State Medicaid Buy-Ins: Key Questions to Consider

STATE Health & Value STRATEGIES | Driving Innovation Across States

Authored by Manatt Health

A grantee of the Robert Wood Johnson Foundation

April 2019

Introduction

Lawmakers across the country are considering Medicaid buy-in programs to stabilize the Affordable Care Act (ACA) insurance market and offer a coverage option that is more affordable and accessible than current options in the individual and employer markets. The concept of Medicaid buy-in is evolving, encompassing the original Medicaid-based proposals and extending to other programs through which the state can leverage its government bargaining power to offer a more affordable coverage option, like state employee health plans (SEHPs) or a Basic Health Plan (BHP). Some refer to this evolving model as Medicaid buy-in, while others label it a "public option," particularly for state-sponsored plans in the marketplace.

So far in the 2019 legislative session, more than 10 states have introduced legislation to study or implement a buy-in.[1] The purpose of this issue brief is to identify the key questions that states pursuing these initiatives will want to consider as they seek to design and implement their proposals.

Federal Buy-in Proposals

After the 2018 midterm election, federal policymakers are re-engaging on health care transformation. Federal buy-in proposals are among the policy options under discussion. The Medicare at 50 Act was re-introduced in February 2019 to expand Medicare eligibility by allowing individuals ages 50 to 64 to buy-in to the program. Additionally, Congress could pass legislation to support state-based innovation with additional authority or funding; for example, the State Public Option Act would extend ACA premiums and cost-sharing subsidies to buy-ins and would provide federal funding for states' costs not covered by enrollee premiums.

Buy-in programs vary significantly in their design depending on a variety of factors including the policy objective(s) they seek to achieve, target population(s), and local market dynamics. But three primary models are beginning to emerge:

Table 1: Emerging State Buy-In Models

Off-Market Buy-In	On Marketplace Buy-In	Basic Health Program Buy-In
The State makes coverage available to consumers who are not eligible for Medicaid as a state-sponsored buy-in plan that leverages the **Medicaid program** or **SEHP**; offered outside the individual market or Marketplace.	The State offers a state-sponsored qualified health plan (QHP) on the Marketplace leveraging Medicaid infrastructure; potentially in partnership with an existing managed care plan (if applicable).	The State offers a BHP to individuals with incomes below 200% of the federal poverty line (FPL) who are not Medicaid-eligible; and allows individuals with higher incomes to buy-in to the program.

Across these models there are common mechanisms that enable states to lower costs and achieve savings. Buy-in products may be less costly due to administrative efficiencies from leveraging existing public infrastructure; the presumption of reduced provider payment rates compared to existing marketplace reimbursement rates; increased competition in the insurance markets; and potential improvements to the individual market risk pool as more people enroll in coverage. These saving opportunities are discussed in greater detail below.

What problem(s) is the state trying to solve?

Buy-in models are not one-size-fits-all, the "right" model will depend on state goals. An important first step for selecting a model and tailoring its features is to get very specific about and prioritize the state's policy goals, and to define the population(s) to which the new coverage option will be targeted. Some models may be more effective than others in addressing specific goals. For example, an on marketplace buy-in is more likely to encourage increased competition; whereas an off-market plan (offered outside the individual market and the marketplace) might facilitate a state's ability to set specific cost-sharing levels. Table 2 below illustrates common state goals and how each model match with and can be tailored to meet state objectives.

Table 2: Matching Buy-In Models to State Goals

State Goals	Off-Market Buy-In or BHP Buy-In	On Marketplace Buy-In
Increasing Affordability: *Reduced Premiums*	Based on design	For unsubsidized (e.g., >400% FPL) *Possibly* for subsidized
Increasing Affordability: *Reduced Deductibles*	Based on design	*Possibly*, depending on design
Providing coverage access for the uninsured and those ineligible for tax credits	May be specifically targeted	Yes*
Injecting greater competition into insurance markets	Outside of the market	*If* other insurers remain
Strengthening the Marketplace by improving participation and the health risk of the market	Outside of the market	By attracting new customers
Leveraging state purchasing power across programs	Under state negotiations	When linked to other programs
Promoting healthcare initiatives that improve health outcomes and result in long-term savings (e.g., social determinants, population health, delivery system reform)	As a stable, long-term issuer	Via contracting

*However, a state may want to offer a plan outside the Marketplace for people who are ineligible for tax credits due to immigration status

Model matches state goals Model *may* match state goals Model *does not* match state goals

When designing a buy-in program, it is important to consider that a buy-in is not likely to meet—or may not be the simplest way to address—all of the state's health policy goals. States may want to consider implementing additional reforms in tandem with a buy-in program. Examples include: outreach to or auto-enrollment of residents who are eligible for, but not enrolled in Medicaid or very low/no-cost marketplace coverage; instituting a state reinsurance program; providing affordability assistance programs, such as state-funded deductible wrap payments or tax subsidies; new requirements on marketplace participating plans, like requiring plans to cover certain benefits before applying a deductible or tying insurer participation on the marketplace to participation in Medicaid or other insurance programs.

What are the potential sources of buy-in cost-savings in the state?

Potential buy-in savings—which generate lower premiums—will vary depending on the status quo in the state market. Each state will have different dynamics and potential sources of savings under a buy-in program. The buy-in model selection and design should play to the state's strengths in terms of opportunities for savings, balanced against the impact these sources of savings will have on other insurers' ability to negotiate, and compete, in the individual market, and on provider participation in the buy-in product.

Provider Payment Rates. A major contributor of savings in the buy-in program are reduced provider reimbursement rates compared to commercial products, which are traditionally higher than in the Medicaid and Medicare programs. Rate-setting is a critical consideration for all buy-in program designs and is likely to be heavily influenced by local market factors. Analysis of state-specific rate dynamics will be important to understanding possible buy-in savings since the existing differentials among commercial, marketplace, and government program provider rates vary considerably by state. States with high marketplace reimbursement rates could see substantial savings under a buy-in at Medicaid or Medicare rates, but may also expect a strong response from provider groups. Alternatively, states with marketplace plans that are already negotiating rates close to Medicare or Medicaid may need to look for other sources of savings for a reduced-cost buy-in. Many states are contemplating buy-in designs with rates pegged to the Medicare fee schedule.[2]

Administrative Efficiencies. Compared to commercial insurance, a state-sponsored buy-in can leverage existing administrative infrastructure and efficiencies. Government programs typically have reduced overhead, strong negotiating power, and potential savings from limited or no tax obligations.[3] A state-sponsored plan offered in partnership with an existing insurer could also have lower administrative costs if profit margins are limited, or a higher medical loss ratio is required by the state for the buy-in plan.

State Purchasing Power. The buy-in product can be linked to other government programs (such as, Medicaid and the SEHP) and benefit from the purchasing power that comes with operating multiple plans with a large number of covered lives. This potentially can increase the state's leverage when negotiating with providers and drug manufacturers. If the state chooses a public-private partnership model (by contracting with an existing insurer/managed care organization (MCO)), the combined purchasing power can change the partnership dynamic, allowing the state to negotiate as an active purchaser equipped to shape the benefit design, premiums, and cost-sharing of the buy-in.

Long-Term Savings Through Investments in Population Health and Delivery Systems. A key assumption for a buy-in is that the state will be a more stable purchaser and payer over time, since the state has a long-term interest in keeping the product in the market and is less affected by fluctuating market and profitability decisions. If enrollees remain in coverage year over year, the buy-in can offer a unique opportunity to invest in value-based payment programs, delivery system reforms, and improved population health in the medium and long-term; the state can also align and leverage these initiatives across all state-sponsored programs including the buy-in, Medicaid, CHIP, and SEHPs.

What are the potential impacts of the buy-in on other insurance markets in the state?

The precise impact of the buy-in on other markets depends on the model selected, the risk profile of enrollees who choose to enroll in the buy-in, and existing insurer responses to the new entrant. As states design a buy-in product, they should take consider these factors and engage with key stakeholders to understand their concerns and perspectives.

Market Competition. Current competition in the state will impact how other insurers react to a buy-in product entrant. If current marketplace insurer participants are limited, or cautious, and the buy-in is priced significantly lower than other options, existing insurers could leave the marketplace, resulting in fewer choices overall. Alternatively, if healthy competition already exists in the market, a buy-in product may help reduce costs for all individual market products as other insurers attempt to compete, particularly if the state is offering the product in partnership with an existing insurer and multiple companies are interested in bidding. Whether existing insurers can compete on reimbursement rates will largely depend on the current rate differentials across Medicaid, Medicare, and current marketplace coverage, and whether the insurers perceive a "level playing field."

Enrollee Health Status. Who chooses to enroll in the buy-in program will have significant market impact, especially for models offered in a separate risk pool, like the off-market buy-in. The movement of healthy or less healthy individuals into, or out of, the individual market will influence its stability and the cost of coverage (discussed in more detail below). Traditionally, healthy individuals are more attracted to lower-cost products, while less healthy individuals seek broad provider networks typically found in higher-cost products. How the buy-in competes on these issues will determine who is attracted to the plan. Other design decisions can influence who enrolls in the buy-in. A buy-in product that is targeted to a specific, narrower population will be better able to predict enrollee health status, giving policymakers and analysts a better sense of population costs, relative to the general marketplace population.

Segmenting or Expanding the Risk Pool. A significant distinction among buy-in models is whether they segment or expand the existing risk pool. This decision will largely be dependent on the state's goals for the buy-in; for instance, whether a state endeavors to offer the lowest possible cost product (with maximum design flexibility) or to stabilize the existing ACA market.

Table 3: Risk Pool Strategy Considerations

Segmenting Risk Pools	Expanding the Existing Risk Pool
Offering a buy-in in a new pool and/ or outside the individual market (*Off-Market Buy-In or BHP Buy-In*)	**Offering a buy-in inside the individual market (*On Marketplace Buy-In*)**
+ Could result in a lower-cost buy-in product with greater state control over design, thereby expanding coverage	+ Could improve coverage and affordability for all individual market enrollees by attracting healthy risk and lowering cost
− Could move enrollees out of the individual market, altering that risk pool and potentially raising premiums for enrollees who remain	− Limits state control over design and may not result in a significantly more affordable option

The impact on the existing individual market of *segmenting the market*, or offering a product in a new risk pool outside the individual market, depends on whether healthier or less healthy consumers enroll in the buy-in product. Healthier individuals moving into a separate buy-in risk pool can increase premiums for enrollees in the existing individual market pool by shifting the risk profile. Similarly, if less healthy current enrollees decide to purchase off-market buy-in coverage, premiums for those in the individual market may go down. In the future, there may also be an opportunity to combine state risk pools under a waiver to stabilize the buy-in pool (such as, Medicaid, BHP, and SEHPs), but there may be additional implications for those programs as a result of combining risk pools.

Expanding the existing pool—or offering the buy-in coverage on the marketplace—can positively impact the market by providing a stable coverage option and attracting new consumers to the marketplace. New entrants will diversify the risk pool and could reduce costs for all market participants if the buy-in attracts healthy, and/or currently uninsured enrollees.

Does the state require, or would it be beneficial to pursue, a 1332 waiver for the buy-in?

States can design a buy-in without seeking an ACA Section 1332 State Innovation Waiver (1332 waiver).[4] However, a unique challenge of buy-in proposals is that most of the program savings for the *subsidized population* accrue to the federal government, as the administrator of premium tax credits, and not the state or consumers. If a state seeks to leverage federal dollars to achieve its coverage and affordability objectives (and reap the benefits of generating savings in the individual market), a 1332 waiver may be necessary. The off-market buy-in model certainly requires a waiver if a state intends to allow consumers to use tax credits to purchase the product. An on marketplace buy-in does not necessarily require a waiver if the state intends for the buy-in product to meet current marketplace rules.

Tax Credit Transfer for an Off-Market Buy-In. Through a 1332 waiver, the state could receive a global payment for the federal tax credits eligible enrollees would have received had they enrolled in coverage on the marketplace. The payment would be used to fund the buy-in program. If the buy-in product is less costly than marketplace plans (the cost of which is used to establish the level of available tax credits), the global payment would cover a larger share of total buy-in costs; alternatively, if the buy-in costs more than marketplace plans (because, for example, the risk pool is less healthy than expected) the state would be at financial risk to cover the higher-than-expected costs.

Marketplace Savings. An on marketplace buy-in product that has a lower premium than current plans is likely to reduce the benchmark for tax credit subsidies, thus reducing aggregate federal costs. A state could apply to access those savings through a 1332 waiver. If approved, the state would receive "pass-through" funding for the value of the federal savings associated with lowering the benchmark for tax credits (similar to pass-through calculations for reinsurance programs), and could use these funds for the program.

1332 Waiver Approval Considerations. There is no precedent for 1332 waivers that include a Medicaid buy-in, and approval of these waivers is at the discretion of the Departments of Health and Human Services (HHS) and the Treasury, even when all waiver "guardrail" criteria are met.[5] The likelihood of waiver approval is therefore highly dependent on the federal administration at the time of waiver submission and whether the administration is likely to view the waiver program as advancing its health care policy objectives, in addition to meeting the guardrails.

Some buy-in models are more likely to require, or benefit from, 1332 waivers than others. The need for a 1332 waiver for program financing stability, and the administrative and financial investment and risk involved in 1332 negotiations should be carefully deliberated when selecting a buy-in model.

Table 4: 1332 Waiver Strategy Considerations

State ***Should*** Consider A 1332 Waiver ***If***…	State ***Should Not*** Consider A 1332 Waiver ***If***…
✓ There is significant pass-through funding potential based on rates or administrative efficiencies; and/or the option will impact individuals with subsidies (under 400% FPL)	✗ A waiver is not required for a plan offered as a Marketplace QHP
✓ The state would like to pursue an off-market buy-in, but wants to allow enrollees to use federal tax credits	✗ The state will administer an off-market buy-in without tax credits (state-only funding) and has limited capacity to negotiate a waiver for additional pass-through funding
✓ The state is considering a buy-in option alongside other market and affordability initiatives that may require a waiver, for example, a reinsurance program	

Is the state well positioned to implement a buy-in?

Experience with Medicaid expansion and marketplace administration has pressure tested many states' capacity to implement, and manage, complex health coverage programs, and to provide outreach to enrollees. A buy-in program could be an appropriate extension of those operational strengths. However, states need to evaluate whether they are positioned to implement a buy-in given other fiscal and administrative priorities, and which model is most appropriate based on their ability to take on fiscal and administrative risk.

State Risk and Funding. A buy-in can be self-sustaining (financed only through enrollee premium contributions), subsidized with state dollars, funded through federal savings obtained under a 1332 waiver, or some combination of these three funding sources. The state will need to determine the level of available funding for the buy-in, and decide if it is prepared to take on financial responsibility for the program if federal funding is not available through a 1332 waiver. Particularly, for off-market programs, the state will need to engage in careful planning to anticipate the buy-in enrollee health risk profile to ensure the risk pool is viable and to accurately assess the potential costs of a buy-in. An unanticipated (or changing) risk pool will impact program costs and should be accounted for in planning. Because federal tax credits are not based on enrollee health status, state financial risk is also a factor under a federal pass-through global payment waiver.

State Administration. The selected model will likely determine which state agency is best positioned to oversee the program—Medicaid, the marketplace, the SEHP-administering agency, or a new agency—and whether the product is administered directly, or in partnership with a third-party administrator or existing insurer/MCO. Existing capacity and expertise within state agencies may also influence these decisions.

Table 5: State Capacity for Buy-In Implementation

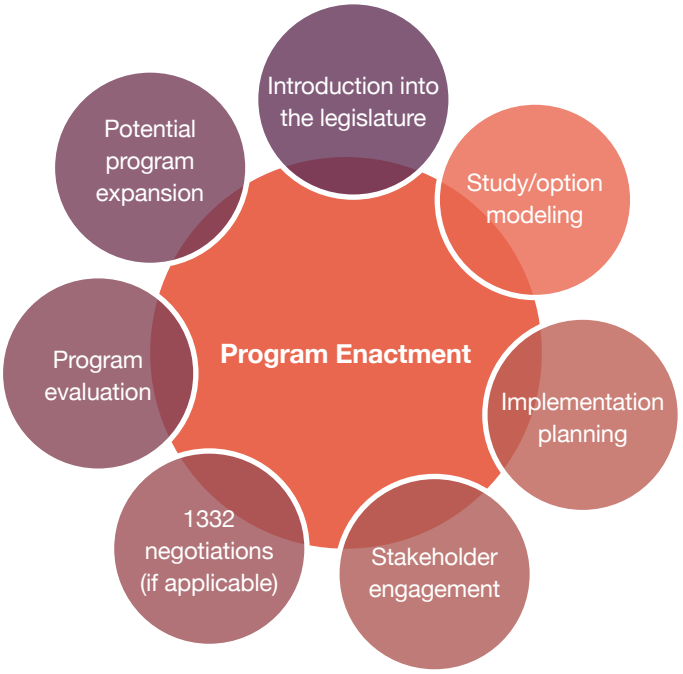
	Off-Market or BHP Buy-In	On Marketplace Buy-in
Funding	› Position to subsidize the program above enrollee premium contributions › Dependency on federal pass-through funding (Note: A BHP offers some guarantee of federal funding)	› Ability to leverage purchasing power for negotiating rates
Risk Tolerance	› Ability and/or political willingness to take on risk for enrollees with unexpected health profiles	› Limited risk if partnered with existing insurer
Administration	› Internal expertise to directly administer the product; or existing insurer/MCO relationships › Capacity within a state agency to oversee the program	› Type of Marketplace or ability to negotiate with Healthcare.gov; a state-based Marketplace will have more flexibility and control › Capacity within a state agency to oversee the program
	High	**State Risk and State Control** **Low**

What key steps should a state take to design and implement a buy-in?

States across the country are taking diverse paths on buy-in legislation, largely depending on who is leading the buy-in charge, such as the executive branch, state legislators, or consumer advocacy groups. Some states are taking a step-based approach, with a study bill followed by implementation/appropriation legislation, or, alternatively, could have one originating bill pre-approving introduction upon conclusion of a study.

Given the potential financial and market impacts of a buy-in, analysis will be needed to inform design prior to implementation. Additionally, stakeholder engagement with consumers, providers, and insurers will help the state refine their goals (and therefore the buy-in design), and ensure stakeholder participation.

Table 6: Key Buy-In Implementation Milestones



After legislative approval, the state will engage in implementation planning, including administrative development; contracting with a partner insurer(s) or directly with providers; coordination with the marketplace; and 1332 negotiations with HHS and the Department of the Treasury, if applicable. Enactment of the product can take place statewide, in a phased approach, or can be geographically targeted depending on the state's needs and capacity. The state may also consider a future expansion of the program (for example, to new populations) after initial implementation and following program evaluation.

Communicating the Buy-In

Given the complexity of a buy-in program, clear communication to stakeholders and the public will be essential throughout the process to ensure program success. Specifically, states should consider:

- Clearly articulating which problems the buy-in is trying to solve, and which it is not
- The timing and medium of communication by audience group
- Tailoring the terminology of the buy-in program (Medicaid buy-in, public option, etc.) to previous state reform initiatives and to what language will resonate with state residents, policymakers, and stakeholders
- Proactively managing stakeholder concerns about market impact and rate mitigation strategies
- Articulating how the buy-in fits into the state's broader landscape of health reform

Conclusion

Given the slim likelihood that health care reform initiatives that address coverage, access, and affordability will emerge at the federal level this year or next, state policymakers are taking matters into their own hands. Medicaid buy-in models are chief among the emerging state-based solutions. Because state markets are unique in their composition and dynamics, state policymakers are considering and tailoring buy-in models to meet a broad array of policy goals. It is essential that states begin the buy-in design and implementation process by being explicit about their goals since they are critical for guiding design decisions. Beyond goal setting, states will need to consider how to fund the buy-in through: premium contributions; state dollars; premium tax credits under current law; pursuing a 1332 waiver to access federal funding; or some combination of these sources. States considering waivers will also need to weigh the likelihood of 1332 waiver approval in the near term. To enact a buy-in, states will require sufficient "lead time" for a broad field of implementation tasks, including: product design; actuarial analysis; development of legislation; and frequent and robust communication with key stakeholders. All of these activities will position states to implement a successful buy-in program that provides a new, affordable health coverage option to state residents.

Support for this research was provided by the Robert Wood Johnson Foundation. The views expressed here do not necessarily reflect the views of the Foundation.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 45 years the Robert Wood Johnson Foundation has worked to improve health and health care. We are working alongside others to build a national Culture of Health that provides everyone in America a fair and just opportunity for health and well-being. For more information, visit *www.rwjf.org*. Follow the Foundation on Twitter at *www.rwjf.org/twitter* or on Facebook at *www.rwjf.org/facebook*.

ABOUT STATE HEALTH AND VALUE STRATEGIES — PRINCETON UNIVERSITY WOODROW WILSON SCHOOL OF PUBLIC AND INTERNATIONAL AFFAIRS

State Health and Value Strategies (SHVS) assists states in their efforts to transform health and health care by providing targeted technical assistance to state officials and agencies. The program is a grantee of the Robert Wood Johnson Foundation, led by staff at Princeton University's Woodrow Wilson School of Public and International Affairs. The program connects states with experts and peers to undertake health care transformation initiatives. By engaging state officials, the program provides lessons learned, highlights successful strategies and brings together states with experts in the field. Learn more at *www.shvs.org*.

ABOUT MANATT HEALTH

This brief was prepared by Patricia Boozang, Chiquita Brooks-LaSure, and Kyla Ellis. Manatt Health is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. Manatt Health helps clients develop and implement strategies to address their greatest challenges, improve performance, and position themselves for long-term sustainability and growth. For more information, *visit www.manatt.com/Health.*

Endnotes

1. Four states—Delaware, Massachusetts, New Mexico, and Oregon—have recently completed studies evaluating buy-in coverage options.

2. As of this writing, Washington's public option bill, SB 5526, requires reimbursement as a percentage of Medicare fee-for-service rates.

3. Medicaid administrative expenses average 5% of total program cost in 2017, compared to 15-20% administrative costs in commercial plans depending on the market. Profit margins will vary by buy-in design and tax obligations will differ by state. The ACA health insurance provider fee could apply to a buy-in, depending on how it is administered (a government entity would be exempt for example).
   Medicaid and CHIP Payment and Access Commission. (2018). MACStats: Medicaid and CHIP Data Book. https://www.macpac.gov/wp-content/uploads/2018/12/December-2018-MACStats-Data-Book.pdf
   Congressional Budget Office. (2016). Private Health Insurance Premiums and Federal Policy. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums.pdf

4. Section 1332 waivers gives states the flexibility to experiment with key components of the ACA insurance markets—coverage mandates, benefits, subsidies, the Marketplace and QHPs—within specified constraints.
   The Patient Protection and Affordable Care Act, H.R. 3590. § 1332 (2010). https://www.govinfo.gov/content/pkg/BILLS-111hr3590enr/pdf/BILLS-111hr3590enr.pdf
   For more information see: Boozang, B., Brooks-LaSure, C. (2018). Medicaid Buy-In: State Options, Design Considerations and 1332 Implications. https://www.shvs.org/resource/medicaid-buy-in-state-options-design-considerations-and-section-1332-waiver-implications/

5. Coverage provided under a 1332 waiver must (1) Be at least as comprehensive as coverage provided absent the waiver; (2) Provide coverage and cost-sharing protections so that coverage is at least as affordable as coverage absent a waiver; (3) Provide coverage to a number of residents of the state comparable to the number of residents that would be provided coverage absent a waiver; and (4) not increase the federal deficit. These are often referred to as "guardrails."