. Florida previously had a cap on enrollment in its buy-in program at 10 percent of total Healthy Kids enrollment, though it never enforced this cap. The cap was officially lifted on July 1, 2008.
16. This analysis does not address whether the buy-in pool is higher risk relative to the eligible population since the subsidized population may also suffer from adverse selection. Indeed past research indicates that children who enroll in public coverage have greater health needs than the children who remain uninsured despite being eligible for coverage (Davidoff et al. 2000).
17. Connecticut previously required a six-month look-back period for ESI coverage, but shortened the period to two months in the hopes of boosting enrollment. However, they found that enrollment did not increase substantially following the change in the look-back period (Belloff and Marquis 2006).
18. Current enrollment data is available on the HUSKY web site at <http://www.huskyhealth.com/pubs.htm>.
19. Behavioral health, dental, and pharmacy services are not included in the base rates negotiated with Connecticut's managed care plans as those services are carved out.

---

20. Information on New Jersey's buy-in program can be found at  
[http://www.horizonnjhealth.com/members\\_nj\\_familycare\\_advantage.asp](http://www.horizonnjhealth.com/members_nj_familycare_advantage.asp).

Copyright © November 2008. The Urban Institute. Permission is granted for reproduction of this document, with attribution to the Urban Institute.