

SCHIP Full-Cost Buy-In Programs

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Abstract

Unlike the subsidized State Children Health Insurance Programs (SCHIP), SCHIP full-cost buy-in programs give states an opportunity to expand coverage without using public funds. The goal is to increase access to insurance to children with family 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.

This report expresses how a SCHIP full cost buy-in program could work in Texas and raises a number of key implementation issues, including flexibility of program designs, potential target population, and adverse selection.

The report also examines experiences of four states that have implemented SCHIP full cost buy-in programs: Connecticut, North Carolina, New York, and Florida. Although the SCHIP full-cost buy-in program has extended coverage to only a limited number of children to date, it provides a moderate vehicle for states to expand coverage.

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Overview

The uninsured population of the United States is disproportionately comprised of lower-income workers and their families whose employers offer no health benefits. In most states, these workers are not eligible for Medicaid, even if their children are. Although employer-sponsored health insurance remains the foundation for coverage of working families, a few states are exploring the ways to allow those uninsured with higher income an opportunity to pay the full premium associated with a state-run insurance program like SCHIP. These eligibility expansions are referred to as full-cost buy-ins.¹

SCHIP Full-Cost Buy-Ins

The State Children Health Insurance Program (SCHIP) differs from Medicaid programs in that SCHIP receives a higher federal match than Medicaid, and SCHIP eligibility was originally limited to low-income children. In recent years, the federal government has begun to allow states more flexibility in expanding their programs to children at higher income levels. A few states have taken advantage of the SCHIP enhanced federal match, implementing some strategies like employer buy-in programs and full cost buy-in programs.

Four states, Connecticut, Florida, New York, and North Carolina, allow moderate-income families to purchase coverage for their children through SCHIP at no state subsidy. These moderate-income families generally have access to the same benefits and health plans as SCHIP-eligible children, but they pay full cost of the premium and may have cost-sharing.

The rationale behind the SCHIP full cost buy-in program is that when public programs become larger and more solid, administrative efficiencies and purchasing power can help people receive lower premiums than what they could receive in the private market. However, the main objective of the full cost buy-in programs is not to constrain the insurance price, but to provide an additional opportunity for affordable access to insurance.²

The following sections describe the experiences of the four states mentioned above on their full-cost buy-in programs for the purpose of exploring the feasibility of developing a similar model for Texas.

Connecticut Experience: Healthcare for Uninsured Kids and Youth

Design Issues

On January 15, 1998, Connecticut submitted a Title XXI State Plan to expand coverage for uninsured children through the combination of a Medicaid expansion for children and the creation of a separate children's program. State legislation authorized the Healthcare for Uninsured Kids and Youth (HUSKY) Plan Part B and the HUSKY Plus Plan Part C programs.

Connecticut makes a buy-in option available to children in families with incomes above 300 percent of FPL with no federal or state subsidy. No federal monies are received for coverage or services delivered to this population.

By March 2000, 5,006 children had been enrolled in HUSKY B. Of this total, only 2 percent of enrollees have household income exceeding 300 percent FPL, and the remaining 98 percent of enrollees are subsidized by SCHIP.³

There is 12-month continuous eligibility. A shorter version of the original application is mailed to the renewing family, with information originally supplied pre-printed on the form. Some documentation is required, but some eligibility exists for substitution of documentation. (In January, 2001, Medicaid expanded to include relative caretakers with income levels up to 150 percent FPL of children. The asset limit was also dropped as an eligibility criterion.)

Benefits Package

Connecticut is using a benchmark coverage benefit package based on the state employee coverage. The coverage is based on the most generous benefits offered under the three state employee options, which are Blue Cross, MD Health Plan, and Kaiser Permanente.

HUSKY Part B benefits includes the following services: hospital inpatient and outpatient, physician, surgical, clinic, health center, ambulatory, prescription drugs, Lab and x-ray, prenatal care, family planning and supplies, inpatient mental health, outpatient mental health, durable medical equipment, disposable medical supplies, home and community-based services, nursing care, abortion (to save life, rape, or incest), dental, inpatient and outpatient substance abuse, enabling, and emergency transportation.⁴

There was great concern that adverse selection would develop, especially among the first batch of children to enroll in the new program. Advocates who had supported a pure Medicaid expansion expressed special concern about the adequacy of the state employee benefit package to deal with children with special needs.

In response to these concerns, the HUSKY Plus program was created to provide a supplemental benefit for children with special needs. The program was designed in two parts. HUSKY Plus Physical was an expansion of the existing Title V program for children with special needs. Eligibility for both Title V and HUSKY Plus was expanded up to 300 percent FPL and the diagnostic/functional criteria were liberalized. In addition,

HUSKY Plus Behavioral was created to provide supplemental benefit for children with special needs with behavioral health insurance. Nevertheless, eligibility for both programs was limited to children with family incomes up to and including 300 percent FPL. In other words, children under the full cost buy-in program are not entitled to the benefits provided by HUSKY Plus.⁵

Cost-Sharing

The HUSKY Plan has no deductibles and coinsurance. Although there is a \$1,250 maximum for children with household gross incomes exceeding 235 percent of the FPL before income disregards, HUSKY imposes no such limits for children in the full-cost buy-in program.⁶ The state officials believe that eliminating the upper limit emphasizes the responsibility on the part of the parent and reduces the stigma of being on a state-sponsored program for many families.⁷

Crowd-Out

A child is not eligible for HUSKY Part B if he/she has been covered by employer-sponsored insurance within the last six months. This may be extended to 12 months if the commissioner determines that six months is insufficient to deter applicants or employers from discontinuing employer-sponsored dependent coverage. However, an application may be approved if the reason for loss of employer-sponsored insurance is unrelated to the availability of the HUSKY Plan B or any of ten other reasons, which include the loss of employment. The exceptions to this six-month waiting period include self-employment, loss of employment, death of parent, and financial hardship (as defined as a family paying more than 10 percent of gross income on health insurance premiums).

During FY 2000, 624 children were denied HUSKY B eligibility due to either having employer-sponsored insurance at the time of application (587) or having dropped it within six months of application (7).⁸ Some parents are frustrated because their current employer-based coverage is expensive and offers limited benefits. They find themselves in a dilemma of not being able to access an extensive and affordable program like HUSKY B. They are essentially penalized for having a certain income and a certain health benefit, however limited. In this light, crowd-out accomplishes the goal of discouraging the substitution of public coverage for private coverage.

Florida Experience: Healthy Kids Program

Design Issues

In 1990, the Florida Legislature established a non-profit Florida Healthy Kids Corporation (FHKC) to administer a comprehensive health insurance program—Healthy Kids Program—for uninsured children. It was incorporated under the Kidcare umbrella with 1998's Florida Kidcare Acts. Healthy Kids is the only program that does not have a maximum income eligibility requirement. Healthy Kids serves children ages 5 through 18 and currently has over 225,000 children enrollees.

Full-cost buy-in program starts at 200 percent FPL. Families that exceed the income level to qualify for subsidy may buy into the program and pay the full-priced premium based on the county in which they live. Currently, 2.76 percent of the families enrolled in Healthy Kids are under full-cost buy-in programs.⁹

Benefit Package

The Healthy Kids benefit package is the existing program benefit package that was cited in the Title XXI legislation as an accepted child health coverage program (Title XXI of the Social Security Act established SCHIP, allowing states to receive \$24 billion in matching funds over 5 years for children's healthcare expansion). This benefit package includes a full range of inpatient and outpatient services. Limitations are placed on psychiatric, rehabilitation, and physical therapy inpatient admission; alcohol and drug services; chiropractic services; podiatry services; outpatient rehabilitation services; and durable medical equipment and remedial devices. The 2000 Florida State Legislature directed Healthy Kids to implement a comprehensive dental benefit and provided funding to enroll 160,000 children who reside in counties that contribute local match, including full-cost buy-in enrollees.¹⁰

Cost-Sharing

Co-payments are charged for a number of services and reflect Title XXI requirements in the Healthy Kids program. The state plan states that cost and utilization rates will be monitored on a quarterly basis to ensure that costs associated with utilizing health care services do not exceed the 5 percent maximum.¹¹ If the family spends in excess of 5 percent of their annual income, it will be notified by the state that it is no longer responsible for cost sharing, and will be reimbursed for excess expenses by Florida Healthy Kids Corporation. There are no different co-payment schedules for full-cost buy-in enrollees. It only requires minimal co-payments for mental-health outpatient services and unauthorized use of emergency services.¹²

Crowd-out

Studies in 1999 have demonstrated that access to employer-based coverage varies significantly by income with families above 185 percent FPL reporting increased access when compared to those with lower income.¹³ Thus, families at the upper end of the income cutoff for government subsidized insurance coverage may have greater access to employer-based dependent coverage than families at the lower end of the income range. Parents that have access to employer-based coverage report it is unaffordable. Without a subsidized insurance option, the majority of these children would be uninsured. According to Florida officials, the care for these children is not being shifted from the private sector to the public sector. Rather, these children are receiving insurance coverage and health care when they might have had no coverage at all and limited health care.¹⁴

According to a recent Healthy Kids program evaluation, 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.¹⁵ Despite some concerns on crowd-out, Florida Healthy Kids program does not impose any waiting period policy except that it requires children be uninsured at the time of application and they must not have received employer-sponsored coverage in the previous 12 months. Besides this, there is an eligibility renewal process that consists a letter sent to each family every six months, containing all of their account information. Families make proper changes to the form and return it to the Healthy Kids, or they can call the program.

However, attempts to expand a full-cost buy-in program to younger children (ages 1 to 5 above 200 percent FPL) have raised fears of crowd-out, and policymakers have delayed expansion until further studies on crowd-out are conducted.¹⁶

New York Experience: Child Health Plus Program

Design Issue

The Child Health Plus program (CHPlus) in New York commenced in 1990. The program is based on a partnership between government and private insurers through the subsidization of private health insurance coverage. An application must be completed for every child applying for Child Health Plus in New York. Children who are not eligible for Medicaid (and the other federal exclusions) and under 19 years of age are eligible for the program at a subsidized level. Those meeting the above criteria but having income above 250 percent of FPL can purchase the product at full price.

Enrollment in the CHPlus program as of September 30, 2000, was approximately 539,000 children (including full cost buy-in enrollees). This is a 150,500 increase over the September 1999 enrollment of approximately 388,500, or a 39 percent increase in CHPlus enrollees.¹⁷ The full-cost buy-in enrollees reached 9,000 at its peak.¹⁸

Benefit Package

Initially, the package of services for the Title XXI program was the same comprehensive benefit package offered by the state-only program. The state's second amendment on Title XXI program, which was approved in September 1998, expanded the CHPlus benefit for durable medical equipment, inpatient and outpatient mental health, speech therapies, and provides coverage for non-prescription medications authorized by a professional licensed to write prescriptions.

There is no difference in benefit package between families with incomes above 250 percent FPL and other enrolled families in the Child Health Plus Program.

Cost-Sharing

The premium is developed at full cost by the insurance plans participating in the program. Some families may have to contribute \$9 or \$15 per child per month depending on their incomes. All other children are fully subsidized by the state or they fully pay the premium.¹⁹ The full premium will vary, depending on the insurer selected. It is probably

much less than one would pay for other private insurance. An additional premium of \$630 will be paid for each extra child enrolled in the full cost buy-in program.²⁰

There are no co-payments on the health care services received from a participating provider. The state has not studied the possible effects of nominal premium contributions on participation in the program. The majority of the enrolled CHPlus population is fully subsidized, and the full-cost buy-in program enrollees receive a different treatment on co-payments.²¹

Crowd-Out

The CHPlus program is designed to prevent crowd-out. Only those children in families who have a net income above 250 percent FPL but do not have access to employer-based coverage are eligible for unsubsidized insurance. An evaluation of the CHPlus program has shown that “crowd-out” has not been an issue for New York State.²²

The state established a policy that if, on average, over a nine-month period the crowd-out percentage equals or exceeds 8 percent, a waiting period may be imposed.²³ Since the approval of New York’s State Plan under Title XXI, the crowd-out percentage over a nine-month period has been below 6 percent.²⁴ According to a recent program evaluation, the crowd-out is not occurring to a significant degree since the implementation of the CHPlus program.²⁵ The state does not feel they have a crowd-out problem and has yet to impose any waiting period. However, they are currently monitoring it through the application process.²⁶ Should crowd-out occur in 8 percent or more of enrollees, one of two options will be implemented: children with access to employer-based coverage will be deemed ineligible for CHPlus, and/or a required period of uninsurance will be imposed.²⁷

North Carolina: NC Health Choice for Children

Design Issues

In 1998, North Carolina created a separate state health insurance program to provide coverage to uninsured children whose family incomes do not exceed 200 percent FPL. Enrollees whose annual incomes increase above 200 percent of the FPL to 225 percent of the FPL will be allowed to buy into the program for one year at full cost.

The North Carolina full-cost buy-in program essentially acts like a COBRA program. A family who has been on North Carolina Health Choice’s (Title XXI) subsidized program for one full year or more but whose family income has gone up at the one-year renewal period so that their children are no longer eligible for the program may elect to purchase for one year their North Carolina health choice benefits at the per-member per-month rate for each child affected.²⁸

Benefit Package

The benefit package is the state employee coverage provided through the North Carolina Teachers and State Employees’ Comprehensive Major Medical Plan (TSECMMP), plus

Medicaid-equivalent benefits for Special Needs Children. Dental, optical, and hearing services are also provided. Children are guaranteed 12 months of continuous enrollment, unless the child receives other insurance coverage during this time period.²⁹

Cost-Sharing

Currently, one child would cost \$120.84 a month, two children \$241.68 per month, and three children \$362.52 a month.³⁰ The payment schedule and mechanism must be worked out with Blue Cross. It is in effect a Blue Cross product designed on the NC Health Choice model.

Crowd-Out

Children are eligible for North Carolina's Health Choice program (Title XXI program) if they are uninsured. The state initially defined uninsured as not having coverage under any private or employer-sponsored creditable health insurance plan for the six-month period immediately preceding the date the Title XXI program became effective. Six months after the state implemented the program, the definition of the term was modified to mean that the applicant has not had coverage for 60 days immediately preceding the date of the child's application. Exceptions are made if the child has lost Title XIX eligibility due to a change in family income or if the family has lost employer-sponsored coverage due to the termination of employment, cessation by the employer of employer-sponsored coverage, cessation of the employer's business, or for a special needs child if health insurance benefits have been terminated due to a long-term disability or substantial reduction in or limitation of lifetime medical benefits or benefit category.³¹ According to the Coordinator of NC Health Choice for Children, they have no evidence that there is any crowd-out in North Carolina to the point that they dropped their two-month waiting period for regular programs.³²

Since the children must meet income requirements before enrolling in North Carolina Health Choice (Title XXI), and must have been enrolled in this for one year before being eligible for the full-cost buy-in, it does not compete with any high-risk pools.³³

Summary of State Experience

Since concerns about substitution of private coverage have risen due to the higher-income target population, the current active full-cost buy-in programs do not include adults. (See Table 1 for a summary of the full-cost buy-in programs of the four states that have them.) In general, targeting children might cause less competition with private insurance products. Because states do not receive federal funding to operate the full-cost buy-in programs, these programs can be designed with greater flexibility than Medicaid and SCHIP. This is why states have different income limits for subsidized coverage.

Table 1.
Summary of SCHIP Full-Cost Buy-In Programs

Program Name	Year Implemented	Population Targeted	Eligibility Range	Time limit (if any)
Connecticut HUSKY	1998	Children	300% FPL	--
Florida KidCare	1992	Children ages 5 to 9	>200% FPL	--
North Carolina Health Choice for Children	1998	Previously enrolled children	200-225% FPL	1 year
New York Child Health Plus	1991	children	>230% FPL	--

Adapted from: State Coverage Initiatives, Robert Wood Johnson Foundation. *SCHIP Full-Cost Buy-In*. Online. Accessible: <http://www.statecoverage.net/fullcost.htm>. Accessed: January 14, 2002.

Full-cost buy-in programs are viable in that states are able to provide a lower premium utilizing administrative efficiencies. According to the New York state officials, New York's Child Health Plus Program created economies of scale by using the administrative framework already in place, allowing the state to process the unsubsidized enrollees at marginal costs.

Flexibility is also part of the reason that some states choose to define a narrower benefit package to reduce the likelihood of adverse selection. For instance, HUSKY Plus, Connecticut's supplemental coverage option for children with intensive physical or behavioral health needs is only available for children in the state's subsidized HUSKY program. The exclusion of full cost buy-in program enrollees from this component of the benefits package was designed as a deterrent for less healthy individuals' enrollment.

There is no evidence of substantial crowd-out, regardless of whether programs required minimum spells without insurance for new enrollees. HUSKY, Connecticut's full-cost buy-in program, 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' employees. According to state officials, the current waiting period is effective in preventing crowd-out. Florida's Healthy Kids and New York's Child Health Plus impose no waiting period on enrollees, and the crowd-out appears to be minimal.

Full-Cost Buy-In Options for Texas

It is estimated that there are 1.4 million uninsured children in Texas.³⁴ The Texas SCHIP program is currently targeting children with household gross income up to 200 percent FPL. The challenge in addressing the situation for families with income above roughly \$33,400 annually for a family of four (above 200 percent FPL) is how to offer them the opportunity to buy into affordable coverage while not undercutting the employer market of which many people in this income group are already part.³⁵

Despite the fact that only four states have implemented it, a SCHIP full-cost buy-in still can be considered as an option to expand the coverage of uninsured children.

Design Issues

Target Population: Children with Household Gross Incomes above 200 Percent FPL

Since the buy-in program would focus on families with higher incomes, it is extremely important to structure the program in a way that will not lead to an erosion of the employer market.

Owing to the absence of private insurance products for children only, targeting children might cause less competition with the private market. With children as the target population, the full-cost buy-in option could be integrated into Texas CHIP.

Adverse Selection Minimization

This program will be subject to the risk of adverse selection, like any insurance product in a voluntary market. One possible policy response is to erect barriers to keep high-risk children from shifting into the program. Waiting periods, or exclusions from the program if other sources of coverage are available, could address some of the selection problem. Such policies have been employed in other government programs, and could apply here. Another form of barrier is to scale back the benefit package or use tightly managed care to control the cost and make the full cost buy-in program less attractive to high-cost population.

Competition with the Private Section

Conditions of Participation: No employer-sponsored coverage at the time of application and at least six-month waiting period. As public programs expand eligibility up the income scale, the state's coverage product begins to compete with private insurance products. Families at a higher income may face a choice about whether to purchase private coverage for their children or join in the CHIP full-cost buy-in program.

The requirements on applicants' pre-existing conditions address the concern of competing with private insurance market. In effect, as moderate-income families decide to purchase a state-sponsored program like full cost buy-in for their children, it may be harmful to private insurance markets. In this sense, it is necessary to ensure that a candidate is not covered by employer-sponsored health insurance at the time of application. A longer waiting period could also prevent the inflow of unhealthy people that might raise premium levels.

Limited benefits coverage: The full cost buy-in program assures that moderate-income children have access to the full range of medically necessary services, guaranteed in a "defined benefit" package, and that they have a variety of health plan choices. The children should not be forced into a few segregated plans. While the benefit package is supposed to include a full range of inpatient and outpatient services, limitations could be placed on certain fields like psychiatric, rehabilitation, durable medical equipment and remedial devices, and the like. The purpose is to avoid the possibility of blending state high-risk pools with full-cost buy-in programs.

Cost Sharing

In order to make an aggregate estimate of premium and cost co-payment for a full-cost buy-in option for Texas, it is important to look first at the current SCHIP premium rates and co-payment. Then, assuming the same risks spread over as SCHIP full cost buy-in enrollees, we will make a rough estimate on the average monthly amount that can be paid to plans per child.

Milliman USA conducted a similar research on Texas SCHIP premium costs in 2002. They concluded that a child currently enrolling in Texas SCHIP costs a premium of approximately \$115 per month. Ignoring state costs to administer, Milliman estimate that the adjusted monthly premium per child is approximately \$90 for a Texas CHIP full-cost buy-in option excluding dental coverage.³⁶ They also estimate the full-cost buy-in co-payments as follows:

- Office visit: \$15
- Emergency room: \$40
- Prescription drugs: \$8/\$15
- Per hospital admission: \$150
- Per outpatient surgery: \$0³⁷

Policy Implications

SCHIP full-cost buy-in programs are targeted for children in moderate-income families who receive inadequate medical attention for quite a long time, have no access to employer-sponsored plans, and have income levels above eligibility thresholds for enrollment into public programs.

In theory, taking advantage of administrative efficiencies and the purchasing power generated from pooling with subsidized SCHIP programs, full-cost buy-ins can offer some children a lower-cost coverage alternative than what is available in the private insurance market. However, the program designers have to strike a balance between the premiums charges for buyers and the premiums paid to providers. As part of a public program, a SCHIP full -ost buy-in cannot raise the premiums beyond enrollees' affordability. On the other hand, the program cannot reduce the prices paid to SCHIP providers, who complained that they have reached maximum capacity to serve paying patients.³⁸ This Catch-22 adds to the difficulty in the implementation of the SCHIP full-cost buy-in program in Texas.

There are also several other concerns associated with a SCHIP full-cost buy-in program. One is competition with the private insurance market products. This is the main reason why the full-cost buy-in options in other states are designed to target children. A second issue is the possibility of the influx of unhealthy populations. As mentioned earlier, some ways to address this concern could include a longer waiting period, medical underwriting, pre-existing condition exclusions, and low benefit levels.

Lastly is the potential for blending the state high-risk pool with SCHIP full-cost buy-in programs. It is of important to ensure that a full-cost buy-in does not perform in the function of a high-risk pool. This can be addressed by either directly banning migration from a high-risk pool to a full-cost buy-in program, or by placing some disincentives to switch. Limiting benefits and avoiding premium capping have proved to be effective in some states.

The full-cost buy-in option is not a panacea. Part of reason is that its principal goal is access to insurance, not necessarily affordability. Enrollment in the SCHIP full-cost buy-in component of a state expansion has typically been less than 5 percent of total program enrollment.³⁹

Although the study of these four states cannot fully prove the effectiveness of a full-cost buy-in program in reducing the number of uninsured, the evidence suggests that with the right blend of objectives and design features that reduce the chances of crowd-out and adverse selection, the full-cost buy-in program may be an option to expand coverage without using public funds. Considering full-cost buy-in programs in other states as a percentage of the enrollment of SCHIP, we should also be aware that full-cost buy-in is only a moderate option for expansion. Since the majority of children above 200 percent FPL have parents who are employed, considerable efforts should be made to work with health plans, businesses, and others in the private sector to make health insurance more accessible and affordable to these working families and their children.

Notes

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⁴ Connecticut Department of Social Services, *Connecticut State Health Plan Under Title XXI of the Social Security Act*, by Linda J. Mead (Hartford, Conn., 1998), p. 22.

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⁶ Connecticut Department of Social Services, *Connecticut State Health Plan Under Title XXI of the Social Security Act*, p.24.

⁷ Ibid., p. 91.

⁸ Connecticut Department of Social Services, *Framework for Annual Report of State Children's Health Insurance Plans*, by Adele Kusnitz, and James Gaito (Hartford, Conn., 2000), p. 16.

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¹² Health Policy Tracking Service, *Florida State SCHIP Plan Summary*. Online. Available: <http://state-serve.hpts.org/hpts>. Accessed: December 20, 2001.

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- ²³ New York State Department of Health, *Framework for Annual Report of State Children's Health Insurance Plans Under Title XXI of the Social Security Act: New York*, by Dennis P. Whalen (New York, NY, 2000), p. 13.
- ²⁴ Ibid.
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³³ Ibid.

³⁴ Cleveland Public Power, *Texas CHIP Fast Facts*. Online. Available: <http://www.cppp.org/products/fastfacts/CHIP.html>. Accessed: January 14, 2002.

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³⁶ Sue Hart, Milliman USA, *Options for Expanding Health Insurance in Texas—CHIP Full Cost Buy-In* (paper presented at Texas State Planning Grant Conference, Houston, Texas, January 31-February 1, 2002), p. 6.

³⁷ Ibid., p. 7.

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