Full-Cost Buy-In Options for Optimizing Coverage through NJ FamilyCare

April 2006

State of New Jersey
Department of Human Services

In Collaboration with
Rutgers Center for State Health Policy

Project funded by the U.S. Department of Health & Human Services,
Health Resources and Services Administration,State Planning Grant # 6 P09 OA 00040-02-01

State of New Jersey
Jon Corzine, Governor
Department of Human Services, Kevin M. Ryan, Commissioner

Lead Agency
New Jersey Department of Human Services (NJDHS)

In Collaboration with
Rutgers Center for State Health Policy (CSHP)

Report Prepared by
Dina Belloff, M.A., Research Analyst, CSHP
M. Susan Marquis, Ph.D., Senior Economist - Health Program, RAND Health

Project Leadership
Ann Clemency Kohler, Director, Division of Medical Assistance & Health Services, NJDHS
Dennis Doderer, Deputy Assistant Director, Division of Medical Assistance & Health Services, NJDHS
Joel C. Cantor, Director and Professor, CSHP
Alan C. Monheit, Professor, UMDNJ and CSHP
Margaret M. Koller, Associate Director for Planning, CSHP

Project Steering Committee
Marie Boragine, Project Administrator, Division of Medical Assistance & Health Services, NJDHS
Virginia Kelly, Manager, Office of Research, Division of Medical Assistance & Health Services, NJDHS
Freida Phillips, Special Assistant to the Deputy Commissioner for Family & Community Services, NJDHS
Michelle Walsky, Chief of Operations, Division of Medical Assistance & Health Services, NJDHS
Joseph Tricarico, Jr., Assistant Commissioner, Managed Care & Health Care Finance, NJ Department of Health & Senior Services (NJDHSS)

Acknowledgements

This research was funded by the NJ Department of Human Services with a State Planning Grant from the Health Resources and Services Administration, US Department of Health & Human Services. Special thanks go to Michelle Walsky, Virginia Kelly, and Dennis Doderer of the NJ Division of Medical Assistance and Health Services who contributed their time and considerable expertise toward refining the approach used in this analysis and who provided necessary NJ FamilyCare program information, and Wardell Sanders, former Executive Director, NJ Individual Health Coverage Program and Small Employer Health Benefit Program Boards, who supplied much needed enrollment and premium information for New Jersey's individual health insurance market. We would also like to thank the members of the State Planning Grant Steering Committee who provided guidance on the direction of the project and preparation of this report. Finally, we extend our special thanks to the state officials who shared their experiences and lessons-learned and provided valuable information about their full-cost buy-in programs.

Table of Contents

Full-Cost Buy-In Options for Optimizing Coverage through NJ FamilyCare

Dina Belloff, M.A.; M. Susan Marquis, Ph.D.

Executive Summary

In July 2005, New Jersey's "Family Health Care Coverage Act" established a full-cost buy-in (FCBI) option through NJ FamilyCare for children above 350% of the federal poverty level (FPL) who do not currently qualify for subsidized coverage through NJ FamilyCare. In addition, gubernatorial candidate, Senator Jon Corzine's health care proposal for New Jersey relies heavily on allowing New Jersey's uninsured the option of enrolling in a NJ FamilyCare FCBI option. An FCBI option allows eligible individuals to purchase health insurance coverage through the state's subsidized coverage program for low income families by paying the full cost that the state pays insurers to cover that individual. These FCBI options are intended to be budget neutral for the state, but provide more affordable coverage to enrollees by leveraging the state's health insurance purchasing power.

To assist New Jersey in better understanding FCBI options in general and the potential impact of a NJ FamilyCare FCBI option, Rutgers Center for State Health Policy interviewed eight officials in other states that currently have, or have had FCBI options and reviewed relevant literature to learn more about experiences in other states. In addition, the project team conducted data simulations with the help of RAND, Inc. to estimate enrollment in a NJ FamilyCare FCBI option. This report focuses on five potential FCBI eligibility groups. They include:

- Children above 350% FPL
- Parents 134% to 350% FPL
- Parents 134% FPL and above
- Childless adults 101% FPL to 350% FPL
- Childless adults 101% FPL and above

These groups do not currently qualify for subsidized coverage through NJ FamilyCare. The purpose of these state interviews and data simulations was to provide enrollment estimates and identify best practices in the design of FCBI options in order to maximize enrollment and minimize adverse selection and private market crowd out.

Key Findings

Information gathered through state interviews and review of the literature shows that:

- States with FCBI options offer enrollees the same benefit package with the same cost sharing (co-payments and co-insurance) requirements that they offer subsidized enrollees, but charge FCBI enrollees the full cost that the state pays for these policies.
- Pricing the FCBI option competitively, and perhaps even a little lower than the cost of insurance in the individual market helps to maximize enrollment and minimize the likelihood of adverse selection.
- States with program-wide look-back periods (the period of uninsurance necessary to qualify for enrollment in the state's subsidized insurance program) did not experience adverse selection in their FCBI options because sick individuals would not risk being uninsured in order to qualify for the FCBI option.
- Regulation of the state's individual health insurance market plays a role in preventing adverse risk selection in the FCBI option. States with non-guaranteed issue, non-community rated individual health insurance markets experienced significant adverse selection in their FCBI options because the FCBI was the only affordable health insurance coverage available for many individuals with chronic illness. States with well-functioning high risk pools or guaranteed issue, community rated individual health insurance markets did not experience adverse selection in their FCBI options.
- Other states did not find that the FCBI option resulted in significant crowd out of their private insurance markets.

Data simulations of a NJ FamilyCare FCBI option show that:

- Enrollment in a NJ FamilyCare FCBI could be very high. Estimates indicate that about 23,000 children above 350% FPL might enroll in the new FCBI option next year. If an FCBI option were available for parents 134% FPL to 350% FPL, about 70,000 might enroll, and 87,000 might enroll if the option was open to all parents 134% FPL and above. If an FCBI option were available for childless adults 101% FPL to 350% FPL, about 51,000 might enroll. That number increases to 113,000 if the option was open to all childless adults 101% FPL and above. (These estimates did not account for the possible effect of enrollee preferences with regard to the benefits offered, provider networks, or stigma of enrolling in public health insurance. Also, these estimates did not account for NJ FamilyCare's six-month look-back period prior to enrollment, which applies to group health insurance coverage. If the simulation model were able to take these factors into account, it is possible that enrollment estimates would be somewhat lower. These estimates also

assume that all NJ residents would be aware of the FCBI option, which would clearly not be the case.)

- Enrollees in a NJ FamilyCare FCBI option would be healthier than those currently enrolled in the program, though slightly older. For adults, using premiums based on age and gender for the FCBI option would result in somewhat younger enrollees compared to those who would enroll if an average FCBI premium were charged.
- Simulations of a NJ FamilyCare FCBI option can not accurately determine whether crowd out would occur in New Jersey.

Full-Cost Buy-In Options for Optimizing Coverage through NJ FamilyCare

Dina Belloff, M.A.; M. Susan Marquis, Ph.D.

Introduction

New Jersey's NJ FamilyCare program has among the most expansive eligibility among S-CHIP programs nationwide. The NJ KidCare program was established in 1997 and the NJ FamilyCare program in 2000. This program provided health insurance coverage to children whose family income was at or below 350% of the Federal Poverty Level (FPL), parents whose income was at or below 200% FPL, and childless adults with income at or below 100% FPL. However, because of severe state budget constraints, enrollment of adults without children was frozen in September 2001 and enrollment of parents was frozen in June 2002. Prior to freezing enrollment, demand for adult enrollment was very strong.

Improvements in New Jersey's economy and state budget situation have allowed NJ to reopen enrollment in NJ FamilyCare to parents at or below 133% FPL and childless adults at or below 100% FPL. This expansion was accomplished through the "Family Health Care Coverage Act" (FHCCA), which Acting Governor Richard J. Codey signed into law in July 2005. The FHCCA also created a full-cost buy-in (FCBI) option through NJ FamilyCare for uninsured children above 350% FPL. Under this FCBI, New Jersey will allow uninsured children to enroll in NJ FamilyCare if the families of these children cover the State's cost for enrolling them in the program's managed care plans plus a modest administrative fee. FCBI options are intended to be cost neutral to the state, while allowing eligible individuals to purchase more affordable health insurance coverage by taking advantage of the state's purchasing power with insurers.

This report describes research conducted to evaluate various FCBI options that might allow New Jersey to expand coverage through NJ FamilyCare to those who are not currently income eligible, thereby increasing insurance coverage in New Jersey. Options considered in this research include the newly enacted FCBI for children with family income above 350% FPL, an FCBI for parents 134% FPL to 350% FPL or 134% FPL and above, and an FCBI for childless adults 101% FPL to 350% FPL or 101% FPL and above.

The research presented here is two-fold. First, interviews were conducted with officials in other states that have offered FCBI options for higher income individuals through their state public health insurance programs. This report highlights lessons learned from the experiences of

these states and implications for possible FCBI options in New Jersey. A literature review was also conducted to further understand the extent to which adverse selection and crowd out are relevant concerns for a potential NJ FamilyCare FCBI option. Second, using household and employer data, simulations were conducted to determine likely enrollment in FCBI options for children, parents, and childless adults, and to examine the health risk profile and prior health insurance coverage of these likely enrollees.

Methods

State Interviews

In Fall 2004, Rutgers Center for State Health Policy conducted eight telephone interviews with knowledgeable government officials in other states that currently have or have had FCBI options for some individuals with higher income who are not otherwise eligible for the state's SCHIP or Medicaid expansion programs. These eight states are Connecticut, Florida, Minnesota, New Hampshire, New York, North Carolina, Rhode Island, and Washington.

Table 1 offers a brief description of the FCBI options available in the states that were interviewed, as well as their experiences with enrollment, adverse selection, and crowd out of private coverage. Lessons learned from these interviews are presented in greater detail in the "Findings" section of this report. The interview guide used to collect information from these state officials is included in Appendix A of this report.

New Jersey-Specific FCBI Data Simulations

This section outlines the methods used to simulate enrollment in potential FCBI options for alternative eligibility groups. It first describes the construction of the database, and then explains the methodology used to choose likely FCBI enrollees. These data were prepared and analyzed by M. Susan Marquis, Ph.D. of RAND, Inc.

Constructing the Database

The analysis relies primarily on data collected in the 2001 New Jersey Family Health Survey (NJFHS). However, the analysis requires details about the health insurance benefits and premiums offered by employers to workers in families with persons eligible for the program, which is not available in the NJFHS. The 1997 Robert Wood Johnson Foundation (RWJF) Employer Health Insurance Survey was used to impute details about the offer of employer health

insurance. The imputation involved matching observations in the NJFHS and the RWJF based on characteristics common to both.

Each worker in the NJFHS was synthetically matched to an employer in the 1997 RWJF Employer Health Insurance Survey. Workers were assigned to employers based on industry, size of the business, whether the employer offers insurance as a benefit to workers, the wage and age mix of the workforce at the business, and the worker's wage and age. Employers and workers were assigned to one of 18 industry/size groups. The industry groups consisted of: agriculture/forestry/fishing; trade, professional services, other services, government, and all other industries. All industries except agriculture/forestry/fishing and government were categorized by the number of workers in the business: fewer than 10, 10-25, 26-50, and 51 or more. These 18 industry/size groups were further divided into groups depending on whether the employer offers insurance as a benefit.

Each of the resulting 36 groups was then classified into one of four additional groups based on the wages and ages of the workers in the business: low-wage businesses, those with 1/2 or more workers earning less than $11 per hour (in 2001 dollars) vs. higher-wage businesses, those with fewer than one-half of workers earning less than $11 per hour; young-worker businesses, those with fewer than one-half of workers over age 40, vs. older-worker businesses, those with one-half or more workers over age 40.

In order to carry out the synthetic match of employers and workers, information on the wage of workers, which was not measured in the NJFHS, is necessary. To impute wages to workers, data from the 2000 Current Population Survey (CPS) was used to estimate the relationship between wages and characteristics that are related to wages including: the age, education, and the race/ethnicity of the worker; the business size and industry; and the number of workers in the family and the family total income. For each worker, expected wages were predicted based on this relationship; a random component was added that was drawn from the empirical distribution of residuals from the fitted equation to preserve the appropriate distribution of wages.

A worker in the NJFHS of a given wage and age was probabilistically assigned to an employer with the same industry/size/offer status/type of business and the proportion of workers in the business in the wage and age group as the worker in question. For example, if 20 percent of all young, low-wage workers in the professional service industry who work for a business that offers insurance and has fewer than 10 workers are in a business with predominantly young, low wage, workers, then a particular young low-wage worker is assigned to a small, professional

service, low-wage young-worker business that offers insurance with probability of 0.2. Within the assigned type of businesses, random selection of employers was made.

Determining Enrollment in an FCBI Option

For each individual in the NJFHS, the current (prior to simulating the availability of the FCBI) cost of coverage was determined. If the individual was currently insured, then the cost of that coverage was used. This may reflect the employee premium through an employer-based plan or the individual coverage market premium. If the individual was currently uninsured, then the lowest cost option, not including the FCBI, was used. This would include health insurance coverage options available to that individual through the employer, individual market, or NJ FamilyCare.

The current cost of family coverage was then compared to the cost of the FCBI. More specifically, for adult buy-in eligibility groups, the current cost of coverage would be the total cost for the entire family when the children were not already enrolled in NJ FamilyCare. The rationale for this was that if the family had not taken advantage of the subsidized coverage through NJ FamilyCare as of yet, then they would likely make coverage decisions based on the lowest cost option for the family as a whole. Also, for families currently enrolled in employer-based coverage, if the adult chose to leave that plan then the children would no longer be eligible for coverage through the employer and so the family must be treated as a unit. When the children are currently enrolled in NJ FamilyCare, the cost of family coverage includes only the cost of insuring the adults because the children are already enrolled in the lowest cost option through NJ FamilyCare. For the child eligibility group, the enrollment decision allowed for parents to choose to either enroll the child in the lowest cost family coverage or to separate the children and enroll them in the NJ FamilyCare program if coverage was cheaper that way.

For the currently insured, the simulated FCBI enrollment decision assumed that those currently insured would remain insured and would choose the lowest cost option. Therefore, if the FCBI option were more affordable then they would enroll. A savings threshold of $50 per member per month was used as a tipping point at which it would be reasonable to change insurance plans. This amount is fairly arbitrary, however, $0 was too little to incite people to change insurance plans given the cost of doing so and the potential for having to switch usual care providers, and $100 was too high for a group of lower income individuals who would be more price sensitive. That said, sensitivity analyses were conducted looking at these two savings thresholds in addition to the $50 threshold, and simulated enrollment estimates remain extraordinarily similar regardless of the threshold used.

To determine FCBI enrollment for the currently uninsured, price elasticities were estimated by fitting a take-up model to the NJFHS. This model accounted for the price of coverage, the number of people in the family to be covered, and income. The cost of the FCBI is then compared to the current lowest cost option available and this change in price, combined with the price elasticity calculated and current participation rates in each insurance option, determined the probability that the uninsured family would enroll in the FCBI option. Again, sensitivity analyses were conducted to determine whether different methods of choosing the price elasticity made a difference in the number that would enroll in the FCBI. Elasticities from relevant literature were also used in place of the elasticities calculated using the fitted regression model with the NJ-specific NJFHS data and again, the results were similar, indicating that the simulated enrollment estimates are robust.

Comparing Costs of FCBI, Employer, and Individual Coverage

To better understand the results of these simulations it is necessary to understand the products and pricing that were compared in arriving at enrollment decisions. Premium information for the employer-based insurance market was taken directly from the RWJF Employer Health Insurance Survey described above. Premium information for the individual health insurance market was derived from enrollment and premiums provided by the NJ Department of Banking and Insurance. The simulations utilized age-gender rated premiums for the Basic & Essential (B&E) plan in the individual market and created weighted average premiums by family structure, age, and gender, based on enrollment. These employer-based and individual health insurance premiums are based on a heterogeneous mix of insurance plans with varying benefits.

The FCBI premium was calculated by the NJ Division of Medical Assistance and Health Services, using the January to June 2006 NJ FamilyCare Part D individual premiums that the state pays to its managed care carriers, plus the state's costs of coverage for AIDS drugs and maternity. These FCBI premiums were based on a benefit package that does not include physical therapy, occupational therapy, speech therapy, mental health, or abortion. A 5.3% administrative fee was then added to this total premium. The simulations were then conducted using both the average premium for current NJ FamilyCare Part D enrollees for adults and children and then separately by age group for children (less than 2 years old and 2 to 18 years old) and age-gender groups for adults (women less than 45 years old, men less than 45 years old, and men and women 45 years and up).

Caveats

Caveats related to the NJ FamilyCare FCBI analysis result in the expectation that actual enrollment in any FCBI option would be less than the estimates that these simulations yield. As a result, the findings presented in this report focus on the group of likely FCBI enrollees that were previously uninsured as a mid-point of enrollment estimates and because the caveats presented here would have less of an impact on the uninsured than on those currently enrolled through an employer or an individual health coverage plan. The caveats discussed here, in particular the six-month look-back period, provide reason to believe that those currently insured through an employer or the individual market would be less likely to enroll in an FCBI option than those who are uninsured.

1. Preferences. The FCBI simulations were unable to take personal preferences into account when simulating enrollment decisions for those currently insured through an employment-based or individual health insurance plan. For example, the scope of benefits or provider networks offered through other plans may differ from those offered through the NJ FamilyCare FCBI option. This analysis did not take those personal preferences into account, but based enrollment "decisions" on cost alone. Moreover, some families may have pre-conceived feelings about enrolling in a public health insurance plan, which might affect their decision-making more strongly than cost savings.
2. Six-Month Look-Back Period. The NJ FamilyCare program currently has a 6-month look-back period before allowing uninsured individuals to enroll. Again, these simulations were unable to consider in the FCBI enrollment "decision" whether a family might choose not to enroll in the FCBI because they do not want to risk being uninsured for six months in order to qualify.
3. Information Gap. These simulations assume that all eligible families will have perfect information about the FCBI option and other insurance options available to them and will make their "decision" based on the cost of all available plans. In reality, families rarely have perfect information and it is likely that many will not be aware of the FCBI option, particularly if New Jersey chooses not to publicize its availability.

Findings

Design and Implementation of FCBI Options

As stated earlier, New Jersey is currently planning the implementation of a NJ FamilyCare FCBI option for children above 350% FPL in an effort to maximize insurance coverage for children in the state. New Jersey, like other states discussed here, has not experienced significant opposition to implementation of this FCBI option, although insurers participating in NJ FamilyCare continue to be concerned about the potential for adverse selection and additional costs that this group might incur. New Jersey is planning to charge FCBI enrollees the full managed care cost of enrolling NJ FamilyCare Part D individuals, plus the cost of providing coverage for AIDS drugs and maternity, and an additional 5.3% to cover administrative costs. The co-payments and co-insurance for FCBI enrollees would be the same as for Part D enrollees. However, certain benefits that the state covers separately from those services covered by NJ FamilyCare health plans would not be included in this FCBI, including physical therapy, occupational therapy, speech therapy, mental health, and abortion.

The target population and design of FCBI options varies considerably across the eight states interviewed for this report (see Table 1). All eight states offered FCBI options for individuals with higher income who were not otherwise eligible for the state's SCHIP or Medicaid expansion programs. Most states only offered the buy-in option to children, with two states (MN, NC) limiting it to children previously in the state's Medicaid/SCHIP program. Only Washington and Rhode Island offered the FCBI to adults, and Rhode Island only offered it to pregnant women.

The following are some lessons learned from other states about benefit design and administration of FCBI options.

- **Reasons for enacting an FCBI option –** Some states implemented FCBI options to help self-employed families purchase insurance and to leverage state purchasing power.
- **Challenges to enacting an FCBI option -** None of the states reported any significant challenges to enacting their FCBI option from health insurers or the business community. After implementation of the FCBI option, health insurers in Florida and Washington became concerned about adverse selection among enrollees. This is discussed further in the section on adverse selection below.
- **Premiums -** Premiums for the FCBI in most states were very close or equal to what the state pays to insure subsidized enrollees in the state plan. Florida, New York, and

North Carolina charged FCBI enrollees the exact same premium as for subsidized enrollees. Connecticut's was a little higher; Minnesota's a little less. New Hampshire added on a $5 per member per month (pmpm) administration fee to cover the state's administrative costs for determining eligibility and enrollment. In Washington, premiums for the FCBI grew, as enrollment became more high risk. Eventually, insurers left the market. Washington did charge a $10 pmpm administration fee for adults while the program was active.

- **Cost sharing and benefit design –** Cost sharing in all states with active FCBI options was the same as the cost sharing requirements of those enrolled in the subsidized portion of the state plan. However, cost sharing in Washington's FCBI was considerably higher than the subsidized plan. All states offered the same benefit package under the FCBI as for their subsidized enrollees. However, Rhode Island's FCBI for pregnant women did not cover maternity and prenatal care services through the state plan, but paid for these on a fee-for-service basis, up to $6,000.
- **Federal match –** Most states did not get a federal match for FCBI enrollees because they were no cost to the state. Only Minnesota received a small federal match for costs incurred by the state for FCBI enrollees because the premiums for the buy-in group were not quite full-cost. The premiums were a little lower than full-cost, since they picked a round number for premiums that did not reflect the true variation in charges by insurers across demographic characteristics and geographic areas. Minnesota was also the only state that filed a waiver with CMS in order to have an FCBI.
- **Eligibility determination, enrollment, and billing –** In all cases, the state determined eligibility through the same system, either within the state or through a third-party administrator, as they did for their subsidized plan. In New York, insurers handled SCHIP applicant and enrollee administration and also conduct these functions for the FCBI. In most cases the state or third-party administrator billed FCBI enrollees for premiums on a monthly basis. The only exceptions to this were New York and Connecticut where the insurer billed program enrollees for their portion of the premium. In all states, enrollees who neglected to pay premiums were disenrolled from the program, though this had not been a significant problem in any of the states.

Table 1: States that Offer Full-Cost Buy-In Options for their SCHIP or Medicaid Expansion Programs

Program (Year FCBI Began)	**Eligibility** (% FPL)	**Premiums** (per member per month)	**Outreach**	**Adverse Selection / Crowd Out**	**Enrollment** (Fall 2004 / % SCHIP/Medicaid Enrollment)
Connecticut HUSKY Part B (1998)	Children 0-19 Above 300%	Premium varies between $158 and $230 depending on insurer and is calculated separately from the subsidized charge (a little higher) with no administrative costs added on.	Publicize FCBI in program-related literature.	No adverse selection / No crowd out.	~540 / 3.5%
Florida Healthy Kids - KidCare (1992)	Children 5-19 Above 200%	Premium is on average $107 depending on insurer and is the same as the subsidized charge with no administrative costs added on.	Only those who inquire about subsidized program learn of FCBI.	Adverse selection / Minimal crowd out.	~5,900 / ~2%
Minnesota MinnesotaCare (1992)	Children 0-20 enrolled whose income goes above 275%	Premium is $300, up to $900 max per family and is calculated separately from the subsidized charge (a little less on average) with no administrative costs added on.	State does not publicize FCBI.	No adverse selection / No crowd out.	316 / <1%
New Hampshire Healthy Kids Silver Buy-In (1995)	Children 1-19 300% - 400%	Premium is $115 and is calculated separately from the subsidized charge (about the same) with $5 added on for administrative costs.	Publicize FCBI in program-related literature.	No adverse selection / No crowd out.	1,278 / 16.8%
New York Child Health Plus Part B (1991)	Children 0-19 Above 250%	Premium is $122 and is the same as the subsidized charge with no additional administrative costs added on. (Insurers do all enrollment and costs already included.)	Only those who inquire about subsidized program learn of FCBI.	Adverse selection not measured / Crowd out not measured.	6,760 / 3.2%
North Carolina Health Choice for Children (1998)	Children 0-19 enrolled whose income goes above 200%	Premium is $168.85 and is the same as the subsidized charge with no administrative costs added on.	State does not publicize FCBI.	Adverse selection / No crowd out.	94 / <1%
Rhode Island Rite Care (1994)	Pregnant women 250% - 350%	Premium is $140.	Not Available to complete interview.	Not available to complete interview.	~12 / <1%
Washington Basic Health Plan (1994 - 2003)	Adults and Children 0-19 Above 200%	In 2001, the adult premium was $260 and was calculated separately from the subsidized charge (a lot more) with $10 added on to the adult premium for administrative costs.	Publicized FCBI in program-related literature and offered brokers a commission for enrolling people in the plan.	Adverse selection caused insurers to leave market entirely / No crowd out.	419 / <1% (in 2003) 25,399 / ~16% (in 1997)

Note: Information based on qualitative interviews with government officials in the Fall 2004.

Enrollment in FCBI Options

Experiences of Other States

Enrollment in FCBI options varied considerably across states (see Table 1). Connecticut, Florida, New Hampshire, New York, and Washington had high FCBI enrollment, defined as enrollment that is greater than 1% of total, both subsidized and unsubsidized, program enrollment. Minnesota, North Carolina, and Rhode Island had low FCBI enrollment, or enrollment that is less than 1% of total program enrollment. The following are factors that seemed to impact FCBI enrollment.

- **Tight eligibility criteria resulted in lower FCBI enrollment.** Minnesota, North Carolina, and Rhode Island had low enrollment due in large part to tight eligibility criteria. Minnesota and North Carolina only enrolled children who were enrolled in the state Medicaid or SCHIP program but no longer qualified because increases in family income placed them above the eligibility threshold. In fact, North Carolina only covered these children for up to one year. Rhode Island's program was only for pregnant women between 250% FPL and 350% FPL.
- **Advertisement of the FCBI option was not associated with greater enrollment.** Connecticut, New Hampshire, and Washington publicized their FCBI option in program-related brochures and literature. All three states had high enrollment relative to their subsidized program. However, Florida, Minnesota, New York, and North Carolina did not publicize the FCBI option, but instead informed potential enrollees of the FCBI when they inquired about SCHIP/Medicaid eligibility. Florida and New York had high enrollment in their FCBI options, while Minnesota and North Carolina did not. As discussed earlier, lower enrollment in Minnesota and North Carolina was likely due to tighter eligibility criteria in both states and not the extent to which the option was publicized.
- **Cost of enrolling in the FCBI option impacted enrollment.** States with higher enrollment, including Florida, New Hampshire, and Washington, reported that the FCBI premium was lower than the cost of purchasing insurance in the state's private market. Connecticut and Minnesota found that take- up was lower than expected because larger families still had to pay premiums per child and might find cheaper family coverage elsewhere. North Carolina believed that lower than expected take-up of the FCBI option was because parents who inquired about subsidized insurance

coverage could not afford to pay a full premium for coverage, they were looking for very low cost coverage and the FCBI did not meet this need.

- **Only two states made any changes in reaction to FCBI enrollment.** In order to increase enrollment, Connecticut reduced its six -month look back period (required period of uninsurance before enrolling in the FCBI option) to a two-month look back period. This change did not have much impact on enrollment. In order to limit further growth in FCBI enrollment, the Florida legislature capped enrollment in the state's FCBI option to control rising costs among these enrollees.
- **Most states did not find that particular demographic groups were more or less likely to enroll in the FCBI option**. However, a few did mention that self employed families were more likely to enroll. In addition, families with only one or two children were more likely as well since per child premiums might make coverage through the state program more expensive for larger families than purchasing family coverage in the private market.

The experiences of other states show that enrollment in a NJ FamilyCare FCBI option can be maximized by allowing a broad group of individuals to buy-in and keeping the cost of enrolling in the FCBI affordable compared to private insurance premiums. The NJ FamilyCare FCBI for children meets both of these conditions in that a large group of children would be eligible for the option and the cost of enrolling would be relatively affordable.

Simulation of NJ FamilyCare FCBI Options

Enrollment in a NJ FamilyCare FCBI could be very high. Table 2 shows estimated enrollment in an FCBI option for children above 350% FPL, parents from 134% FPL to 350% FPL, parents from 134% FPL and above, childless adults from 101% FPL to 350% FPL, and childless adults from 101% FPL and above.[1] However, the actual number of FCBI enrollees would be closer to the number estimated for the previously uninsured. As was discussed in the "Methods" section of this report, three important caveats illustrate that enrollment in an FCBI option would likely remain significantly less than the maximum number estimated by these simulations. In particular, movement from employer-based and individual health insurance plans to the FCBI option would be limited. Although these factors might also serve to limit enrollment of the uninsured, the impact would be greatest on those who are currently insured through an employer or the individual health coverage market. In particular, the six-month look-back period would have a strong impact on those currently insured through an employer.

1. These simulations could not account for preferences among eligible enrollees. The simulations essentially assume that the insurance products are the same and that the only difference is the cost. However, the benefits offered by the plans may differ as well as the provider networks and other characteristics. Whether a potential FCBI enrollee is interested in the benefit package offered is a matter of preference, which can not be simulated. Similarly, FCBI-eligible individuals may have preferences about enrolling in public health insurance that limit their likelihood of taking advantage of the FCBI option, which also can not be simulated.
2. As noted, NJ FamilyCare has a six-month look-back period to help reduce crowd out of the private insurance market. This provision makes it unattractive for families to switch from group coverage to the FCBI because they would have to risk being uninsured for six months, which is particularly undesirable for families with a member who is chronically ill.
3. Not all FCBI-eligible individuals will become aware of their eligibility for the FCBI option, limiting the number who would actually enroll.

Taking these caveats into account, it seems likely that a more accurate projected enrollment in a NJ FamilyCare FCBI option would be roughly equal to the number of estimated enrollees who were previously uninsured. About 23,000 children might enroll in an FCBI option for children above 350% FPL. About 70,000 might enroll in an FCBI option open to parents 134% to 350% FPL, while about 87,000 parents above 133% FPL might enroll if the option was available to them. Similarly, about 51,000 childless adults with income between 101% and 350% FPL might enroll in an FCBI option, while 113,000 might enroll if the option were open to all childless adults over 100% FPL.

Table 2: Estimates of Enrollment in a NJ FamilyCare FCBI Option

	New Enrollees Using Age-Gender Based Premiums	New Enrollees Using Average Child/Adult Premium
Children Above 350% FPL		
Maximum Enrollees	75,300	79,600
Previously Employer Group	36,295	37,492
Previously Individual[b]	15,813	18,865
Previously Uninsured	23,192	23,243
-Previously Uninsured 6 Months or More[c]	15,286	15,283
Parents 134-350% FPL		
Maximum Enrollees	196,300[a]	171,700
Previously Employer Group	82,446	52,025
Previously Individual[b]	44,168	44,127
Previously Uninsured	69,687	75,548
-Previously Uninsured 6 Months or More[c]	55,357	61,812
Parents 134% FPL and Above		
Maximum Enrollees	246,000	236,400
Previously Employer Group	103,320	71,629
Previously Individual[b]	55,350	60,755
Previously Uninsured	87,330	104,016
-Previously Uninsured 6 Months or More[c]	69,372	85,104
Childless Adults 101-350% FPL		
Maximum Enrollees	146,100[a]	143,000
Previously Employer Group	58,732	53,339
Previously Individual[b]	36,671	45,331
Previously Uninsured	50,551	44,330
-Previously Uninsured 6 Months or More[c]	35,795	26,741
Childless Adults 101% FPL and Above		
Maximum Enrollees	357,200	339,500[a]
Previously Employer Group	166,098	173,485
Previously Individual[b]	77,870	86,233
Previously Uninsured	113,232	79,783
-Previously Uninsured 6 Months or More[c]	35,720	26,821

[a] Columns do not add exactly because of rounding. [b] The NJFHS contains an overrepresentation of the number of people enrolled in the individual health insurance market because some with coverage through NJ FamilyCare misreported that they had an individual health insurance policy. [c] This measure in the NJFHS is actually uninsured six months or more during the past year. These are most often consecutive months. This number is a subset of the previously uninsured number.

Crowd Out of Private Insurance Coverage

Experiences of Other States

None of the states interviewed reported notable crowd out of private insurance coverage as a result of their FCBI option. Enrollment in the FCBI, in some states, was so small that meaningful crowd out of private insurance could not have occurred. Furthermore, states with FCBI options benefited from provisions in their subsidized programs that prevented crowd out. Many states attributed program-wide look-back or waiting periods during which individuals may not have had private coverage prior to enrollment in the FCBI as a significant deterrent to crowd out. Minnesota officials felt that crowd out did not occur in their state because premiums for the FCBI option were similar to those in the private insurance market and they did not allow people to enroll in the FCBI if their employer contributed at least 50% toward employer-based coverage.

While states have conducted little formal investigation of the impact of offering an FCBI option on crowd-out of the private health insurance market, research on crowd out due to subsidized state health insurance programs has been inconclusive. Researchers from the State Health Access Data Assistance Center (SHADAC) with support from The Robert Wood Johnson Foundation recently published a synthesis of research findings on public program crowd out of private insurance coverage and found that public programs with higher income thresholds (above 200% FPL) are more likely to result in some crowd out than those with lower income thresholds (under 100% FPL) because enrollees with higher income are more likely to have viable private coverage options, while those with lower income find private coverage to be too costly or not available to them.[2] Researchers found that many states implemented policies in their public programs to reduce the likelihood of crowd out including cost sharing requirements and look-back periods. However, there are no current estimates measuring the effectiveness of these policies.

In summary, the experiences of other states indicate that crowd out under a NJ FamilyCare FCBI would be negligible since NJ FamilyCare has anti-crowd-out provisions, including a six-month look-back period.

Simulation of NJ FamilyCare FCBI Options

Determining the number of people who would drop their current insurance coverage in order to qualify for a NJ FamilyCare FCBI is not possible given the constraints of these simulations. As discussed earlier, the six-month look-back period imposed by NJ FamilyCare would serve as a significant deterrent to switching from an existing employer-based insurance

plan to the FCBI option because the family would have to risk being uninsured for that period of time. Furthermore, individual preferences might lead many currently covered individuals to stay with their current coverage. Finally, imperfect information means that many who qualify for the FCBI, by way of their family income, may not be aware that the option exists since they are currently insured and would not have reason to contact NJ FamilyCare to inquire about coverage.

The results of these simulations, accounting only for responses to price without consideration of the other pertinent constraints, predict that at most 9% of individuals with employer-based health insurance would enroll in the FCBI. Moreover, given large price differentials with the individual market, the model predicts that at most 70% of those with non-group coverage would enter the FCBI. However, given the limitations of these simulations, it is impossible to determine the long-term ramifications of a NJ FamilyCare FCBI option on crowd out.

Adverse Selection in FCBI Options

Lessons Learned from States with Higher Risk FCBI Enrollees

Officials interviewed in three states reported experiencing adverse selection - Florida, North Carolina, and Washington. Adverse selection problems in Florida and Washington were so severe that Florida capped enrollment and Washington's FCBI is now inactive.

Due to adverse selection, in 1998, Washington de-linked the premiums of the subsidized and non-subsidized programs in the Basic Health Plan and allowed insurers to close their non-subsidized products to new enrollees. This change was followed by premium increases for the FCBI of 70% in 1998 and 62% in 1999.[3] Numerous plans also stopped offering coverage to new enrollees. By 2003, all plans had ceased offering coverage under the FCBI, thus ending the program, though it is still active in state regulation.

The unraveling of Washington's FCBI option was strongly related to market regulation in their individual health insurance market. Between 1995 and 2000, rate regulation in the individual market was replaced with a minimum medical loss ratio of 72% and medical underwriting was allowed.[4] Sick individuals rejected from the individual market could seek coverage through the state's high risk pool, but the premiums were unaffordable for many. Because of this, many sick individuals chose to enroll in the Basic Health Plan FCBI option, which was more affordable than the state's high risk pool. Therefore, the FCBI eventually became a high risk pool until insurers halted their participation in the program.

In Florida, FCBI enrollees were sicker than subsidized enrollees and the state was concerned about their impact on premiums for subsidized enrollees. Insurers worried about high cost cases coming in through the FCBI option. Florida's legislature believed that enrollees in the FCBI program should purchase coverage in the private market, and as a result of their concern about adverse selection in the SCHIP program, they capped FCBI enrollment. As was the case in Washington, Florida's individual health insurance market had no guaranteed issue provision. Applicants could be turned away or only offered limited coverage because of their health status.[5] Pre-existing condition exclusions also apply in Florida. Because of weaker market regulation, families with sick children were likely to seek coverage through the state's FCBI option where premium rating was based on the costs of all children in the SCHIP program. The cap on FCBI enrollment eliminated this coverage option for many sick children.

North Carolina has also found that FCBI enrollees cost more than subsidized enrollees, but they chose not to do anything about it because there were so few enrollees in the FCBI option that their costs had little impact on the program in general. As in the two other states experiencing adverse selection in their FCBI options, North Carolina allowed health rating in its individual health insurance market and did not require guaranteed issue.[6] Unlike Washington and Florida, North Carolina did require Blue Cross Blue Shield to guarantee issue in the individual market. However, since Blue Cross Blue Shield was also permitted to medically underwrite the premiums, this plan effectively became a high risk pool. Because of the difficulty in finding affordable coverage in North Carolina's individual market, sick children were likely to enroll in the FCBI option when it was available to them.

Officials in all three states reporting adverse selection indicated that their programs attracted comparatively high risk individuals because their FCBI options offered a rich benefit package at a much lower cost than that found in the private market. Unlike New Jersey, all three states had nearly unregulated individual health insurance markets where individuals could be rejected by private insurers based on health status or charged very high premiums for coverage. These market conditions make enrollment in the FCBI option the only affordable choice for sick individuals that qualify, so it is understandable that these programs experienced adverse selection. These three states were also the only states that did not enforce look-back periods to prevent adverse selection. Families with chronically ill children would not risk being uninsured for a few months in order to qualify for the state's FCBI option because it is too likely that their child may need costly care during that time period. Because Florida, North Carolina, and Washington did not enforce look-back periods, chronically ill children could move directly from more costly private coverage to the FCBI plan.

Lessons Learned from States with Lower Risk FCBI Enrollees

Officials in three other states did not report adverse selection – Connecticut, Minnesota, and New Hampshire. The Connecticut official felt that their program's look-back period was a deterrent to enrollment of higher risk children because families with chronically ill children would not want to risk leaving their child uninsured for months in order to qualify for the state's FCBI. In general, all three states enforced look-back periods for their program in general.

Two of the three states that did not experience adverse risk selection, Minnesota and New Hampshire, offered affordable alternative coverage to individuals who were high risk, therefore protecting the FCBI option from becoming a de facto high risk pool. Both Minnesota and New Hampshire allowed rating based on health status in their individual health insurance markets and did not guarantee issue.[7, 8] However, both maintained functioning high risk pools, the Minnesota Comprehensive Health Association and the New Hampshire Health Insurance Risk Pool. These high risk pools offered comprehensive coverage to individuals and dependents that qualified for coverage through HIPAA and/or were rejected by the state's individual insurance market, or were offered coverage that was more costly than coverage through the high risk pool. Premiums for the high risk pool, while much higher than those offered through the state's individual health insurance market, were reasonable. (Connecticut also maintained a high risk pool for otherwise uninsurable adults.[9] However, children did not qualify for the high risk pool and adults were not eligible to enroll in the FCBI option so the high risk pool did not serve as a potential alternate source of coverage for sick children.)

New York had not yet measured adverse selection among only FCBI enrollees. However, New York's individual health insurance market is guaranteed issue and community rated.[10, 11] Therefore, sick individuals can get coverage in the individual market and their premium rate is reasonable because it is based on the average risk of all enrollees.

It is likely that adverse selection under a NJ FCBI would be minimal. Insurers in NJ's individual health insurance market are required to issue community rated policies to all individuals that apply regardless of health status. So, higher risk enrollees would not be forced to seek coverage through the state's NJ FamilyCare FCBI option. Moreover, despite comparatively high premiums in New Jersey's individual market, new plan offerings (the Basic and Essential Plan) provide access to more affordable age-rated individual coverage. In addition, NJ FamilyCare already has a six-month look-back provision to prevent chronically ill individuals from switching from a more costly private insurance plan to a more affordable FCBI option.

Simulation of NJ FamilyCare FCBI Options

Table 3 shows comparisons of the predicted FCBI enrollees who were previously uninsured and current NJ FamilyCare enrollees. This comparison provides the best picture of possible risk selection in an FCBI because, as discussed in the "Enrollment" section of this report, it is likely that actual FCBI enrollment would come largely from this group. This comparison also provides a good test for risk selection because, on average, the uninsured have lower health status than people with private coverage. More detailed demographic comparisons for these eligibility groups are included in Appendix B of this report. Similar comparisons were conducted for the maximum number of predicted enrollees (i.e., including those with prior private coverage) and, with those larger sample sizes, differences in most demographic measures between new enrollees and existing NJ FamilyCare enrollees were statistically significant. Risk findings for this larger group are similar to those limited to likely FCBI participants who were previously uninsured.

Findings indicate that risk selection among FCBI enrollees, as measured by self-reported health status, is expected to be *better* than that of current NJ FamilyCare enrollees (Medicaid and SCHIP). For children above 350% FPL, about 75% of likely FCBI enrollees report having "Excellent" or "Very Good" health, while only 57% of current NJ FamilyCare enrollees report the same. For parents who might enroll in a NJ FamilyCare FCBI option, between 83% and 85% report having "Excellent" or "Very Good" health, while only 68% of parents currently enrolled in FamilyCare report the same. For childless adults who might enroll in a NJ FamilyCare FCBI option, between 77% and 85% report having "Excellent" or "Very Good" health compared to 58% of childless adults currently enrolled in NJ FamilyCare. One reason for favorable risk selection among new enrollees is their higher income profile, which is generally associated with better health. In addition, the children who would enroll in NJ FamilyCare as a result of their parents enrolling in an FCBI option would be few and their health status would be better than children currently enrolled in NJ FamilyCare.

For children above 350% FPL, likely enrollees in an FCBI option would be older than children currently enrolled in NJ FamilyCare, 61% would be age 13 to 18, compared to 25% of children currently enrolled in NJ FamilyCare who are between those ages. For parents, likely enrollees in an FCBI option would be only somewhat older than currently enrolled NJ FamilyCare parents, between 24% and 34% of likely FCBI enrollees would be age 45 and older compared to 17% among parents who are currently enrolled and in that age group. For childless adults, the age distribution depends more heavily on the method of pricing the FCBI option. If the age-gender based premiums were used, then the age distribution for childless adults would be

younger than the distribution for currently enrolled childless adults; i.e., between 36% - 39% would be age 45 and older, compared to 68% for currently enrolled childless adults. However, if the average premium were used then the age distribution would be quite a bit older; i.e., 85% - 92% would be age 45 and older, compared to 68% who are currently enrolled and are 45 and older.

Pricing the FCBI premiums differently based on age and gender improves the risk selection among those who enroll. Table 3 shows that while the self-reported health rating is similar among those who enroll regardless of whether the age-gender based premium or the average premium is used, the group of likely enrollees is much older using the average premium than it would be if the age-gender based premiums were used. Since older age is generally associated with higher expected expenditures among adults, using average premiums would likely lead to higher plan costs. The method of pricing premiums has little impact on average health status or age among previously uninsured children or among the maximum group of likely enrolled children, for which these findings are statistically significant.

Table 3: Comparison of Health and Age of Likely FCBI Enrollees Who Were Previously Uninsured to Current NJ FamilyCare Enrollees

	NJ FamilyCare Current Enrollees	New Enrollees Using Age-Gender Based Premiums	New Enrollees Using Average Child/Adult Premium
Children Above 350% FPL[a]			
Health Status			
Excellent/Very Good	56.9 %	74.8 %	74.8 %
Good/Fair/Poor	43.1 %	25.2 %	25.2 %
Age		*	*
Under 13	75.0 %	38.8 %	38.8 %
Age 13-18	25.0 %	61.2 %	61.2 %
Parents 134-350% FPL[b]			
Health Status			
Excellent/Very Good	68.2 %	82.6 %	82.5 %
Good/Fair/Poor	31.8 %	17.4 %	17.5 %
Age			
Age 19-34	59.2 %	44.4 %	40.9 %
Age 35-44	23.6 %	32.0 %	28.9 %
Age 45 and Up (excluding Medicare)	17.2 %	23.6 %	30.2 %
Parents 134% FPL and Above			
Health Status		*	*
Excellent/Very Good	68.2 %	84.4 %	85.1 %
Good/Fair/Poor	31.8 %	15.6 %	14.9 %
Age			*
Age 19-34	59.2 %	45.2 %	39.7 %
Age 35-44	23.6 %	30.8 %	26.6 %
Age 45 and Up (excluding Medicare)	17.2 %	24.0 %	33.7 %
Childless Adults 101-350% FPL[b,c]			
Health Status		*	
Excellent/Very Good	58.4 %	80.4 %	77.8 %
Good/Fair/Poor	41.6 %	19.6 %	22.2 %
Age		*	
Age 19-34	18.7 %	29.0 %	14.6 %
Age 35-44	13.9 %	34.7 %	0.0 %
Age 45 and Up (excluding Medicare)	67.5 %	36.3 %	85.4 %
Childless Adults 101% FPL and Above[c]			
Health Status		*	*
Excellent/Very Good	58.4 %	85.3 %	76.7 %
Good/Fair/Poor	41.6 %	14.9 %	23.3 %
Age		*	*
Age 19-34	18.7 %	25.0 %	8.1 %
Age 35-44	13.9 %	36.5 %	0.0 %
Age 45 and Up (excluding Medicare)	67.5 %	38.5 %	91.9 %

Note: Except where noted, estimates are based on sample sizes of 50 or more. Care should be used in interpreting estimates based on small sample sizes. [a] Estimates based on fewer than 25 likely FCBI enrollees. [b] Estimates based on fewer than 50 likely FCBI enrollees. [c] Estimates based on fewer than 50 NJ FamilyCare enrollees.
*Comparison is statistically significant.

Summary of Key Findings and Implications

Interviews with officials in other states and data simulations of a NJ FamilyCare FCBI option provide valuable insight for optimal design and enrollment of FCBI options, as well as methods for limiting crowd out of private insurance coverage and minimizing adverse risk selection. Though some constraints must be considered to fully understand the limitations of this report's simulation findings, these results provide noteworthy perspective for implementing a NJ FamilyCare FCBI option. This report is particularly timely in light of the fact that the FCBI option for children above 350% FPL will become active in January 2006.

In summary, the data simulations reported here could not account for three factors that could play a critical role in people's decision-making with regard to health insurance enrollment. For one, the simulations could not account for people's preferences in terms of plan design or their source of health insurance coverage, be it through an employer, the individual market, or a public health insurance program. Second, the simulations could not account for the six-month look-back period, which New Jersey enforces in its NJ FamilyCare program. And finally, the simulations could not account for the probable difficulties of reaching potentially eligible New Jersey residents with information about the new NJ FamilyCare FCBI options.

Interviews with FCBI officials in other states show that most states with FCBI options charge enrollees the same premiums that they pay insurers to cover their highest income subsidized enrollees. A few states added on an administrative fee to the FCBI premium. They also enroll FCBI participants in the same insurance plans with identical cost-sharing (co-payments and co-insurance) mechanisms and benefits as subsidized enrollees. New Jersey is planning a similar approach with its upcoming FCBI option for children above 350% FPL, though there are a few noteworthy differences. New Jersey will charge the full NJ FamilyCare Part D premium for FCBI enrollees, including the costs of AIDS drugs and maternity, plus a 5.3% administrative fee. However, New Jersey will not include mental health services, physical, occupational, and speech therapies, or abortion coverage in the benefit package for FCBI enrollees, as it does for subsidized enrollees.

Other states found that tight eligibility criteria, understandably, limited enrollment in their FCBI options. New Jersey's upcoming FCBI option will be open to all uninsured children above 350% FPL, so enrollment may be significant. In fact, simulations show that enrollment for this group may be as high as 23,000 children. Simulations show that if a NJ FamilyCare FCBI option for adults were available, enrollment could be three or four times higher than for children, depending on income eligibility ranges for the benefit.

The cost of enrolling in an FCBI option has a strong impact on the success of the FCBI option. State interviews show that the cost should be competitive and even somewhat less than what is available in the individual insurance market in order to optimize enrollment and to prevent adverse risk selection among the FCBI enrollees. New Jersey's FCBI option for children seems to meet this criterion.

Other states report that crowd out of the private insurance market as a result of their FCBI option was not significant for two reasons. For one, enrollment in their FCBI options was so small relative to the size of their private markets that even if crowd out was occurring, the impact on the market was small. And secondly, officials in states with program-wide look-back periods felt that crowd out was limited because people did not want to forego health insurance coverage in order to qualify for the state's FCBI option. Because NJ FamilyCare FCBI simulations could not account for this look-back period, preferences, or lack of information, findings for crowd out of the private insurance markets should be interpreted with caution. The factors not accounted for in the modeling, however, would on balance tend to discourage crowd out.

Look-back periods were also praised by officials in other states for helping to minimize adverse selection in their FCBI options. The NJ FamilyCare program currently has a six-month look-back period prior to enrollment in the program, which will help prevent adverse selection in the upcoming FCBI option for children.

In addition, the ability of sick individuals to get health insurance coverage through the state's individual health insurance market played a critical role in the prevalence of adverse selection in other state's with FCBI options. States with non-community-rated, non-guaranteed issue health insurance markets were much more likely to have significant problems of adverse selection in their FCBI options because this was the only form of affordable coverage available to chronically ill individuals who needed access to health care. States with well-functioning high risk pools or community-rated, guaranteed issue individual health insurance markets were far less likely to experience adverse selection in their FCBI options. New Jersey currently has a stable individual health insurance market, with regulations that provide guaranteed issue and community-rating. So, it is unlikely that New Jersey will experience significant adverse selection among FCBI enrollees so long as FCBI premiums remain competitive with, even somewhat below, premiums in the individual health insurance market.

In fact, simulations of NJ FamilyCare FCBI options predict that enrollees would be healthier than current NJ FamilyCare enrollees, though slightly older. Furthermore, using age-gender based FCBI premiums for adult FCBI options would result in a younger mix of enrollees

than using an average adult premium, since this rating makes the insurance product more affordable, and therefore, more attractive to younger adults.

In conclusion, findings from state interviews and data simulations indicate that a NJ FamilyCare FCBI option could yield considerable enrollment without significant adverse selection. Methodological and data limitations did not permit a conclusive analysis of possible crowd out implications of an FCBI option for employer-based or individually purchased coverage.

Endnotes

[1] Adult income ranges up to 200% FPL are not included here because sample sizes were too small for meaningful analysis.
[2] Davidson, G.;Blewett, L.A.; and Call, K.T. *Public program crowd-out of private coverage: What are the issues?*. Research Synthesis Project Report No. 5. The Robert Wood Johnson Foundation. June 2004.
[3] Madden, C.; Katz, A; Gardner, M.; and Birnbaum, A. *Lessons in the Health Care Financing Reform: The Washington State Experience.* University of Washington. Unpublished manuscript, March 2003.
[4] Kane, N.M.; Turnbull, N.C. *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Short Case Studies of Six States*. Commonwealth Fund, Unpublished Draft Based on Long Version, October 2004.
[5] Georgetown University Health Policy Institute. *A Consumer Guide to Getting and Keeping Health Insurance in Florida, Chapter 3. Your Protections When Buying Health Insurance.* www.healthinsuranceinfo.net/fl03.html. Last updated June 2004. Accessed 12/22/2004.
[6] Georgetown University Health Policy Institute. *A Consumer Guide to Getting and Keeping Health Insurance in North Carolina, Chapter 3. Your Protections When Buying Health Insurance.* www.healthinsuranceinfo.net/nc03.html. Last updated February 2001. Accessed 12/22/2004.
[7] Georgetown University Health Policy Institute. *A Consumer Guide to Getting and Keeping Health Insurance in Minnesota, Chapter 3. Your Protections When Buying Health Insurance.* www.healthinsuranceinfo.net/mn03.html. Last updated June 2002. Accessed 12/22/2004.
[8] Georgetown University Health Policy Institute. *A Consumer Guide to Getting and Keeping Health Insurance in New Hampshire, Chapter 3. Your Protections When Buying Health Insurance.* www.healthinsuranceinfo.net/nh03.html. Last updated July 2002. Accessed 12/22/2004.
[9] Georgetown University Health Policy Institute. *A Consumer Guide to Getting and Keeping Health Insurance in Connecticut, Chapter 3. Your Protections When Buying Health Insurance.* www.healthinsuranceinfo.net/ct03.html. Last updated June 2004. Accessed 12/22/2004.
[10] Georgetown University Health Policy Institute. *A Consumer Guide to Getting and Keeping Health Insurance in New York, Chapter 3. Your Protections When Buying Health Insurance.* www.healthinsuranceinfo.net/ny03.html. Last updated June 2004. Accessed 12/22/2004.
[11] Kane, N.M.; Turnbull, N.C. *Insuring the Healthy or Insuring the Sick? The Dilemma of Regulating the Individual Health Insurance Market: Findings from a Study of Seven States*. Commonwealth Fund, Unpublished Draft, October 2004.

Appendix A

STATE INTERVIEW GUIDE

STATE:

DATE OF CALL:

CONTACT PERSON:

CONTACT'S TITLE AND DEPARTMENT:

PHONE NUMBER:

MAILING ADDRESS:

EMAIL ADDRESS:

Confirm Facts about the Program:

Program Name:

Year Implemented:

Year Ended (if applicable):

Program Financing Source (Past and Current):

Target Population (including child age cut off):

Eligibility Range (%FPL):

Current FCBI Enrollment (and date):

Peak FCBI Enrollment (and date):

FCBI as a Percent of All Enrollment:

History of the Program:

What was the impetus for allowing full-cost buy-in?

Did you face any challenges to enacting the full-cost buy-in option (FCBI)? What were they?

Program Operations:

What is the current FCBI premium?

How was the FCBI premium determined? (How does it compare to the per capita rates for the state plan?)

Does it cover all/some/any administrative costs of operating the FCBI option?

Are there any other cost sharing requirements? What are they? (How do they compare to the costs for the state plan?)

Does the FCBI benefit package cover all of the same services as the program in general?

More specifically, does the benefit package cover dental, vision, maternity, etc?

Has the FCBI benefit package changed over time?

If so, how has it changed?

Why was it changed?

What was the impact on enrollment of the change?

How was the eligible population determined?

Have there been any changes to the eligible population over time?

If so, what were they and why?

What was the impact on enrollment?

How does the program determine an applicant's eligibility for the FCBI?

Does the state receive a federal match for FCBI enrollees?

Did the state need to get a federal waiver in order to allow FCBI?

If so, what was required in order for CMS to accept the FCBI waiver in terms of cost neutrality, eligibility, etc?

Does your program contract with managed care companies to service the program and FCBI enrollees?

If so, what is and was the reaction of these insurers to the FCBI option? (Were insurers worried about risk selection? Did they want to charge higher premiums as a result?)

Does the state manage eligibility and enrollment into the FCBI or is that contracted to a managed care company?

Who collects premiums from FCBI enrollees?

How are these premiums collected?

What, if any, are the ramifications if an enrollee does not pay the premium? (Is there a grace period before FCBI participants are disenrolled?)

<u>Take-Up</u>

Has take-up of the FCBI option been what you expected? Has it been higher or lower than expected?

Which features do you think may have led to **higher/lower** than expected take-up?

Are there any demographic characteristics of the eligible population that you feel may have led to **higher/lower** than expected enrollment?

Has **higher/lower** take-up resulted in any additional burden to the program (financial or otherwise)?

If high/low take-up has been a problem for the program, did the state make any changes to the FCBI program to improve things?

If so, what were they? Did they help?

Are there any subgroups of the eligible population that you have found are more likely or less likely to enroll in the FCBI option?

What groups are they?

And why do you feel they are more or less likely to enroll?

Has the program conducted any outreach/education efforts to let potentially eligible people know about the FCBI?

If so, what were these efforts? Were they successful? How much funding was sued for this outreach?

Adverse Selection:

Has the FCBI program experienced adverse selection?

If so, how did you address this problem?

Why do you think the problem occurred? (Do you feel that the benefit design of the program may have attracted adverse selection?)

If not, what aspects of the FCBI do you feel prevented adverse selection? (Do you feel that the benefit design of the program may have prevented adverse selection?)

How was adverse selection measured?

If adverse selection was a problem for the FCBI, has the state implemented any changes to the program to address this?

If so, what were those changes? How effective were they?

Crowd Out:

Has the FCBI resulted in any crowd out of private insurance coverage?

If so, was/is crowd out a significant problem?

Which features of the FCBI (eligibility or benefits) may have caused crowd out?

If not, which features of the FCBI (eligibility or benefits) may have prevented crowd out?

How was crowd out measured?

Have you created any provisions to the program to reduce the likelihood of crowd out (look-back period, currently insured excluded, access to private/employer coverage excluded)?

Are these provisions the same as in the program in general?

How are these provisions enforced?

If implemented after the start of the FCBI, have these changes had any perceived impact on crowd out?

Appendix B

Table B1: Demographic Comparisons of Likely Enrollees Who Were Previously Uninsured to Current NJ FamilyCare Enrollees

	NJ FamilyCare Current Enrollees	New Enrollees Using Age-Gender Based Premiums	New Enrollees Using Average Child/Adult Premium
Children Above 350% FPL[a]			
Race/Ethnicity			
White, Non-Hispanic	28.0 %	36.2 %	36.2 %
Other	72.0 %	63.8 %	63.8 %
Family Structure			
Single Parent	63.9 %	58.1 %	58.1 %
Two Parent	36.1 %	41.9 %	41.9 %
Number of Kids in the Family		*	*
One	17.4 %	60.6 %	60.6 %
More than One	82.6 %	39.4 %	39.4 %
Parents 134-350% FPL[b]			
Race/Ethnicity		*	*
White, Non-Hispanic	31.8 %	66.4 %	61.3 %
Other	68.2 %	33.6 %	38.7 %
Family Structure		*	*
Single Parent	54.8 %	33.1 %	32.0 %
Two Parent	45.2 %	66.9 %	68.0 %
Number of Kids in the Family			
One	29.8 %	33.7 %	31.1 %
More than One	70.2 %	66.3 %	68.9 %
Parents 134% FPL and Above			
Race/Ethnicity		*	*
White, Non-Hispanic	31.8 %	65.7 %	61.6 %
Other	68.2 %	34.3 %	38.4 %
Family Structure		*	*
Single Parent	54.8 %	36.8 %	37.3 %
Two Parent	45.2 %	63.2 %	62.7 %
Number of Kids in the Family			
One	29.8 %	38.3 %	35.7 %
More than One	70.2 %	61.7 %	64.3 %

Childless Adults 101-350% FPL[b,c]			
Race/Ethnicity			
White, Non-Hispanic	43.2 %	62.1 %	58.0 %
Other	56.8 %	37.9 %	42.0 %
Family Structure			
Single	75.0 %	82.1 %	67.1 %
Married	25.0 %	17.9 %	32.9 %
Childless Adults 101% FPL and Above[c]			
Race/Ethnicity		*	
White, Non-Hispanic	43.2 %	63.0 %	59.7 %
Other	56.8 %	37.0 %	40.3 %
Family Structure			*
Single	75.0 %	75.3 %	54.9 %
Married	25.0 %	24.7 %	45.1 %

Note: Except where noted, estimates are based on sample sizes of 50 or more. Care should be used in interpreting estimates based on small sample sizes. [a] Estimates based on fewer than 25 likely FCBI enrollees. [b] Estimates based on fewer than 50 likely FCBI enrollees. [c] Estimates based on fewer than 50 FamilyCare enrollees.
* Comparison is statistically significant.

State of New Jersey
Department of Human Services

In Collaboration with
Rutgers Center for State Health Policy

Project funded by the U.S. Department of Health & Human Services,
Health Resources and Services Administration,State Planning Grant # 6 P09 OA 00040-02-01