REPORT OF THE
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

# State Children's Health Insurance Program (SCHIP) Buy-In Programs

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA


# HOUSE DOCUMENT NO. 48

COMMONWEALTH OF VIRGINIA
RICHMOND
2006

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# Preface

The 2006 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to:

> Review and evaluate State Children's Health insurance Program (SCHIP) Buy-In programs for children that are operating in other states, which allow families with income in excess of the state's Title XXI program eligibility limits to purchase health insurance for their children. This review, including recommendations regarding the development of a SCHIP buy-in program in Virginia, shall be presented to the Chairman of the House Appropriations and the Senate finance Committees, and the Joint Commission on Health Care by October 1, 2006.

Within DMAS, the Division of Maternal and Child Health was tasked to research the existing SCHIP Buy-In programs operating in other states and to develop recommendations regarding the feasibility of implementing a similar program in Virginia. The Division of Provider Reimbursement provided significant additional research and analysis for this report.

# Executive Summary

The 2006 Appropriations Act directed the Department of Medical Assistance Services to review existing State Children's Health Insurance Program (SCHIP) Buy-In programs operating in other states, make recommendations on developing such a program for Virginia and report findings by October 1, 2006.

SCHIP Buy-In programs allow families with incomes in excess of a state's SCHIP eligibility limit (200% FPL in Virginia) to purchase health insurance for their children through the state's SCHIP program (FAMIS in Virginia). Families are usually responsible for paying for all or most of the cost the state incurs for operating the program. While no federal SCHIP money is available to cover the cost, state dollars can be used to subsidize Buy-In programs.

This report provides detailed information on the eight currently existing SCHIP programs operating in other states. While there are similarities among the programs, states have designed them to reach different target populations, implemented various strategies to control program size and differ in whether or not they provide a direct state subsidy to keep costs low for participating families.

In surveying these states and examining available research, it is clear that Buy-In programs are subject to "adverse selection" whereby healthy people are less likely to purchase the insurance than are people who are sick. Research also shows that if monthly premiums are set above what families consider affordable (generally 3% - 5% of income), the number of participants will be low and limited to those with greater medical needs. If the premium amount is then based solely on the costs of the buy-in population the resulting premiums are likely to be too high to be attractive to families with healthy children. If however, premiums are based on a blended rate, combining the SCHIP and Buy-in group, then premiums can be kept at more affordable levels. However, while the per member per month (PMPM) cost for the buy-in group will be therefore be reduced, the PMPM for the FAMIS population will increase slightly, causing a need for increased federal and state funds.

If a FAMIS Buy-In program were to be budget neutral for the Commonwealth, this additional cost for the FAMIS program, as well as Buy-In administrative costs would have to be borne by families through the monthly premium. These additional charges could again make the premiums unattractive for lower income families with healthy children.

Lastly, related issues such as the reauthorization of SCHIP in 2007 and the Family Opportunity Act are discussed as having bearing on the feasibility of a SCHIP Buy-In program at this time in Virginia. Options of delaying a decision, implementing a small or limited program with some degree of state subsidy or implementing a larger scale program to help reduce the number of Virginia children without health insurance are presented.

# Background

The State Children's Health Insurance Program (SCHIP) was enacted through the Balanced Budget Act of 1997, (P.L. 105-33), as Title XXI of the Social Security Act. Congress established SCHIP to make health care coverage available to low-income uninsured children whose family incomes are above state Medicaid income eligibility standards. Under SCHIP, states are offered capped federal funds that can be used either to expand Medicaid or to finance coverage under a separate child health program. States also have the ability to use a combination of these two approaches. SCHIP has helped close the insurance gap for children, both by extending fiscal incentives that encouraged and enabled states to expand coverage and by triggering aggressive efforts to enroll children eligible for both SCHIP and Medicaid.

The Family Access to Medical Insurance Security (FAMIS) program is Virginia's separate State Children's Health Insurance Program for low income children funded under Title XXI of the Social Security Act. Implemented on August 1, 2001, FAMIS provides comprehensive health coverage to uninsured eligible children from birth through age 18 in families with income too high for Medicaid but at or below 200% of the federal poverty level (FPL). The FAMIS and FAMIS Plus (Medicaid for children) programs have successfully reached most low-income families in Virginia and current estimates are that over 90% of eligible children are enrolled. As of September 1, 2006, 422,988, or approximately 1 in 5 Virginia children receive their health care coverage through these state and federally funded programs.

While FAMIS and FAMIS Plus have helped decrease the number of uninsured children in Virginia during a time when the rate of non-elderly adults without coverage has continued to increase, there are still thousands of uninsured children in Virginia. The 2005 Current Population Survey (CPS) estimates that there are 164,000 children uninsured (all incomes) in the Commonwealth of Virginia.[1] It is further estimated by the State Health Access Data Center (SHADAC) that among uninsured children, 27.5% did not receive any medical care in 2003 compared to just 10% of insured children.[2] According to Families USA, uninsured children are nearly eight times less likely to have a regular source of care than insured children.[3] In addition, they estimate that in the Commonwealth of Virginia, $715,839,000 in health care costs for the uninsured were left unpaid last year alone. Projections are that by 2010 that figure will be over a billion dollars, resulting in a 7.7% mark-up on private health insurance premiums.[4]

Providing a low cost health insurance program for children in low to moderate income families who earn too much to qualify for FAMIS, yet too little to afford private insurance could produce a small but meaningful reduction in the uninsured population of Virginia.

# SCHIP Buy-In Programs in Other States

Some states have developed SCHIP Buy-In programs as one vehicle to fill in gaps in health insurance coverage. In a buy-In program, families with incomes in excess of the state's SCHIP eligibility limit (200% FPL in Virginia) are allowed to purchase health insurance coverage for their children through the state's SCHIP program. Families are responsible for paying for all or most of the cost the state incurs for operating the program. While no federal SCHIP money is available to cover any of the cost for covering these children, state dollars can be used to subsidize the Buy-In programs.

As of July 2006, eight states are currently operating some form of SCHIP Buy-In program. They are: Connecticut, Florida, Illinois, Maine, North Carolina, New Hampshire, New York, and Pennsylvania. Florida has the longest running program which predates the creation of SCHIP in 1997 and Illinois' buy-in program, "All Kids", was just implemented on July 1, 2006. Each state's program is unique but there are some similarities. All eight states offer the same benefit package to buy-in recipients that SCHIP recipients receive. All but one state, New Hampshire, utilize the same vendors and contracts for the Buy-In populations. Four of the eight states offer the Buy-In program to all children regardless of income and are part of comprehensive efforts to cover all children in the state.

**Connecticut**

In Connecticut, the *HUSKY-B (Healthcare for UninSured Kids and Youth),* Buy-In program is made available to all children with family incomes over 300% of FPL, which is the upper limit of the state's SCHIP program. The program is administered through the same contract as the SCHIP program and offers the same benefits. There is no enrollment cap for the program and no time limit on participation; however, there is an annual income redetermination for families to renew coverage. This insures that should a family's income decrease, the children would then be enrolled in the SCHIP program allowing the use of federal and state dollars to cover the costs. The monthly premiums in the buy-in population range from $158 to $230 per child per month, depending on the plan chosen by the family. State dollars are used to cover the administrative costs of the program, but not to subsidize the premiums paid by the families.

**Florida**

Florida's *KidCare* Buy-In program is also made available to all children in the state with income above the SCHIP limit of 200% FPL. The program is administered through a contract with Florida Healthy Kids Corporation (FHKC), a non-profit organization. The benefits for the buy-in population are the same as the SCHIP population; however, the Buy-In group has the option to exclude dental coverage, which reduces the monthly premium. Enrollment in the Buy-In is capped at 10% of total SCHIP program enrollment. When contacted, Florida reported that although the program has been in existence for over 10 years, they

have just now reached the 10% cap on enrollment and are in the process of determining how to address this issue. Families pay a premium of $110 per child per month, which reflects the statewide average cost of the SCHIP program. If the family opts out of dental coverage, the monthly premium is reduced to $98.

**Illinois**

The state of Illinois' newly implemented Buy-In program offers health insurance to all children in the state above 200% FPL through the *All Kids* program. Parents pay monthly premiums and co-payments for doctor's visits and prescription drugs. The rates for *All Kids* coverage are based on a family's income and range from $15 to $300 per child per month with the state subsidizing premiums for lower income families. Families are required to pay co-pays that range from $100 per family per year maximum for all covered services, to $5000 per child for hospital services per year, depending on family income. Illinois also offers coverage to parents through *FamilyCare* for families with income up to 185% FPL. Parents pay small monthly premiums ranging from $15 to $40, depending on family size.

According to the Illinois Office of the Governor, the state is able to offer *All Kids* insurance coverage at lower than market rates for middle-income families by leveraging the significant negotiating and buying power it already has through Medicaid and expansion of its SCHIP program[5]. The state is using savings from placing its Medicaid and SCHIP enrollees into managed care to provide a subsidy to families, keeping the monthly Buy-In premiums low.

**Maine**

Maine's Buy-In program also offers the same benefit package as the SCHIP population receives and administers the program through the same contract. A unique feature of *MaineCare* is that it functions as a COBRA type of health plan and enrollment is limited to families that have lost SCHIP coverage due to an increase in income (200%FPL). While there is no cap on family income, enrollment is limited to the first eighteen months after loss of SCHIP coverage. Families pay a premium of $102 per month with no direct state subsidy. Additionally, Maine has no enrollment cap or requirement for annual income redetermination for its Buy-In program.

**North Carolina**

Like Maine, the Buy-In program in North Carolina, *NC Health Choice*, functions as a COBRA type of health plan with the same benefits as the SCHIP program. Eligibility for the Buy-In program is limited to families that had previously been enrolled in SCHIP for at least one year with incomes between 200% and 235% of FPL. There is no enrollment cap or annual income redetermination. However, participation is limited to the first twelve months after loss of SCHIP coverage. Families pay a per child premium of $196.74 per month. North Carolina uses the same contract to administer both the SCHIP and Buy-In program.

**New Hampshire**

In New Hampshire, the New Hampshire Healthy Kids Corporation (NHHK), the vendor that manages the state's SCHIP program, operates the buy-in program outside of its contract with the state. In doing so they were able to negotiate with insurers to donate administrative cost so that the only administrative cost added to the family premium is that incurred by NHHK. The benefit package available to the buy-in population does vary from the SCHIP group in that it does not provide prenatal, or labor and delivery coverage. Eligibility is limited to families with income between 300% (SCHIP limit) and 400% of FPL. There is no state subsidy for the monthly premium of $130 per child, and there is no limit on enrollment. Like Florida and New York, New Hampshire's *Health Kids* Buy-In program existed prior to SCHIP.

**New York**

Families enrolled in both SCHIP and the Buy-In programs in New York have a choice of benefit plans, therefore the monthly premium varies. All families with incomes that fall above SCHIP eligibility levels (> 208% FPL), are given the option of buying into the program. Families with incomes over 250% FPL pay the full cost of the monthly premium but the state subsidizes the monthly premium for families between 208% FPL and 250% FPL. This results in subsidized premiums of $15 per child per month for families up to 250% FPL and, on average, about $130 per month (no state subsidy) for the higher income families. Additionally, there is no cap on enrollment and no time limit on participation in the program.

New York's Buy-In program also existed prior to SCHIP and the state is in the process of reviewing the program to make it more affordable for families. The state is exploring the option of using state and federal subsidies to lower the per month premium families currently pay.

**Pennsylvania**

Pennsylvania's *CHIP (Children's health Insurance Program)* allows families with incomes between 200% (SCHIP limit) and 235% FPL to purchase benefits for their children at the state's negotiated rate. The benefits are exactly the same for the buy-in population as the SCHIP group and the same eight contractors are used to administer the program. There is no time limit on participation, nor is eligibility limited to previous SCHIP enrollees. Monthly premiums are subsidized by the state up to 50% of the premium per child. The average monthly cost to families is $67 per child per month (family pays 50% of the rate of the contractor that they choose to provide their benefits).

Like New York, Pennsylvania is currently exploring expanding its program to cover all children in the state. Governor Ed Rendell announced the *Cover All Kids* initiative to expand SCHIP to all children in the state as part of the state's 2006 - 2007 Budget. The expansion would allow families to purchase the benefit at low cost ($23 - $32 based on income). Those with incomes above 350% would be able to purchase the benefit at the state's negotiated rate. This would be

accomplished through a SCHIP State Plan Amendment and would use federal financial participation for children up to 350% of poverty. Funding was included in the state budget but enabling legislation has been delayed. [6]

Table 1 on the following page provides information on the existing SCHIP Buy-In programs in the eight states.

## Table 1: Buy-In Programs Operating in Other States

| | Connecticut | Florida | Illinois | Maine | North Carolina | New Hampshire | New York | Pennsylvania |
|---|---|---|---|---|---|---|---|---|
| **Income Eligibility** | >300% FPL | >200% FPL | >200% FPL | >200% FPL | 200-235% FPL | 300-400% FPL | >208% FPL | 200-235% FPL |
| **Monthly Premium** | $168-$220 depending on the plan | $110($98 without dental coverage | $15-$300 depending on family income | $102 | $196.74 | $130 | $97-$152 depending on the plan | $132 |
| **Direct State Subsidy** | Yes only for admin. costs | No | Yes premium subsidized | No | No | No | No | Yes premium subsidized 50% |
| **September 2005 Buy-In Enrollment / Total SCHIP Enrollment** | 708 / 14,963 | 20,401 / 202,133 | Began July 2006 | 100 / 14,300 | Unknown / 130,291 | 1,409 / 7,114 | 12,262 / 340,000 | 7,881 / 128,589 |
| **Time Limit on Participation** | No Limit | No Limit | No Limit | 18 months after loss of SCHIP coverage | 12 months after loss of SCHIP coverage | No Limit | No Limit | None-must remain within income limits |
| **Required Income Redetermination** | Annually | Annually | Info not Available | Never | Never | Never | Never | Annually |
| **Limited to SCHIP Graduate** | No | No | No | Yes | Yes | No | No | No |
| **Enrollment Limit** | None | Capped at 10% of SCHIP enrollment | None | None | None | None | None | None |

Source: DMAS staff research

# Program Design Questions

It is clear from the eight Buy-In programs currently operating in other states that there are a variety of program models that could help reduce the number of uninsured children in Virginia. Some basic program design questions must first be addressed before developing a Buy-In program for the Commonwealth:

- Who should the target population be?
- Should the size of the program be controlled or limited, and if so, how?
- Should the state subsidize the program to reduce the cost to families, and if so, how much?

**Target Population**

There are numerous options available to the Commonwealth to target an SCHIP Buy-In program to certain populations. Some states (Maine and North Carolina) limit program eligibility to SCHIP graduates (previous SCHIP enrollees who lost coverage due to increase in family income). Other states limit eligibility to certain levels of federal poverty. For example, Pennsylvania and North Carolina limit eligibility to families between 200% and 235% of FPL, while New Hampshire limits eligibility to families not exceeding 400% of FPL. Other states, Connecticut, Florida, Illinois and New York, have no limits on eligibility, and offer coverage to all children.

**Controlling Program Size**

Setting a limit on the size of a SCHIP Buy-In program is advisable to insure that costs do not escalate beyond available funding and the buy-in population does not negatively impact the "risk pool" of the SCHIP program (see section on Determining the Premium). Determining the optimal size of a SCHIP Buy-In program is directly correlated with targeting the population. In addition to limiting eligibility, Maine and North Carolina keep the size of their Buy-In programs small by limiting the period of eligibility to the first 18 months (ME) or 12 months (NC) after loss of SCHIP coverage. These are examples of very lean programs, designed to keep the population small, and costs low.

Several states do not limit eligibility to a specific time frame. Instead, annual income re-determinations are used to curb program growth. In this way, families that exceed set income levels (NC, NH, and PA) are canceled from the program and families with a decreased income may be moved into the state's SCHIP or Medicaid program. While Florida has no income limit or time limit, they go a step further by capping the buy-in population at 10% of SCHIP enrollment.

Another option available to Virginia would be to cap the buy-in population at a certain number of participants. Currently, there are no states that have adopted this method. New York and New Hampshire place no time limits on

eligibility, have no required income redeterminations, nor do they place a numerical or percentage cap on enrollment.

**State Subsidy**

The Commonwealth must consider if any state dollars should be utilized to keep costs to families low when developing a FAMIS Buy-In program. From conversations with other state's SCHIP coordinators, it appears that all states operating SCHIP Buy-In programs are using state dollars to lower the cost of monthly premiums paid by families at least to some extent. There are two forms of subsidy that states make use of when operating SCHIP Buy-In programs. The first form of subsidy is a direct appropriation of state funds. This is when state general fund dollars are specifically allocated to cover the administrative costs of operating the program and/or reduce the monthly premium families' pay. The second form of subsidy is indirect, and will be referred to as the Blended Rate Subsidy. With this form of subsidy, states combine the populations from the SCHIP group with the Buy-In group to obtain a blended capitation rate for both groups, making the monthly premium more affordable.

Direct State Subsidy: Connecticut, Illinois and Pennsylvania provide direct subsidies to their Buy-in programs. In Connecticut, the state dollars are used to subsidize the administrative cost of operating the Buy-In program but not to reduce premium amounts. In Illinois, state dollars subsidize not only the administrative cost, but the per month premium families pay as well, depending on income. Pennsylvania uses state dollars to cover both the administrative costs plus 50% of the monthly premium families would be required to pay.

Blended Rate Subsidy: Several states currently operating SCHIP Buy-In programs use a blended capitation rate to determine the monthly premium family's pay. By combining the SCHIP and buy-in population together, the risk is spread over more members, thereby reducing the premium for the Buy-In group, but potentially increasing the per member per month cost of the SCHIP group. This can result in states drawing down additional federal SCHIP dollars which require additional state matching funds to support the SCHIP program. The blended rate subsidy is discussed in greater detail in a later section of this report.

## Factors Affecting Cost and Affordability

The purpose of a FAMIS Buy-In Program would be to reduce the number of uninsured children in the Commonwealth by offering an insurance package that is financed, wholly or in part, by premiums collected from families who enroll their children in the program. In structuring a sustainable Buy-In program that is affordable to the target population, several issues must be considered. These include: the risk of adverse selection, the likely medical costs of the buy-in population, the determination of a premium amount, and methods for financing the program. Each of these issues is discussed below.

**Adverse Selection**

In general, insurance is attractive to individuals who believe that the cost of the insurance outweighs the loss that might occur in the absence of insurance. When deciding to purchase insurance, people weigh the likelihood of experiencing a loss that might be covered by the insurance against the desire to use the money that would be spent on premiums to purchase other goods or services. In those situations where there is little or no cost for the insurance, like the current FAMIS program, the choice is obvious, and the phenomenon of adverse selection does not exist.

Adverse selection, also referred to as anti-selection, is a term used to describe higher risk persons purchasing health coverage with greater frequency than healthy persons offered at the same per member rate without individual underwriting. People who are healthy and use few medical services are less likely to purchase health insurance than are people who are sick and expect to use a high level of services. Therefore, as premiums increase, there is a greater propensity for sick people (those with higher morbidity) to purchase insurance, while healthy people may forego insurance. The result is that the number of people covered by the insurance plan grows smaller. In addition, the health status of the survivors (the "risk pool") deteriorates. If this process continues over a number of years an "assessment spiral" or "death spiral" results with an ever smaller risk pool and ever larger premium increases. The high premium increases eventually lead to negative publicity and/or a program that no longer accomplishes its original goal of reducing the number of uninsured.

In October 2005, Ross Health Actuarial performed an analysis of the Florida Healthy Kids program which provides medical and dental coverage to eligible children between the ages of 5 and 19 years.[7] They compared the costs of two groups; one group of children with family income up to 200% FPL whose premium was subsidized and paid $15 to $20 (subsidized group) in monthly premiums and another group who paid a premium of $110 per child (full pay group). Their findings included:

- Pharmacy utilization for the full pay group was 1.67 times that of the subsidized group with a relatively higher use of:
  - Antidepressants, suggesting higher levels of mental illness,
  - Blood glucose regulators, suggesting a higher mix of diabetic population,
  - Antineoplastics, suggesting a higher mix of cancer patients.
- The full pay group had approximately three times the inpatient utilization of the subsidized group, due to both a higher admission rate and a longer average length of stay.

Taken together, these results point to a relative cost for the full pay group in the range of 180% to 200% of the subsidized group.

Another source of experience that was reviewed is the experience of State High-Risk Health Insurance Pools. Although these pools cover population groups that are not entirely similar to the group that would be covered under Virginia's Buy-in program, they do require significant premiums from participants in order to obtain coverage. To make High Risk pools more affordable, all states set limits on premiums based on the rates available in the individual medical plan marketplace. Typical limits range from 125% to 200% of the average standard rates for comparable individually purchased insurance.[8]

Similar to the experience in Florida's Buy-In program, actual program costs in the High-Risk Health Insurance Pools exceeds the premium charged for coverage by a wide margin. In 1999, medical loss ratios (defined as the ratio of claims paid to premiums earned) ranged from a low of 1.14 in Oklahoma's pool to 4.84 in Washington with an average loss ratio of 1.94, meaning that the cost of the care was nearly double the price of the premium.[9]

Experience in other states has shown that adverse selection does occur with SCHIP Buy-In populations. In fact, Florida's SCHIP Buy-In program showed that the buy-in population's costs were about 1.5% to 2.5% higher than the regular SCHIP population.[10] Additionally, Connecticut has experienced adverse selection with the Buy-In population as well, primarily in the area of behavioral health services. Therefore, it can be expected that a Virginia buy-in population will be similar to that experienced in Florida, and the determination of premiums should take this information into account.

**Determining the Premium**

In order to determine the appropriate premium to be charged for the Buy-In coverage, assumptions regarding the number of participants expected to elect coverage as well as their resulting medical costs are required. As was previously indicated, the number of participants that are likely to enroll in the coverage is a function of the premium amount. As the premium increases, the percentage of the population that elects coverage will decrease.

Research suggests that the demand for health insurance decreases rapidly as the price of insurance increases. When the price of health insurance is one or two percent of income, 50 to 60 percent of families will purchase insurance, and as the price increases to five percent of income, many families will drop their coverage; participation in one study fell to around 20 percent. However, the remaining 20 to 30 percent of the population hold onto health insurance, even as the price increases to 10 percent or more of their income. [11]

The presumably healthier population will drop coverage as the price increases, while the smaller, sicker portion will retain coverage. The people that do not enroll, when premiums exceed 5 percent of income tend to be of lower income, less well educated and more likely to be members of a minority group.[12]

In conclusion, it is important to keep premiums at a level where the buy-in is attractive to families with healthy children, in order to avoid a rapid increase in premiums as time goes on.

Virginia contracts with seven managed care organizations (MCOs) to provide services to eligible Medicaid and FAMIS recipients. Currently, approximately 79% of all FAMIS enrollees are enrolled in one of these contracted health plans. MCOs are paid a monthly capitation rate to cover the cost of care for recipients enrolled in their plan. Capitation rates are based on two years of cost experience which are adjusted and inflated, based on expected cost and utilization trends. Rates are developed for sub-groups within the population, based on age, gender and geographic location. A FAMIS Buy-In program could be made available to children in areas where no contracted MCO exists if the Commonwealth is willing to assume the full risk for the amount of the monthly premium. A separate analysis of this much smaller population and potentially a separate rate structure could be determined for a Buy-In program operating in a fee-for-service environment. However, since the majority of buy-in children, like FAMIS children, would be enrolled in an MCO, the current FAMIS MCO population and capitation rates will be utilized to estimate potential FAMIS Buy-In monthly premiums for this report.

**Sample FAMIS Buy-In Program:**

To illustrate how the monthly premiums might be established in a fairly restricted sample FAMIS Buy-In program, analysis was developed based on the following assumptions:

- Enrollment would be limited to children who had lost coverage in FAMIS due to an increase in family income above 200% FPL but no greater than 300% FPL;
- There will be 1,000 Buy-In enrollees in the Virginia plan which represents 2.7% of Virginia's total SCHIP population enrolled in a MCO *(3.5% of Virginia's SCHIP population with income greater than 150% of FPL)*;
- FAMIS Buy-In would offer the same benefits as the FAMIS Managed Care plans;
- Services would be delivered through contracted MCOs;
- The same contractor would be utilized to administer the Buy-In program (enrollment, premium collection, etc.) as is utilized for FAMIS; and
- The children participating in the Buy-In program will have the same age/gender distribution as the entire MCO population that lost coverage due to higher income.

Based on the age/gender distribution in July 2006, the average Fiscal Year 2007 capitation payment for the FAMIS program was $99 per member per month (PMPM) for the over 150% FPL group and $102 PMPM for the under

150% FPL group.[i] If we assume that the FAMIS buy-in group will experience adverse selection similar to the Florida experience, then it is reasonable to expect that the buy-in premium determined solely on the basis of the buy-in group's actual claim experience will range from approximately $178 PMPM to $198 PMPM. That is, the buy-in premium will be 80% to 100% higher than the current premium for the FAMIS Over 150% FPL group.[ii]

If the Commonwealth chooses to develop the premium based solely on the experience of the buy-in population, then the resulting premiums as a percentage of household income would range from a low of 4.29% for a family of three with one child and income at the 300% of FPL level to a high of 11.86% for a family of four with income at the 200% of FPL level. As was noted earlier, when premiums as a percentage of income reach these levels, the number of families that elect coverage is significantly reduced.

Alternately, the Commonwealth could treat the FAMIS and Buy-In programs as a single group and calculate premiums based on their combined medical experience. The advantage of combining the groups is that the higher risk of the Buy-In population is spread across a larger and healthier population. Combining the populations would result in lower buy-in premiums and slightly higher FAMIS capitation rates.[iii] If this approach were used, the buy-in premium, as a percentage of household income, would be more affordable. This method of premium determination is the method utilized by the majority of the states that DMAS contacted (4 out of 5).

If we assume that there are 1,000 buy-in participants whose per capita claim experience is 80% higher than the FAMIS group, the resulting premium, based on the combined experience of the two groups, would be $104 PMPM for the FAMIS under 150% FPL group and $101 PMPM for the FAMIS over 150% FPL and buy-in groups.

If the Commonwealth chooses to develop the premium based on the combined experience of the Buy-In and the FAMIS populations, the resulting premium as a percentage of household income would range from a low of 2.43% for a family of three with one child and income at the 300% of FPL level to a high of 6.07% for a family of four with income at the 200% of FPL level.

**Financing the FAMIS Buy-In Program**

If the Commonwealth decides to base the premium solely on the experience of the buy-in population, then the program could be completely

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[i] *The average payment will change, based on changes in the population mix.*

[ii] *The calculation assumes that the administrative costs of the Buy-In group are equal as a percentage of premiums to the administrative costs for the FAMIS group.*

[iii] *Higher FAMIS capitation rates will require an increase in General Funds and will result in the drawing down of more Federal SCHIP matching funds.*

financed by the buy-in participants (i.e. the plan would be self supporting) but participation is likely to be very low. If, however, the premium determination for the buy-in group is based on the combined experience of the Buy-In and FAMIS populations, then there will be an inherent subsidy provided to the buy-in group.

The inherent subsidy can be calculated on a per member per month basis as the difference between the premium rate of the FAMIS over 150% of FPL population ($99 PMPM) and the premium rate of the combined FAMIS and Buy-In population ($101 PMPM). If the premium is determined based on the combined experience of the two groups, the total dollar amount of the implicit subsidy for Fiscal 2007 is estimated to be between $923,000 and $1,016,000.[iv] Financing for the implicit subsidy would be provided through a combination of state and, potentially, federal funds.

The implicit subsidy represents the total amount of additional funds that would be required to finance the subsidized premium rates. Of that amount, some portion would be available in the form of Federal Financial Participation (FFP) dollars. Currently, DMAS obtains FFP in the amount of 65% of health expenditures for child health assistance. In the absence of any limit on FFP, 35% of the dollar amount required for the implicit subsidy would have to come from sources other than the Federal government (i.e. state general funds). This would amount to $599,950 to $660,400 federal funds and $323,000 to $356,000 state funds.[v]

Surcharge: An alternative to a subsidy is to add a "surcharge" to the blended premium rate for the buy-in participants. The surcharge would be the amount required to minimize and/or eliminate any funding by the State for the implicit subsidy. The premium rate for the Buy-In group would then require a surcharge of $27 PMPM resulting in a total premium rate of $128 PMPM.

Administrative Costs: In addition, the Buy-In program would generate certain administrative costs for operations. At a minimum, functions such as answering callers questions, processing applications, determining eligibility, mailing premium notices, collecting premiums (possibly via credit cards, electronic checks, electronic fund transfers, etc), canceling members, and generating program reports would be required. While these functions could be contracted out to managed care plans, it is likely to be more cost effective to extend the contract with the single vendor that performs much of these same functions for the FAMIS program. In an effort to determine potential administrative costs, DMAS requested estimates from the current contractor operating the FAMIS Central Processing Unit. Based on a program enrollment of 1,000 it was estimated that administrative costs for the addition of the Buy-In

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*[iv] Assuming 1,000 Buy-In participants whose average claim cost is 80% to 100% higher than the FAMIS Over 150% FPL group and 36,000 FAMIS MCO participants.*

*[v] Assuming 1,000 Buy-In participants whose average claim cost is 80% to 100% higher than the FAMIS Over 150% FPL group.*

program would be approximately $150,000 a year or $12,500 per month. Again, if the intent is to keep the cost of the program totally budget neutral for the Commonwealth, an additional $12.50 would need to be added to the cost of each child's monthly premium assuming 1,000 participants.

In the example presented, the cost of the blended rate (assuming 180% risk for Buy-In population), plus the surcharge to cover increased state costs for the FAMIS program, plus the administrative cost of the Buy-in program would result in a per child monthly premium of $140.00.

**$101 blended rate + $27 surcharge + $12.50 admin. = $140.50 family premium**

Keeping in mind the research presented earlier regarding the ratio of premium amount to income as it relates to the affordability of insurance, it is unlikely that many families would consider the Buy-In program affordable and those most likely to take up the offer would be those with the sickest children.

The following table illustrates the affordability of the buy-in premium including the surcharge and estimated administrative costs. Data is presented for three different income groups (200%, 250% and 300% FPL) and two family types for each (single parent/1 child and 2 parents/2 children). The unshaded areas demonstrate where the potential premiums (blended rate alone or blended rate + surcharge + admin. costs) might be considered affordable by the families (3% - 5% of income). It is clear, that if the full cost of the program is charged to families and no subsidy is provided by the Commonwealth, few families in the lowest income levels should be expected to be able to afford the program. Thus, there could be an unintended gap in health care coverage for those just above 200% FPL.

## Table 2: Affordability of Buy-In Premiums

| Family Income & Size | Monthly Gross Income | 3% of Monthly Income | 5% of Monthly Income | Blended Rate @ 180% Risk | Blended Rate + Surcharge + Admin |
|---|---|---|---|---|---|
| 200% FPL<br>Family of 2 – 1 Child | $2,200 | $66 | $110 | $101<br>4.6% | $140<br>6.4% |
| 200% FPL<br>Family of 4 – 2 Children | $3,334 | $100 | $167 | $202<br>6.1% | $280<br>8.4% |
| | | | | | |
| 250% FPL<br>Family of 2 – 1 Child | $2,750 | $83 | $138 | $101<br>3.7% | $140<br>5.1% |
| 250% FPL<br>Family of 4 – 2 Children | $4,168 | $125 | $208 | $202<br>4.8% | $280<br>6.7% |
| | | | | | |
| 300% FPL<br>Family of 2 – 1 Child | $3,300 | $99 | $165 | $101<br>3.1% | $140<br>4.2% |
| 300% FPL<br>Family of 4 – 2 Children | $5,001 | $150 | $250 | $202<br>4.0% | $280<br>5.6% |

# Other Related Issues

**The Family Opportunity Act**

On February 8, 2006, the President signed into law the Deficit Reduction Act of 2005 that includes the Family Opportunity Act (FOA). FOA creates a new option that allows states to offer Medicaid buy-in coverage to children with disabilities in families with income below 300% of the federal poverty level starting January 2007. Coverage may be phased in on the following schedule: in 2007 the option would be available to children under 6, in 2008 to children under 12, and in 2009 to children under 19. According to the Kaiser Commission on Medicaid and the Uninsured, the Congressional Budget Office estimates that 115,000 children with disabilities will gain Medicaid coverage by 2015 as a result of these provisions and about two-thirds of the states will eventually participate in this program.[13]

If Virginia elects to participate in the FOA, the risk pool for the SCHIP Buy-In population would most certainly be affected. The degree to which adverse selection would be minimized can not immediately be determined. However, it can be assumed that the risk will decrease among both the FAMIS and FAMIS Buy-In populations, as families with disabled children choose enrollment in the Medicaid Buy-in where the benefits are more generous and premiums are subsidized with federal and state dollars. The existence of a Medicaid Buy-In program in Virginia would therefore result in a lower PMPM cost for the FAMIS and FAMIS Buy-in programs.

**SCHIP Re-Authorization**

SCHIP's current period of authorization is scheduled to end after federal fiscal year 2007. Under the current authorization, the federal government provides a capped amount of funds to states on a matching basis for federal fiscal years 1998 through 2007. The matching rate for SCHIP is higher than the matching rate states receive for Medicaid. Under the current formula, Virginia's FAMIS program is funded with 65% federal dollars and a 35% state match. Reauthorization of Title XXI of the Social Security Act will necessarily include the amount of federal allocations to states for future years. As of the publication of this report, Congress is just beginning to hold hearings on the future of SCHIP and Virginia's federal allotment beyond FFY 2007 is therefore unknown. While SCHIP programs enjoy strong bi-partisan support both nationally and in Virginia, it is too early in the process to predict future funding levels.

**Current FAMIS Expenditures**

Like most states, Virginia's SCHIP program, FAMIS, has grown significantly since its inception in 1998. The funding formula established by Congress almost 10 years ago is now inadequate to fully support the SCHIP program nationwide. It is projected that 17 or 18 states will exceed available funding (federal and state) before the end of FFY 2006 and will need an additional appropriation by Congress to prevent shortfalls and curtailment of

existing programs. Although Virginia's FFY 2006 expenditures to support the FAMIS program also exceed the FFY 2006 funding level, carryover funds from previous years will offset the shortage in Virginia. However, if the current federal funding levels were to remain constant following reauthorization of Title XXI in 2007, Virginia, like approximately 40 other states, would not be able to sustain the current program levels without additional state support.

# Options for Virginia

The following three options for creation of a SCHIP Buy-In program for Virginia are presented for consideration.

### Option 1: Delay Decision on FAMIS Buy-In Program

While it is clear that a FAMIS Buy-In program could be designed to help reduce the number of uninsured children in Virginia, there are factors on the horizon that could significantly impact the program's viability. Whether or not Virginia elects to exercise the new option available through the Family Opportunity Act to provide Medicaid coverage for disabled children up to 300% FPL would have significant impact on the risk pool of FAMIS Buy-In participants and the resulting costs. In addition, the future level of SCHIP funding available to Virginia beyond 2007 is not clear at this time so any program expansion that has the potential to increase SCHIP expenditures even slightly may be seen as premature. Both of these unknowns could be resolved during 2007 and it may therefore be more prudent to consider implementing a Buy-In program at that time.

### Option 2: Implement a Small/Limited FAMIS Buy-In Program

The Commonwealth may opt to move forward with development of a small, somewhat limited FAMIS Buy-In program as an initial step. The program could be designed to limit eligibility to a small income range (i.e., 200% - 250% FPL) and/or limit enrollment to previous SCHIP enrollees who have lost coverage due to increase in family income (FAMIS Graduates). Additionally, length of enrollment could be limited to 12 or 18 months so the program would serve as a COBRA-like policy. As demonstrated earlier in this report, some level of state subsidy would be required to keep premiums affordable enough for lower income families to participate.

### Option 3: Implement a Comprehensive FAMIS Buy-In Program

Lastly, in an effort to make affordable insurance available to more children and help curb the rising number of Virginians without health insurance, a FAMIS Buy-In program could be implemented on a larger scale. Eligibility could be set at higher income levels such as 300% or 400% FPL, or eliminated completely so

the program would be available to all children in the Commonwealth. Even with no restraints on income eligibility, the program could be limited to a certain percentage of total FAMIS enrollments or to a specific number of enrollees in order to minimize the impact on FAMIS rates. Once program design elements are decided, additional analysis would be required to determine actual program costs, the necessary state appropriation and potential premium amounts.

# Appendix i

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301. E. The Department of Medical Assistance Services shall review and evaluate State Children's Health Insurance Program (SCHIP) buy-in programs for children that are operating in other states, which allow families with income in excess of the state's Title XXI program eligibility limits to purchase health insurance for their children. This review, including recommendations regarding the development of a SCHIP buy-in program in Virginia, shall be presented to the Chairmen of the House Appropriations and Senate Finance Committees, and the Joint Commission on Health Care by October 1, 2006.

# Appendix ii

## EndNotes

[1] U.S. Census Bureau, Current Population Survey, 2006 Annual Social and Economic Supplement. Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2005
[2] State Health Access Data Assistance Center (SHADAC). The State of Kids Coverage, August 2006. Available at: http://www.rwjf.org/files/publications/other/KidsCoverage2006Final.pdf.
[3] Families USA. Paying a Premium: The Added Cost of Care for the Uninsured. June 2005. Available at http://www.familiesusa.org/assets/pdfs/Paying_a_Premium_rev_July_13731e.pdf
[4] Families USA. Appendix Table 1-2. Pgs. 32-33.
[5] Illinois Office of the Governor, Rod R. Blagojevich. Gov. Blagojevich recognized by Families USA for outstanding commitment to healthcare; Speaks to national health conference about landmark All Kids insurance program. January 2006. Available at: http://www.illinois.gov/PressReleases/PressReleasesListShow.cfm?RecNum=4607
[6] DMAS Staff Research. Interview with William A. Shaffer, Chief Policy and Planning Division Pennsylvania Insurance Department Office of CHIP and adultBasic. July 2006.
[7] Actuarial Analysis of Full Pay Enrollees in the Florida Healthy Kids Program.
[8] Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools. Mathematica Policy Research, Inc.. Prepared by Lori Achman and Deborah Chollet. 2001.
[9] Ibid.
[10] Actuarial Analysis of Full Pay Enrollees in the Florida Healthy Kids Program. Prepared for Florida Health Kids Corporation. Prepared by Timothy M. Ross, Ross Actuarial. October 6, 2005.
[11] Using Medicaid to Cover the Uninsured: Medicaid Participant Buy-In Program. National Academy for State Health Policy. Prepared by Kay, N. & Wysen, K. 2003.
[12] Ibid.
[13] Kaiser Commission on Medicaid and the Uninsured. Medicaid Long-Term Services Reform in the Deficit Reduction Act. April 2006. Prepared by Jeffery S. Crowley, Health Policy Institute, Georgetown University. Available at: http://www.kff.org/medicaid/upload/7486.pdf