STATE COVERAGE INITIATIVES
Issue Brief

A National Initiative of
The Robert Wood Johnson Foundation

August 2001

Full-Cost Buy-Ins: An Overview of State Experience

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All 50 states offer subsidized health insurance to low-income individuals through public programs such as the State Children's Health Insurance Program (SCHIP), Medicaid, and other state-designed programs. These programs provide premium subsidies to children and families with incomes below a given threshold, often on a sliding-scale basis. A less common approach, which has been taken by the five states featured in this Issue Brief, is to further expand coverage by making higher-income families eligible for unsubsidized insurance through the same programs.

These eligibility expansions are referred to as full-cost buy-ins, or FCBIs. Although they have extended coverage to only a limited number of children and families to date, FCBIs provide another vehicle for states to expand coverage. Unlike subsidized programs, FCBIs have no upper income threshold; they target families with incomes above state limits for subsidized coverage. These families often do not have access to employer-sponsored coverage and cannot afford the premiums charged in the individual market.

The FCBIs currently in operation primarily target children, and several states are considering adding FCBIs onto their SCHIP programs. Two states (Minnesota and Washington) enabled adults as well as children to purchase coverage at full cost through public programs, but their FCBIs are now closed (see Table 1). Except in the case of Washington, enrollment in the FCBI component of a state expansion has typically been less than 5 percent of total program enrollment.

Through administrative efficiencies and the purchasing power generated from pooling with subsidized programs, FCBIs can offer some families a lower-cost coverage option than what is available in the private market. However, the main objective of these programs is not to constrain the price of insurance, but to provide families with another vehicle for obtaining coverage, especially in cases where employer-based coverage is not available.

This Issue Brief describes the experience of five states that have developed FCBIs — Connecticut, Florida, Minnesota, New York, and Washington — and outlines the major program design issues involved in establishing a full-cost buy-in option.

Design Issues

In developing full-cost buy-in programs, states have sought to ease the transition between public and private coverage. When the eligibility status of a subsidized enrollee changes, due to an increase in income, for example, employer coverage is often unavailable. FCBIs provide enrollees with a coverage option outside of the individual insurance market.

The people targeted by public programs typically cannot afford private insurance. However, as public programs expand eligibility up the income scale, the state's coverage product enters into competition with products on the private market. Families at higher incomes may face a choice about whether to purchase private coverage or join an FCBI. Their decision depends largely on the cost of the coverage (including premiums and other cost-sharing), the benefits offered by the plans, and the restrictions – if any – on enrollment. States can use program design features to ensure that implementing an FCBI does not provoke an exodus of covered individuals from the private market. In addition, states need to ensure that their FCBI will not attract a disproportionately unhealthy population and result in premium increases from adverse selection.

Because states do not receive federal funding to operate FCBIs, they have greater flexibility in designing these programs than they do for Medicaid and SCHIP. Which design features are appro-

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Table 1
Characteristics of Five Full-Cost Buy-In Programs

State	Minnesota		Washington	Florida	New York	Connecticut
Program Title	MinnesotaCare		Basic Health Plan	Healthy Kids	Child Health Plus	HUSKY
Program Type	Medicaid program implemented under 1115 waiver		State-only program	Originally state-only program, now SCHIP	Originally state-only program, now SCHIP	State-designed SCHIP program
Target Program	Children; parents	Other adults	Children; adults	Children 5 and up	Children	Children
FCBI starts at (share of FPL)	275%	175%	200%	200%	250%	300%
Peak FCBI enrollment[1]	1,000		25,000	5,000	9,000	200
FCBI as % of all enrollment	2 percent		20 percent	3 percent	2 percent	3 percent
Implemented	1992		1996	1992	1991	1998
FCBI status	Repealed in 1998		Discontinued in 2000	Active	Active	Active

priate varies by state, according to policy goals, income limits for subsidized coverage, and the structure of the private insurance market. In general, FCBIs targeting children may cause less competition with the private market than do those that include adults, owing to the absence of private insurance products for children only.

Benefits Package

Some states have benefit limitations in place in their public programs that help limit adverse selection. For example, the MinnesotaCare benefit package includes a $10,000 inpatient benefit cap for adults.[2] When the state's FCBI was still in operation, this benefit limit applied to both the subsidized and unsubsidized components of the program, and this deterred enrollment in the FCBI by less healthy individuals. Similarly, HUSKY Plus, Connecticut's supplemental coverage option for children with intensive physical or behavioral health needs, is available only to children in the state's subsidized HUSKY program. The exclusion of FCBI enrollees from this component of the benefits package was designed to reduce the likelihood of adverse selection.[3]

By contrast, Basic Health Plan's FCBI offered a range of maternity, prescription drug, and mental health benefits that were not available in comparably priced private insurance policies, thereby reducing incentives for higher-cost individuals to purchase private insurance in the individual market. Many individuals moved into unsubsidized BHP coverage for short stints, particularly to take advantage of maternity and hospital benefits.[4] This surge in enrollment among individuals needing specific services drove up premiums and made the FCBI less affordable.[5]

Pre-existing Conditions Exclusions

FCBI programs can establish pre-existing conditions exclusions to deter adverse selection. In an attempt to preserve access to coverage as private insurance market reforms were weakened, Washington reduced Basic Health Plan's waiting period for pre-existing condition exclusions from twelve to three months. This shift gave high-cost individuals better access to the program and made it easier for them to leave the private market in favor of the FCBI.[6] A longer waiting period can help prevent individuals from enrolling in

FCBIs only when they need care. However, states with FCBIs have not pursued this design feature to date, probably because imposing look-back and waiting periods for children would provoke strong public opposition and require states to build a new component into their eligibility determination process.

Premiums

Because FCBIs are unsubsidized, they cannot ensure affordability for all applicants. Connecticut officials see HUSKY's FCBI primarily as a conduit between uninsured children and private health plans that provides an additional coverage option. The state has not tried to influence the premium.[7]

But FCBIs do offer states an existing administrative structure to determine eligibility and complete enrollment. These efficiencies can create savings that result in lower premiums for enrollees. New York's Child Health Plus program, for example, created an economy of scale by using the administrative framework already in place for its 500,000 subsidized enrollees; this allowed the state to process unsubsidized enrollees at marginal administrative costs. New York advertises to FCBI enrollees that the "full premium...is probably much less than you would pay for other private insurance."[8]

While using administrative efficiencies to create savings may be successful, attempting to cap an FCBI's premium could backfire. When Washington first implemented an FCBI in 1996, the premium in the unsubsidized component of Basic Health Plan was capped at 105 percent of the subsidized program's premium. Insurers, who were required to participate in the FCBI or forgo existing business in the subsidized program, began to incur losses on FCBI enrollees but could not increase their premiums. The resulting conflict between the state and insurers led to removal of the premium cap, followed by annual premium increases of more than 60 percent in 1998 and 1999, and an eventual insurer walk-out on the FCBI.[9]

Keeping FCBIs Separate from High-Risk Pools

Ensuring that an FCBI does not perform the function of a high-risk pool is important to its stability and longevity. This can be achieved either by directly prohibiting migration from a high-risk pool to an FCBI or by blunting the incentives to migrate. When Basic Health Plan imposed a premium cap on its FCBI and reduced its waiting period for pre-existing conditions, many Washington residents dropped their high-risk pool coverage and enrolled in the FCBI. The high-risk pool took on no new members between 1996 and 1999, and enrollment dropped from over 10,000 to about 1,000.[10] The FCBI became the state's de facto high-risk pool and eventually saw a premium spiral as a result of adverse selection. At one point, the FCBI had about 25 times the enrollment of the state high-risk pool, and this level of high-cost enrollees proved unsustainable.[11] By contrast, MinnesotaCare's inpatient benefit limits deterred high-cost adults from enrolling and the state high-risk pool was stable. Enrollment in MinnesotaCare's FCBI peaked at about one-tenth of the high-risk pool's.[12] These experiences indicate that measures to prevent migration from a high-risk pool can protect the viability of an FCBI.

Copayments

States have more flexibility in setting copayments for FCBI enrollees than they do for subsidized SCHIP and Medicaid enrollees. Connecticut has used this flexibility to establish higher copayment requirements on a range of outpatient services and prescription drugs for FCBI enrollees in HUSKY. While cost-sharing, including copayments, cannot exceed $1,250 per family per year for children in the subsidized program, HUSKY imposes no such limits for children in the FCBI.[13] According to state officials, the goal of eliminating copayment limits is to avoid making the program more attractive than insurance purchased in the private market, particularly for enrollees who are likely to use many services.[14] By contrast, some states do not implement different copayment schedules for FCBI enrollees. These include New York, which currently requires no copayments,[15] and Florida, which requires minimal copayments for mental-health outpatient services and unauthorized use of emergency services.[16]

Contracting with Insurers

Insurers can be powerful opponents or strategic allies to states in their efforts to expand coverage. Basic Health Plan's initial policy of mandatory participation in the FCBI at a capped premium alienated health plans, which had been partners in the subsidized program since its implementation, and forced plans to choose between bidding on a new and untested program or giving up existing business. Insurers lobbied successfully to remove the state's bidding requirements,[17] and ultimately walked away from the FCBI. A less adversarial approach, based on negotiations and consultations between policymakers and health plans on goals and key policy decisions, will likely prove more effective.

Maintaining a partnership with insurers does not preclude states from using their purchasing power to leverage favorable premiums for FCBI enrollees. New York, Connecticut, and Florida require participating insurers to serve both subsidized SCHIP and FCBI enrollees. States can help negotiate affordable rates for their FCBI enrollees by setting premiums that reflect the average costs of the larger and potentially more stable SCHIP risk pool (comprised of both subsidized and unsubsidized enrollees). Ensuring that participating health plans serve many more subsidized than unsubsidized enrollees can also reduce the impact of FCBI enrollees on each plan's profit margins. As long as FCBIs do not force insurers to take finan-

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cial losses or lose volume in the private market, states can effectively use their negotiating power to facilitate insurer participation.

Crowd-Out

Public insurance expansions, particularly under SCHIP, have addressed crowd-out in the past. However, FCBIs that target higher-income enrollees may increase concern about substitution for private coverage. Current evidence from active FCBIs indicates no substantial crowd-out, regardless of whether programs choose to require minimum spells without insurance for new enrollees. Nevertheless, crowd-out warrants immediate attention from policymakers because it can provoke opposition from insurers and undermine political support for FCBIs. In Minnesota, concerns about crowd-out helped frame the policy debate on the design of MinnesotaCare and contributed to the eventual repeal of the program's FCBI.[18]

Connecticut policymakers have paid considerable attention to crowd-out. HUSKY requires new enrollees to have completed a six-month waiting period and audits 20 percent of enrollee applications by contacting the benefit managers of parents' employers. Although the state has recently secured federal approval to extend HUSKY's waiting period to a full year, state officials have determined that current requirements are effective in preventing crowd-out, and have no plans to increase the waiting period.[19]

Florida's Healthy Kids and New York's Child Health Plus impose no waiting period on enrollees. According to a recent Healthy Kids program evaluation, crowd-out appears to be minimal and is no more likely to occur in the FCBI than in the subsidized program.[20] Nevertheless, attempts to expand an FCBI to younger children[21] have raised fears of crowd-out, and policymakers have delayed expansion until crowd-out is studied further.[22] Child Health Plus has not experienced significant crowd-out to date, in either the subsidized program or the FCBI, according to an ongoing quarterly analysis of prior insurance coverage among new enrollees.[23] However, New York officials stress the importance of a continued focus on this issue.

Conclusion

FCBIs give states an opportunity to expand coverage without using public funds, but they are not a panacea. Their role is to increase access to insurance for families with incomes too high to qualify for subsidized public programs, but who may not have access to employer-based coverage and who cannot afford the premiums charged in the individual market. When public programs become larger and more established, administrative efficiencies and purchasing power can help make coverage through a full-cost buy-in program more affordable than that purchased in the private market. But these affordability gains are secondary to increased access, and insurers may decline to participate in FCBIs if premiums are insufficient. The challenge for states is to design and implement FCBIs that provide the maximum possible benefit to the public without undermining the private insurance market.

[1] These enrollment data were obtained in telephone interviews with state officials.

[2] MinnesotaCare's inpatient benefit limit applies to single adults, childless couples, and parents above 175 percent of poverty. It does not apply to pregnant women or children, or to parents under 175 percent of poverty.

[3] Telephone interview with state official.

[4] Kirk, A. M. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts." *Journal of Health Politics, Policy and Law.* Vol. 25, No. 1, February 2000, p. 142.

[5, 6, 7] Telephone interview with state official.

[8] New York Child Health Plus promotion: www.health.state.ny.us/nysdoh/chplus/brochure.htm.

[9] Insurers in Washington are no longer taking on new enrollees in the unsubsidized BHP, notwithstanding some minor variation by county. Plans in some areas have agreed to continue coverage for current enrollees; however, members in other areas have been disenrolled.

[10, 11, 12] Telephone interview with state official.

[13] Connecticut State Child Health Plan under Title XXI of the Social Security Act: Jan 7, 1998, p. 24.

[14] Telephone interview with state official.

[15] New York Child Health Plus promotion: www.health.state.ny.us/nysdoh/chplus/brochure.htm.

[16] Florida state SCHIP plan summary: http://state-serv.hpts.org/hpts2000.

[17] Kirk, A. M. "Riding the Bull: Experience with Individual Market Reform in Washington, Kentucky and Massachusetts." *Journal of Health Politics, Policy and Law.* Vol. 25, No. 1, February 2000, p. 142.

[18, 19] Telephone interview with state official.

[20] Florida KidCare Program Evaluation Report. Institute for Child Health Policy, University of Florida. January 2000, p. 61. Only 11 percent of all Healthy Kids enrollees — including those in the unsubsidized component — had employer-based coverage in the year preceding enrollment, compared to 17 percent for Medicaid beneficiaries who have lower incomes. Healthy Kids enrollees are, therefore, less likely to have employer-based coverage.

[21] Florida's Medicaid-based FCBI would be implemented under SCHIP and would target children ages one to five above 200 percent of poverty. The current Healthy Kids FCBI targets children ages five and older.

[22, 23] Telephone interview with state official.

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