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The Landscape of Federal and State Healthcare Buy-In Models:

Considerations for Policymakers

Chiquita Brooks-LaSure, Managing Director
Hailey Davis, Director
Kyla M. Ellis, Manager
Cindy Mann, Partner

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Chiquita Brooks-LaSure
Managing Director
Manatt Health
202.585.6636
cbrooks-lasure@manatt.com

Cindy Mann
Partner
Manatt Health
202.585.6572
cmann@manatt.com

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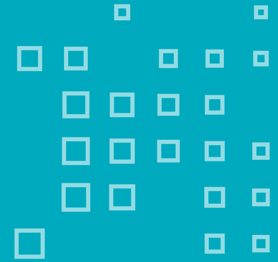

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Executive Summary

Across the country, policymakers, healthcare stakeholders and consumer advocates are motivated to expand affordable coverage, with the overarching goals of lowering the uninsured rate, addressing affordability and access to care issues (such as high premiums, deductibles and cost-sharing), and reducing the cost of healthcare borne by individuals and state and federal governments. Bolstered by the popularity of public health insurance programs and public interest in increasing insurance market stability, policymakers and stakeholders are turning their attention to government-sponsored "buy-in" programs or "public options."

A buy-in program (which can include a public option) involves the federal or state government offering consumers a new, more affordable healthcare coverage option by leveraging, in some way, the administrative savings and bargaining power of public programs, such as Medicare or Medicaid. Buy-in programs can be offered through private plans, like Medicare Advantage or Medicaid managed care plans, or through direct arrangements between the government and healthcare providers. While buy-in programs can vary widely and be tailored to meet specific health reform goals and market dynamics, each government-sponsored buy-in relies on a common set of mechanisms to lower costs and achieve savings that can be passed to consumers and/or the government: administrative efficiencies from leveraging existing public infrastructure; the presumption of reduced provider payment rates compared to commercial payment rates; increased competition in the insurance markets; and improvements to the individual market risk pool. In addition, depending on design, a buy-in program may include a full or partial subsidy to further reduce consumers' out-of-pocket costs.

This paper, funded by Arnold Ventures, provides an overview and discussion of several types of buy-in programs being considered at the national and state levels—federally-sponsored buy-in models that leverage Medicare and state-sponsored buy-in models that leverage Medicaid or the Basic Health Program. These models include:

- **Medicare or Medicaid-Based Public Options**, where the federal or state government would offer a new coverage plan on the federal and/or state-based Marketplace(s). The government-backed plan would use existing public infrastructure and be administered either directly by a government agency, such as the Centers for Medicare & Medicaid Services (CMS) or state Medicaid agency, or in partnership with a contracted insurer.
- **Targeted Medicare Buy-Ins**, where the federal government would allow consumers who are currently ineligible for Medicare to purchase Medicare coverage. An age-based targeted buy-in would make Medicare coverage available to younger populations (e.g., 55- to 64-year-olds) through payment of a monthly premium.
- **State Medicaid Buy-Ins**, in which a state makes Medicaid-like coverage available to consumers who are not eligible for Medicaid—for example, individuals with incomes higher than Medicaid eligibility levels but who find coverage unaffordable or individuals who would be eligible for Medicaid if not for their immigration status—through an off-Marketplace, state-sponsored plan. The state could choose to make eligibility for the plan open to a broad or targeted population and could finance the program through consumer premium contributions, general fund contributions, federal pass-through funding obtained through a federal waiver, or some combination of these sources.

- **The Basic Health Program (BHP)**, which is a state option made available under the Affordable Care Act (ACA) in which a state receives federal funding to provide state-sponsored coverage to individuals with income below 200% of the federal poverty level (FPL) who would otherwise be eligible to purchase coverage through the Marketplace and who are not eligible for federally-funded Medicaid. States with a BHP could choose to expand the program by allowing individuals not currently eligible under ACA rules to buy into BHP coverage.

Of note, while "Medicare for All," and other single-payer proposals, share some of the same goals and characteristics of buy-in programs, they ultimately envision replacing current sources of coverage with one overarching financial system for the entire country or state. In contrast, buy-in programs seek to offer an additional coverage option to consumers. This paper focuses on buy-in programs and does not discuss single-payer proposals.

Policymakers and stakeholders contemplating buy-in proposals should carefully evaluate a number of issues, many of which will be specific to local markets and policy priorities, to ensure the buy-in program achieves its overarching objectives. Key considerations include:

- **Administration:** Buy-in proposals are intended to leverage existing infrastructure and have minimal overhead; however, operations would likely require some level of new resources and authority for the agency administering it (e.g., CMS or state Medicaid agency). Buy-in models that utilize the Marketplaces—either for eligibility determinations and enrollment functions only or by participating as a designated "qualified health plan" (QHP)—will also require coordination with the federal and/or state-based Marketplaces.
- **Provider Payment Rates:** As a primary driver of reduced cost in a buy-in product, provider payment rates have a large influence on the ultimate affordability of coverage. Many buy-in proposals—federal- or state-sponsored—recommend provider payment at Medicare rates, but some assume Medicaid rates or some factor above existing Medicaid rates. While rates are an important tool to help bring down costs and increase affordability for consumers, they must also allow for adequate provider participation in the program. Provider reaction to buy-in proposals will depend on both current payment rates in the region and who the buy-in program attracts. For example, if the buy-in plan enrolls individuals who are currently uninsured, provider revenue would likely increase; if it primarily attracts individuals currently enrolled in commercial coverage, provider revenue could decrease (depending on commercial payment rates and how they compare to proposed buy-in rates).
- **Impact on the Existing Market:** The impact of Medicare- and Medicaid-based buy-in programs on other markets depends on multiple factors, among them: buy-in enrollees' health status, in which risk pool the buy-in enrollees are placed, the target population for the buy-in program, and the popularity of the program. Premium pricing, cost-sharing levels, benefit design and network breadth all play a role in consumers' decision-making and impact these market factors as a result. For example, if the buy-in is offered as part of the individual risk pool and attracts new, healthy individuals, it may improve the risk pool; conversely, a buy-in offered outside of the individual market that attracts current healthy Marketplace enrollees could hurt the existing risk pool (by pulling healthy individuals out of the existing market). Risk stabilization initiatives can be leveraged to minimize market impact, though insurer reaction is a critical consideration, particularly in states or regions with small markets or a limited number of participating insurers.

Choosing the appropriate model will depend, in large part, on the problems policymakers are hoping to resolve. A federally-sponsored buy-in program has some clear advantages, among them: the size, national reach and popularity of the Medicare program; having one authority administer the program; offering a standardized option across the country; and more streamlined deployment of savings that accrue to the federal government. However, state-administered buy-in programs offer something distinctive—a more localized solution to the problems of a particular region, tailored to unique market dynamics. They may also be more attainable in today's political environment, as many state-based approaches do not require approval from the federal government.

In exploring the myriad design options and impacts of various buy-in models, this paper presents both the merits and limitations of federally-sponsored and state-sponsored buy-in programs and provides an overview of key considerations for policymakers and stakeholders as they consider buy-in as a tool for ongoing health reform.

Introduction

After years of uncertainty about the future of the Affordable Care Act (ACA), policymakers, healthcare stakeholders and consumer advocates are motivated to expand affordable coverage, with the overarching goals of lowering the uninsured rate, addressing affordability and access to care issues (such as high premiums, deductibles and cost-sharing), and reducing the overall costs of healthcare borne by individuals and state and federal governments. This motivation has spurred an interest in new and innovative reform proposals, among them a government-backed "buy-in" or "public option."

Box 1. Need for Additional Coverage Options

Under the ACA, nearly 20 million people gained access to healthcare coverage, bringing uninsured rates to record lows. However, gaps in coverage remain, due in large part to uneven adoption of Medicaid expansion and the persistently high cost of private coverage.[1] As of early 2018, 28.3 million people were uninsured, including 12.5% of non-elderly residents.[2]

Cost remains a significant obstacle to coverage. This year, the average monthly premium for a 40-year-old purchasing the second-lowest-cost silver-level, or "benchmark," plan on the Marketplace is $495.[3] While that amount is substantially offset by federal tax credits for those eligible to receive them, it remains high for individuals who cannot access tax credits. Further, deductibles are growing; in 2019, the average combined medical and prescription drug deductible for silver-level plans is $4,375, up 8% in just one year, making care inaccessible for many.[4]

Finally, for many individuals who are able to purchase coverage, the number of options available to them may be limited: this year, 37% of counties across the country have only one insurer participating in the Marketplace.[5]

Under a buy-in—a term that can refer to several different reforms, including a public option—the federal or state government offers consumers a new, more affordable healthcare coverage option by leveraging, in some way, the administrative savings and bargaining power of public programs, such as Medicare or Medicaid. Buy-in coverage can be provided through private plans (e.g., a public-private partnership between the government and insurers, such as Medicare Advantage or Medicaid managed care plans), where the government plays a role in procurement and oversight, or through direct arrangements between the government and healthcare providers.

Buy-in proposals have reemerged as a policy option due, at least in part, to the popularity of public health insurance programs and interest in increasing stability and lowering costs in the insurance market, where insurer participation and costs fluctuate regularly. Recent polling shows that individuals who receive coverage from government-sponsored or -assisted plans are more satisfied with the current healthcare system compared to individuals receiving insurance from other sources.[6] Medicare remains a highly popular option: three-quarters of beneficiaries believe the program works well and offers strong financial protection.[7] Further, state Medicaid expansions, along with the efforts to repeal and replace the ACA, have increased awareness of and support for Medicaid in communities around the country, and today some 74% of people of all political affiliations (across expansion and non-expansion states) hold favorable views of Medicaid.[8]

In the individual health insurance market, buy-in programs are also garnering attention among state policymakers and consumers looking for a reliable Marketplace option. Creating a stable insurance option for people to purchase coverage on the Marketplace is critically important given that federal subsidies for individual market insurance are currently available only to consumers purchasing Marketplace coverage (called "qualified health plans," or QHPs). This is especially true in parts of the country with limited coverage options. While Marketplaces have stabilized recently in much of the country, insurers have no obligation to offer Marketplace coverage year-to-year. In 2018, 40 counties were at risk of having no Marketplace insurer before successful state negotiations with insurers; in 2019, more than one-third of counties across the country have only one Marketplace insurer, and five states—Alaska, Delaware, Mississippi, Nebraska and Wyoming—have only one option statewide.[9] Buy-ins are also attracting interest as a way of reducing the cost of coverage, increasing premium affordability and/or lowering out-of-pocket costs (e.g., deductibles and other cost-sharing). Between 2018 and 2019 alone, average deductibles rose by 8%, to over $4,000 per year for a silver-level plan.

Importantly, buy-in proposals represent a category of reforms rather than a specific program. Buy-in plans vary greatly and can be tailored to meet health reform goals that reflect the specific market dynamics where they are being implemented. These goals often include:

- Reducing the uninsured rate by expanding access to subsidized or lower-cost coverage (e.g., for individuals who find coverage unaffordable and/or who are ineligible for subsidies due to immigration status).
- Reducing costs and increasing the affordability of coverage and care for consumers (e.g., for both the uninsured and those currently enrolled in coverage).
- Introducing a new, stable option into the individual market.
- Injecting greater competition into insurance markets.

- Simplifying coverage, particularly for families with members enrolled in different coverage programs and individuals who "churn" into and out of different coverage programs (e.g., Medicaid).

Box 2. Buy-In as One of Many Reform Options

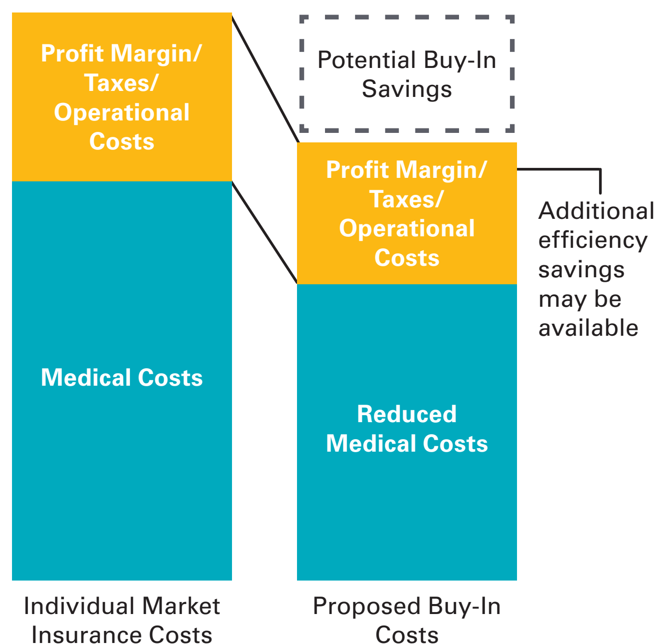
States may want to consider other reforms, outside of buy-in, to increase competition and lower healthcare costs. Buy-in programs may not be the simplest way to address high out-of-pocket costs or high premiums, for example, and may not change behavior among people who are currently eligible for public programs but remain unenrolled.

Other possible reforms include, but are not limited to: setting a state individual mandate; "tying" insurer participation across markets (e.g., by requiring insurers who offer state employee health plans or Medicaid coverage to participate in the individual market); enhancing risk adjustment programs; capping provider rates; and providing supplemental state-funded premium subsidies or deductible "wraparound" payments to consumers.

Buy-in proposals will differ depending on the policy objective(s) they seek to achieve, local market dynamics, the target population(s) (which can be broad or narrow), the intended pace of reform and the program administrator (the federal or state government). But there are a common set of mechanisms that enable buy-in models to lower costs and achieve savings that can be passed to consumers and/or the government (see Box 3 for details), depending on the approach. These mechanisms come with additional implementation considerations are explored in more detail throughout the paper.

- **Administrative Efficiencies:** As government-sponsored programs, buy-ins use existing administrative infrastructure and efficiencies for implementation, thereby reducing overhead costs. Additionally, a government-backed buy-in plan could ensure direct negotiation of prices and, depending on its structure, could be a nonprofit program and/or have lower or no tax obligations.[10]
- **Provider Payment Rates:** Traditionally, payment rates to providers are lower in the Medicare and Medicaid programs than in commercial insurance programs, although the gap varies considerably by location (both across and within states). In some locations, Marketplace plan payment rates may not be much higher than Medicaid or Medicare rates, while in other areas, they may be far higher.[11] Research has found that in areas with less insurer or provider competition, Marketplace

Figure 1: Achieving Lower Costs Through Government-Sponsored Buy-In



rates tend to be well above Medicare rates.[12] Quantitative analyses of two different state-sponsored buy-in proposals, in Colorado and New Mexico, indicate that setting provider payment rates for buy-in coverage at Medicare or Medicaid reimbursement levels would produce savings and produce lower-cost coverage, relative to average individual market coverage (see Box 6 for details). Importantly, savings achieved by not relying on commercial rates would need to be balanced with assuring adequate provider payment and program participation. Thus, rate-setting is a critical consideration for all buy-in program designs and is likely to be heavily influenced by local market factors.

- **Increased Competition:** In theory, introducing a new, lower-cost coverage option to an insurance market should help drive down costs in that market as other insurance offerors adjust their pricing and purchasing behavior to compete. Depending on buy-in design, however, the addition of a new coverage option may impact the size and makeup of existing risk pools and other factors, which could have a negative effect on competition.
- **Improving the Individual Market Risk Pool:** A potential additional source of savings for buy-in programs is their ability to attract enrollees with a better "risk profile" than that of current individual market enrollees. For example, a buy-in program that is offered on the Marketplace and in the individual market risk pool and attracts healthy consumers who were previously uninsured would improve the entire individual market risk pool and could lower costs as a result. A buy-in program offered in a separate risk pool that shifts

Box 3. How Certain Buy-In Programs Can Reduce Federal Costs

Much of the cost of commercial coverage purchased on the federal or state-based Marketplaces is federally-funded through advanced premium tax credits available on a "sliding scale" basis to eligible individuals earning up to 400% of the federal poverty level (FPL). These premium tax credits are calculated based on the price of the "benchmark plan," which is the second-lowest-cost silver-level plan available in the Marketplace. If introduction of a buy-in option **on the Marketplace** lowers the price of the benchmark plan, the value of the premium tax credits would decrease, yielding savings for the federal government. Similarly, buy-in models offered **outside the Marketplace** can lower the number of individuals receiving tax credits on the Marketplace, which can also produce federal savings.

These savings could be retained by the federal government, or, if they are the result of a state-sponsored buy-in program, they could be passed on to the state to invest in other healthcare initiatives (through a 1332 waiver, described in Box 5). In either scenario, the government (federal or state) could use those funds to further reduce costs or expand coverage and administer the buy-in program.

The fact that at least some of the savings produced by many buy-in models accrues to the federal government, means policymakers considering state-sponsored buy-in proposals should factor in collaboration between the state and federal governments, to allow the state to make use of any savings their buy-in programs may create.

less healthy individuals away from the individual market risk pool could also improve the risk profile of the individual market and reduce costs for those remaining in it. A key consideration for policymakers and stakeholders weighing buy-in proposals is whether the buy-in program is separate from or a part of the individual market risk pool. As discussed in greater detail below, the impact of a buy-in program on current markets will vary greatly depending on the buy-in program's risk pool, in relation to the individual and other markets, as well as its enrolled population.

This paper, supported by Arnold Ventures, examines these issues and the sometimes competing design considerations. It begins with an overview of buy-in options and then discusses several different types of buy-in programs being considered at the national and state levels, including federally-sponsored buy-in models that leverage Medicare and state-sponsored buy-in models that leverage either Medicaid or the BHP.[13] Figure 2 provides a high-level overview of the different buy-in programs discussed in this paper.

Figure 2. Overview of Buy-In Models

Federally-Sponsored Models		State-Sponsored Models		
Targeted Medicare Buy-In	**Medicare-Based Public Option**	**State Medicaid Buy-In**	**Medicaid-Based Public Option**	**Basic Health Program (BHP)**
The federal government allows consumers who are currently ineligible for Medicare to purchase coverage. An age-based targeted buy-in extends Medicare coverage to younger populations (e.g., 50- or 55-64-year-olds).	The federal government offers a government-backed QHP on the Marketplace; plan leverages Medicare infrastructure; administered by a government agency or in partnership with existing insurers.	The state makes Medicaid-like coverage available to consumers who are not eligible for Medicaid; coverage offered as an off-Marketplace, state-administered buy-in plan.	The state offers a state-sponsored QHP on the Marketplace (as a Marketplace plan); plan leverages Medicaid infrastructure; potentially in partnership with an existing managed care plan (if applicable).	The state offers a state-sponsored BHP plan to individuals with incomes up to 200% FPL who are not eligible for federally-funded Medicaid. The state could expand the BHP to allow other individuals to buy into the program.
In Medicare or Separate Risk Pool	**In Individual Market Risk Pool; Could Be in Marketplace**	**Outside of Individual Market Risk Pool**	**In Individual Market Risk Pool; Could Be in Marketplace**	**Outside of Individual Market Risk Pool**
Federal Legislation Required	**Federal Legislation Required**	**1332 Waiver for Pass-Through Financing**	**QHP Certification and/or 1332 Waiver**	**1331 Authority (1332 Waiver for Buy-In)**

By exploring the design and impact of these models relative to the goals and objectives, this paper offers insights for federal and state policymakers, consumer advocates, and other healthcare stakeholders considering buy-in implementation.

Federally-Sponsored Buy-In Models

Medicare is a significant source of healthcare coverage, providing coverage to 14% of the population and accounting for 20% of national health expenditures.[14] The size and national reach of the program gives it substantial purchasing power and influence throughout the healthcare sector. While the current program serves a subset of the population (people aged 65 or older and people with disabilities or end-stage renal disease), its popularity, efficiency and scale make it a natural platform for health reform proposals aimed at increasing affordability and access.

Federally-sponsored buy-in programs would—in different ways, depending on the design—leverage the Medicare program to make coverage more affordable and accessible to a wider population. They would allow individuals currently ineligible for Medicare to purchase (with or without subsidies) Medicare or Medicare-like coverage from the federal government, leveraging Centers for Medicare & Medicaid Services (CMS)'s infrastructure (e.g., plan and/or provider contracting, claims processing, oversight and auditing). Importantly, a Medicare buy-in would require amending federal law to either expand Medicare eligibility to allow for currently ineligible individuals to enroll in Medicare coverage or allow CMS to administer a new buy-in program outside of traditional Medicare. Such a nationwide coverage option, operated by an existing federal agency, would provide administrative efficiencies and bargaining power. Perhaps as a result, most of the legislative Medicare buy-in proposals that have been recently introduced call for national implementation.[15] (See Box 4 and the appendix for more information on introduced Medicare buy-in proposals.) However, a federally-sponsored buy-in program could be offered as a state option and pursued at the discretion of the state.

Medicare buy-in proposals can vary greatly in their design and scope. This paper discusses two main types of Medicare buy-in: (1) a Medicare buy-in that would allow targeted populations to purchase Medicare coverage, and (2) a Medicare "public option" that would create a new coverage option that uses the Medicare infrastructure and is available to a broader population. Under both types of Medicare buy-in, eligible individuals could apply and enroll in one or more ways: through the federal Marketplace (Healthcare.gov) or state-based Marketplaces, which would determine eligibility and facilitate plan selection and enrollment; by modifying the Medicare enrollment system;[16] or through a newly introduced central enrollment system. Several Medicare buy-in legislative proposals also include provisions that would allow consumers who have access to federally-funded premium tax credits to apply their tax credits to the cost of buy-in coverage. Similarly, depending on design, employer contributions could also go toward the cost of coverage.

Of note, while "Medicare for All", and other single-payer proposals, share some of the same goals and characteristics of buy-in programs, they ultimately envision replacing current sources of coverage with one overarching financial system for the entire country or state. In contrast, buy-in programs seek to offer an additional coverage option to consumers.

Box 4. Introduced Medicare Buy-In Legislation

Targeted Medicare Buy-In Proposals:

Medicare at 55 Act (Stabenow)

Medicare Buy-In and Health Care Stabilization Act of 2017 (Higgins)

Medicare Public Option Proposals:

The Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act (Schakowsky/ Whitehouse)

Medicare-X Choice Act of 2017 (Bennet/ Higgins)

Choose Medicare Act (Merkley/Richmond)

More information about these proposals is included in the appendix.

This paper focuses on buy-in programs and does not discuss single-payer proposals.

Overview of Models Leveraging Medicare

Targeted Medicare Buy-In

A targeted Medicare buy-in would offer Medicare or Medicare-like coverage to a new eligibility group(s)—such as individuals aged 50 to 64 years, individuals in particular industries or regions, or other defined groups. The goal of this model is to provide certain populations with an opportunity to enroll in a new, stable and lower-cost coverage option. A targeted Medicare-based buy-in could also be designed to improve the health risk of existing insurance markets, for example, by attracting the older populations currently purchasing coverage on the individual markets to Medicare buy-in coverage. Making the Marketplaces more attractive to healthy individuals, particularly those under 30 years of age, is a key goal for many stakeholders.

While targeted Medicare buy-ins could be designed to attract different population groups, proposals to date (see Box 4 and the appendix for more information) have been age-based—allowing younger populations to enroll in Medicare coverage by paying a premium contribution. Such a program would **expand** Medicare eligibility, incorporating buy-in enrollees into the existing Medicare structure to receive Medicare benefits, Medicare cost-sharing levels and access to Medicare providers.

Because the targeted Medicare buy-in would not meet all individual market rating obligations, an expanded Medicare eligibility buy-in plan would not qualify as a Marketplace QHP under current law. As a result, while the plan could be available on federal or state-based Marketplaces for eligibility determination and plan enrollment purposes, buy-in enrollees would likely be outside the individual market risk pool and, depending on design, part of either the Medicare risk pool or a new, separate risk pool. Legislation, or additional authority, would be required to allow enrollees to use federal tax credits to purchase Medicare buy-in coverage (as coverage that is "equivalent" to approved Marketplace plans) or to change the definition of QHPs to include Medicare.

The benefit and cost-sharing variations between Medicare and Marketplace plans are also an important differentiator that should be considered by policymakers and stakeholders. Specifically, cost-sharing obligations for certain individuals under a Medicare buy-in plan could be higher than under traditional Marketplace plans, which have maximum out-of-pocket caps. Today, many Medicare beneficiaries receive cost-sharing assistance through the purchase of supplemental "Medigap" coverage, by enrolling in Medicare Advantage, or through Medicaid or employer-sponsored coverage. Some buy-in models would allow individuals who are not eligible for Medicare

to also purchase Medigap coverage or to pay an additional premium for Medicare Advantage, to address the cost-sharing obligations. However, the potential need to purchase supplemental coverage in addition to traditional Medicare coverage may influence whether consumers view the buy-in program as a cost-effective option compared to Marketplace coverage; it may also influence which consumers choose to enroll in the Medicare buy-in. Another important consideration is family coverage since under a targeted Medicare buy-in, only eligible individuals would be permitted to enroll, so family coverage would not be offered.

Medicare buy-in proposals could address both cost-sharing and family coverage in their design and implementing legislation, but changes to these policies would differentiate the coverage or require system-wide changes to the current Medicare program (e.g., instituting an out-of-pocket maximum for all Medicare beneficiaries).

To limit the impact on the existing Medicare program, legislative proposals that advance a targeted Medicare buy-in model would segregate financing for buy-in enrollees from the traditional Medicare population. To avoid disruption to the Medicare Trust Fund, buy-in premiums could be designed as a self-sustaining revenue source (i.e., the price of the premiums could cover program costs). The program could also be administered through a separate trust or internal accounting mechanism, and/or the federal government could subsidize coverage by authorizing additional appropriations specific to the buy-in population.

Medicare-Based Public Option

Unlike the targeted Medicare buy-in that offers Medicare coverage to a new eligibility group (for example, one defined by age), this option would entail CMS offering a public option that operates as a QHP on the Marketplace, but leverages Medicare's administration, and potentially also its delivery system infrastructure. This approach, which would involve offering coverage that is part of the individual market risk pool, would be available to all consumers purchasing on the Marketplace, alongside other QHP options. Importantly, the Medicare-based public option would follow Marketplace rating rules and would mirror the ACA's essential health benefits package, meaning it would not be Medicare coverage, but rather **Medicare-like.**[17] Consumers eligible for federal tax credits could apply their tax credits to the cost of Medicare buy-in coverage.

The goal of a Medicare public option are to offer a stable, lower-cost plan to a broad population of Marketplace consumers. It may also increase competition on the Marketplaces, potentially slowing the rise in healthcare costs, if existing insurers alter their offerings to compete alongside the public option. To the extent that the Medicare public option is lower-cost than other Marketplace options (and that calculations of the premium tax credit remain consistent with current policy), it could also achieve savings for the federal government by reducing the amount of premium tax credits that the federal government must provide to consumers for access to affordable coverage (see Box 3 for more details).[18]

Premiums for the public option coverage would be established consistent with Marketplace policies on actuarial value and metal tiers, and would be separate from—and therefore would not impact—the existing Medicare program. To manage costs and premiums, Medicare public option provider reimbursement rates could be set by enacting legislation to utilize Medicare or "Medicare plus" rates, or by negotiating provider rates as needed to ensure adequate provider participation.

Variations of this option could involve offering the public option outside of the Marketplace risk pool and aligning coverage features with those of

Medicare (e.g., mirroring Medicare's benefits and cost-sharing levels, instead of adopting Marketplace standards, for administrative simplicity and/or alignment with the existing Medicare program). However, changes to the benefit package and cost-sharing levels, absent corresponding legislative changes to underlying Marketplace rules and premium tax credit calculations, might complicate consumer choice when comparing the buy-in and traditional Marketplace coverage.

State-Sponsored Buy-In Models

As the federal government grapples with whether, or how, to advance national health reforms, individual states are actively considering—and in some cases, moving forward with—proposals that aim to improve healthcare coverage and delivery systems for their residents. While a federal buy-in program would provide a standardized Medicare-based option across the country, state-based reforms can be designed to meet local needs, factoring in the state's coverage continuum, cost drivers and market dynamics, and may be implemented without federal legislation. State reforms can also serve as an incremental step toward or "test case" for future national policy. State implementation may also be more likely in the near term, given divided government at the federal level.

Among the healthcare reforms being considered by state policymakers are state-sponsored buy-in programs. As with a federally-sponsored buy-in, a state-sponsored buy-in approach uses administrative efficiencies and government purchasing power to make coverage more affordable and accessible to a wider population—but by leveraging existing or new state programs rather than Medicare. Also like federally-sponsored buy-in, state-sponsored approaches can vary widely and, to an even greater extent, be tailored to address local health reform objectives and market characteristics. For example, designs can include on- or off-Marketplace products, plans with robust or limited benefit packages and/or different levels of cost-sharing, and/or "sliding scale" subsidies to increase affordability for certain populations. While there will be state-specific variations, today states are primarily considering models that leverage aspects of the state's Medicaid program.[19] Some may also be considering utilizing and/or expanding the BHP option available to states under the ACA.

Medicaid-based buy-in programs utilize the Medicaid program in some way (e.g., through use of the state's Medicaid administrative infrastructure, provider reimbursement levels, provider network and/or benefit package) in an attempt to achieve state goals. State administration can mean more than just rate-setting and network utilization; it could also include working with existing insurers or adopting policies that tie health insurance offerings to government contracting.

Two Medicaid buy-in models are emerging from state work to date: (1) a more "traditional" state Medicaid buy-in, where the state makes some form of **Medicaid-like** coverage (Medicaid coverage without federal Medicaid matching funds and not bound by federal Medicaid requirements) available to individuals who are not eligible for Medicaid; and (2) a state-sponsored QHP, or "public option," that builds from the Medicaid program. Both of these options address different goals, and both have pros and cons. Their own design variations that should be considered carefully based on state-specific needs and conditions.

A state-sponsored alternative to Medicaid-based buy-in is the BHP. Created by the ACA, the BHP is a tool for states to offer an additional coverage option to low-income individuals, who are not eligible for federally-funded Medicaid, with federal funding. While only two states have a BHP in place today— Minnesota and New York— more states are contemplating administration of the BHP as a new coverage option, or as an option to leverage for a future, expanded eligibility buy-in program.

Critical to designing a state-sponsored buy-in are defining local access barriers and determining the population(s) most in need of a new coverage option. For example, based on an analysis of its uninsured population, one state may wish to target its buy-in program to individuals with income below 400% of the FPL or to subpopulations within this income group, while another state may wish to focus on higher-income individuals who currently lack access to subsidized coverage (e.g., individuals with income above 400% of the FPL). Alternatively, some states may seek to focus on specific insurance markets, such as the small group insurance market. Understanding the state's unique coverage dynamics and defining program goals at the outset are critical first steps for policymakers and stakeholders considering a buy-in program, as such factors should drive the program's design.

While federal legislation is not needed for a state-sponsored buy-in to proceed, many—but not all—of the state-sponsored buy-in design proposals being considered by policymakers would require, or at least benefit significantly from, cooperation and/or support from the federal government under specific statutory authorities, mainly approval of an ACA Section 1332 State Innovation Waiver ("1332 waiver").[20] (See Box 5 for more information.) Such waiver approval—which gives states the flexibility to experiment with their health insurance markets within specified constraints, subject to federal discretion—would be needed for the state to capture and reinvest any savings that their reforms (in this case, a state-sponsored buy-in) produce for the federal government; without such a waiver, the federal government can retain those savings.

Of note, several objectives of buy-in programs—for example, lowering costs for consumers—may be achieved without a 1332 waiver. For example, a state-sponsored buy-in program operating on the Marketplace as a QHP public option can qualify for federal subsidies without a waiver and a BHP is authorized under ACA Section 1331 authority and does not require a waiver for federal funding. Waiver approval takes the reform a step further, however, and allows states to reap additional financial benefits from their reforms and further invest in lowering costs or achieving other state goals.

Overview of Models Leveraging Medicaid

State Medicaid Buy-In

In a Medicaid buy-in, the state allows consumers who are not eligible for Medicaid—for example, individuals whose income is higher than Medicaid eligibility levels but who find coverage unaffordable, or individuals who would be eligible for Medicaid if not for their immigration status—to purchase Medicaid-like coverage. The buy-in program could rely heavily on the state's Medicaid program to keep the cost of coverage low, but without federal Medicaid funding (which could be obtained only through a Section 1115 Medicaid waiver),[21] the state has the flexibility to decide which, if any, federal Medicaid rules it would follow. For example, it could adopt the state's Medicaid benefit package with certain likely exceptions (e.g., long-term care services) or choose to cover the state's Marketplace benchmark benefit package. Similarly the state could decide whether or not to use the Medicaid delivery infrastructure (i.e., the state's fee-for-service program, third-party administrator or

Box 5. 1332 "State Innovation Waiver" Basics

Section 1332 of the ACA permits states to request waivers from the Departments of Health and Human Services (HHS) and the Treasury on key components of the ACA: coverage mandates, benefits, subsidies, the Marketplace and QHPs.

All Section 1332 waivers must comply with guardrails protecting consumers and ensuring deficit neutrality:

- **Scope:** The waiver must provide coverage to at least as many people as the ACA would provide without the waiver. (Under new guidance, this is interpreted as access to coverage and is calculated based on the aggregate population rather than the impact on vulnerable groups.)
- **Comprehensiveness:** The waiver must provide coverage that is at least as "comprehensive" as coverage offered through the Marketplace. (Under new guidance, this is interpreted as access to coverage.)
- **Affordability:** The waiver must provide access to "coverage and cost-sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as Marketplace coverage. (Under new guidance, this is interpreted as access to coverage.)
- **Federal Deficit:** The waiver must not increase the federal deficit, including all changes in income, payroll or excise tax revenue, as well as any other forms of revenue.

States with reforms that reduce federal costs, such as federal premium tax credit spending, can receive "pass-through" funding in the amount of the savings to the federal government.

managed care plans). The state could set provider reimbursement rates (e.g., by leveraging Medicaid or Medicare benchmark rates) and could streamline administration by adopting or recognizing Medicaid enrollment, billing and other processes, so that participation in the buy-in program is not an added burden for providers or the state. Such a buy-in model would be offered off the federal or state-based Marketplace and outside the individual risk pool, given key coverage differences from Marketplace plans (e.g., benefits and rating rules). The program would also operate outside of the Medicaid risk pool, absent additional federal authority.

States may choose to open eligibility for the Medicaid buy-in program to a broad range of residents or narrow it to address specific coverage gaps (e.g., focusing on currently uninsured groups only). Buy-in enrollees would pay a monthly premium and cost-sharing associated with the Medicaid-like coverage, though the state could choose to offset some of these costs through state-funded subsidies to make coverage more affordable(on a sliding scale based on income.)

States could finance a Medicaid buy-in program through premium contributions from consumers and/or the state general fund, new assessments, or other state funding sources. Should a state wish to draw down federal Medicaid matching funds, it

would need to obtain Section 1115 waiver authority. If the state seeks to finance all or part of the program through the savings produced by the program, it would need to obtain a 1332 waiver to receive pass-through funding from the federal government, as noted above. Securing a waiver from the federal government would require state planning and coordination with and support from federal officials, and there is no guarantee that such a waiver would be approved under the current administration.[22]

Medicaid-Based Public Option

A Medicaid-based public option is similar to the Medicare-based public option discussed above, with the notable difference that a Medicaid-based public option would operate at the state level. Under a Medicaid public option, the state offers a new, state-sponsored coverage option on the Marketplace that operates as a QHP, meeting federal and state benefit and rating requirements. The state would leverage aspects of its Medicaid program, just as it might with a more targeted Medicaid-buy in, to keep the cost of coverage down, as long as QHP requirements are met. For example, the plan would include the ACA's essential health benefits rather than the state's Medicaid benefit package, but may leverage the state's Medicaid provider network to offer these benefits. Individuals would pay premiums and cost-sharing associated with coverage, just as they do for QHP coverage today and, depending on their income, they could qualify for the tax subsidy available to all QHP enrollees on the Marketplace. The public option could be open to individuals and employers who are currently able to purchase coverage on the Marketplace, across the state or in limited geographic regions (to fill a gap in insurer participation, for example).

A goal of the public option would be to provide a stable, lower-cost option to consumers. Importantly, given that the value of federal tax credits is tied to the cost of the Marketplace's benchmark plan, and that the introduction of a lower-cost public option could reduce the cost of the benchmark plan, individuals eligible for tax credits would not see a reduction in the cost of coverage. The people who would initially benefit from the lower-cost coverage are consumers without access to federal tax subsidies, for example, due to the ACA's "family glitch," their immigration status, or their income levels being above 400% of the FPL.[23] (Of note, lower-income individuals in this category would still likely need a subsidy to be able to afford the buy-in coverage, even with its lower cost.) The federal government—which would be making smaller tax subsidy payments as a result of the lower-cost benchmark plan—would also financially benefit from the buy-in. Should a state wish to capture the savings accruing to the federal government, it would need to obtain a 1332 waiver to apply the savings to buy-in program administration or use it to make coverage even more affordable.

Federal Authority for Medicaid-Based Buy-In

As noted, states do not need any federal approval to implement a Medicaid buy-in program that does not draw on federal funding, but states might consider pursuing a 1332 waiver to use pass-through funding or allow for federal tax subsidies to be used outside the Marketplace. By law, Section 1332 waivers must comply with guardrails protecting consumers and federal resources (see Box 5). Even if guardrails are met, there is limited precedent, and waivers are always under the discretion of HHS and the Treasury.

In the fall of 2018, CMS released new 1332 guidance and provided four model concepts outlining the types of waivers the current federal administration is likely to approve under their interpretation of the guardrails. While the guidance does not directly address buy-in, it indicates that the administration will consider allowing the use of premium tax credits on products outside the Marketplace for the first

time. This policy was designed to support less costly alternative plans, such as short-term limited duration health insurance plans, but buy-in proposals could rely on similar logic. The guidance does indicate a preference for private coverage innovations over public options, so it is unclear how the federal

Box 6. Lessons from Medicaid Buy-In Studies in New Mexico and Colorado

New Mexico and Colorado are two states looking to implement a Medicaid buy-in program. Proposal development in these states offer examples of how buy-in products can be tailored to meet state goals based on policy objectives, unique market features, healthcare industry dynamics (e.g., provider reimbursement rates), stakeholder needs and required federal authorities.

New Mexico. Forty percent of New Mexico's population is enrolled in Medicaid, a program administered by the state with strong managed care participation. In the individual market, the state's Marketplace has four insurers offering coverage, with average premiums lower than in many other states; and is one of the few states that still operates a high-risk pool that helps lower premiums. Still, the state has one of the highest uninsured rates in the country (at more than 9%) and 88% of the uninsured have income less than 400% of the FPL. New Mexico is evaluating whether a buy-in could increase affordability, expand coverage and improve access to care, particularly for populations who cannot access federal subsidies or public coverage. An initial study identified four potential approaches that could benefit New Mexicans: (1) implementing a targeted Medicaid buy-in, (2) offering a Medicaid-based public option, (3) introducing a BHP, and (4) pursuing a broad Medicaid buy-in for all. A second study modeled the impact of the targeted Medicaid buy-in option, with a particular focus on consumers with income under 200% of the FPL and on individuals and families that are not currently eligible for subsidized coverage, even though they have incomes under 400% of the FPL. This design would rely on premium contributions and state subsidies and would not require a 1332 waiver. The modeling found that a targeted buy-in that has a separate risk pool and is based on Medicaid provider rates would be more affordable, with have premiums that are 23%-28% lower than estimated average individual market premiums.[24]

Colorado. Colorado has focused its buy-in discussions on affordability, after average benchmark premiums in the state rose by 72% between 2014 and 2018—largely due to reduced competition, particularly in rural areas. In 2018, there was only one insurer in 22% of counties, and residents in the rural western part of the state faced silver-level plan premiums that were 42% higher, on average, than in the capital region. State policymakers and other stakeholders are considering coverage alternatives, and consumer advocates conducted a qualitative and quantitative feasibility assessment for a Medicaid buy-in product available to all Coloradans outside the individual market risk pool. The study found that with Medicare provider reimbursement rates, a buy-in plan could have a 28% lower premium than the average individual market plan in Colorado before the buy-in; this could mean $2,228 in annual savings for an unsubsidized individual. The state continues to explore additional options that would be offered on the Marketplace.[25]

government will respond to new coverage option waivers. To date, no new waivers have been approved since this new guidance was issued.

Uncertainty around meeting 1332 waiver requirements and/or securing 1332 authority may influence states' decisions relating to buy-in design or implementation timeline. State policymakers should consider the level of administrative and financial investment and risk they are willing to take, in the event a waiver is not approved or if limited flexibility is granted by the federal government under global pass-through payments.

There may be other opportunities for the federal government to support state-sponsored buy-ins through federal legislation, which are outlined in Box 7.

Overview of Models Leveraging the Basic Health Program

As state policymakers and stakeholders define and consider approaches to achieving their healthcare coverage and affordability goals, they may consider the BHP as authorized under the ACA or in an expanded form. Establishing a BHP accomplishes similar goals as a Medicaid buy-in for low-income populations, with clear authority under established statute to capture and utilize federal subsidies to fund coverage.

BHP as an Alternative to Buy-In

State implementation of the BHP, as authorized by the ACA, would entail creating a new coverage option for low-income residents; specifically, individuals with incomes below 200% of the FPL who would otherwise be eligible to purchase coverage through the Marketplace. This includes

Box 7. Federal Legislative Support for Medicaid Buy-In

Federal legislation could support state efforts to implement state-sponsored buy-in programs by providing direct authority for states to establish buy-in programs (potentially circumventing the need for federal waivers), creating new financing mechanisms, or even allowing states to "tie" provider participation in the state's Medicaid buy-in program with participation in Medicare. However, the current political landscape may make bipartisan passage of a Medicaid buy-in support bill, and any additional funding, challenging.

One such proposal was introduced during the 2018 legislative session: the **State Public Option Act** (Schatz/Luján). This act would extend ACA premium and cost-sharing subsidies to states that offer a silver-equivalent plan on the Marketplace (similar to the Medicaid public option discussed in this paper). In addition to providing tax credits to state-backed plans on the Marketplace, the bill would:

- Cap premium contributions at 9.5% of income for all income levels (including individuals with income above 400% of the FPL);
- Provide federal matching payments for state costs not covered by premiums and cost-sharing;
- Require reimbursement of primary care providers at Medicare rates or above; and
- Allocate $100 billion in grant funding for increased provider payments in the Medicaid program.

individuals who would be eligible for federally-funded Medicaid if not for their immigration status.[26]

To finance the BHP, states receive federal funding equal to 95% of the amount of the federal subsidies that would have been provided to (or on behalf of) BHP-eligible individuals if these individuals had enrolled in coverage on the Marketplace. States have the flexibility to design their BHP to align with Medicaid or QHP coverage. Benefits, plans and provider networks could resemble Medicaid or QHP coverage (provided that at least the ten essential health benefits required by the ACA are covered). BHP premiums and cost-sharing levels must meet certain parameters (e.g., premium obligations cannot exceed what they would have been in the silver benchmark plan, and cost-sharing must be at least as generous as the equivalent platinum-level plan for each income level). As with Medicaid buy-in, coverage could be provided through Medicaid managed care plans or QHP offerors. Importantly, eligible individuals would be required to enroll in a BHP plan to obtain subsidized coverage (meaning that they could not choose between BHP or QHP coverage), and BHP coverage must be in a new risk pool, separate from the individual market.

Two states currently have a BHP: Minnesota and New York. Both have seen success in lowering costs for consumers and saving money for the state, due to the fact that Minnesota and New York had state-funded programs in place prior to the ACA to cover at least some of the BHP-eligible population.[27]

Box 8. Federal Legislative Support for BHP Expansion

Similar to Medicaid-based buy-in, federal legislation could circumvent the need for federal waivers to expand the BHP. During the 2018 session, the **Basic Health Program Expansion Act** (Cantwell) was introduced, which would encourage state use of the BHP option and allow states to expand the BHP program to CHIP eligibility levels for the , typically between 200% and 400% of the FPL, without specific waiver authority.

Expanding BHP Through a BHP Buy-In

Once a BHP is in place, a state could apply for a 1332 waiver to **expand** its BHP that would allow individuals with incomes above 200% of the FPL to purchase BHP coverage. A state could choose to expand its BHP narrowly (e.g., just to individuals with incomes below 400% of the FPL) or broadly (e.g., to all individuals in the state).

Considerations

Policymakers contemplating buy-in should carefully explore a number of design, administrative and market considerations to ensure buy-in achieves underlying health reform objectives. Among those considerations are how best to utilize government administration and bargaining power, provider reimbursement and participation, and impact on other markets. For state-sponsored programs, local characteristics, such as the makeup of the states' uninsured population, its existing individual market enrollment, and its insurer and provider participation, are critical to understanding the impact of different buy-in approaches.

Administration

Federally-Sponsored Buy-In. While a targeted Medicare buy-in program could largely leverage existing resources and processes at CMS for

program administration, the Medicare public option would require new resources and administrative authority to operationalize the program. For example, because the public option would be offered to a wider population and additional benefits, not commonly used by Medicare beneficiaries (e.g., pediatric care, reproductive services and family healthcare), would be needed, requiring CMS to contract and negotiate with more, and different, providers and potentially modify payment rules and delivery systems.

Further, many of the Medicare buy-in proposals under consideration would allow enrollees to utilize federally-funded premium tax credits to purchase buy-in coverage, meaning the federal or state-based Marketplaces would need to play a role in determining eligibility and facilitating plan selection and enrollment, or CMS would need to perform these functions for buy-in enrollees. Such coordination with the Marketplaces could involve substantial administrative and logistical work; for a Medicare buy-in program with sizeable enrollment, it may be more efficient for CMS to take on more of the eligibility and enrollment functions for buy-in coverage as a result. As policymakers weigh how best to leverage government resources for lower-cost coverage, these potential efficiencies and impacts on the existing systems merit careful consideration.

State-Sponsored Buy-In. Medicaid buy-in and BHP models also utilize existing state government resources and infrastructure, though they would likely require additional resources for the design and operation of the new coverage product (e.g., support for actuarial analyses related to enrollment, population health risk and product pricing). States with Medicaid managed care programs could contract with one of their managed care plans to administer buy-in coverage, either off the Marketplace (e.g., as a Medicaid buy-in) or on the Marketplace (e.g., as a QHP public option). While states already undertake rate-setting, oversight and other regulatory functions in the context of administering their Medicaid program, additional investments would still be needed to implement a new buy-in program.

Provider Reimbursement and Participation

Many Medicare-based buy-in proposals presume Medicare-level, or slightly enhanced, provider reimbursement rates. State-based buy-in proposals to date typically presume Medicaid, Medicaid plus or Medicare rates. Wherever a buy-in is implemented, provider payment rates should be set to ensure adequate provider participation and reimbursement for provider costs.

Savings for a buy-in based on Medicare rates will differ considerably among states since Marketplace plan and current provider reimbursement rates vary, as described above. Similarly, buy-ins that use Medicaid rates, which are often lower than Medicare rates, may result in even greater savings and corresponding provider reaction, depending the differential between current Medicaid and Marketplace plan reimbursement levels. Providers will likely be skeptical of any large-scale buy-in program that would lower reimbursement rates, especially if the buy-in target population is currently enrolled in commercial coverage. This could lead to provider participation and network adequacy issues. One way buy-in models can promote provider participation and network adequacy is by “tying” provider participation in Medicare, Medicare Advantage, Medicaid or other state programs with participation in a buy-in. Tying to the Medicare program, for example, would likely ensure significant provider participation and potentially streamlined contracting, since more than 90% of the country’s primary care physicians currently participate in the Medicare program.[28]

Buy-ins could also benefit providers in several ways. Buy-ins that target currently uninsured populations could result in increased provider revenue, even with rates lower than commercial rates, by decreasing uncompensated care. In a Medicare-based buy-in, providers may also see administrative savings and welcomed simplification in a buy-in program that is closely aligned with the Medicare program through streamlined contracting requirements (e.g., credentialing and enrollment requirements), billing practices, and quality standards and reporting processes.

Impact on Other Markets

The precise impact of both federal- and state-sponsored buy-in on other markets will be based on enrollee behavior and existing insurer response to a new entrant. The impact will likely depend on multiple factors, among them: enrollees' health status, into which risk pool the buy-in enrollees are placed; the target population; and public receptiveness to the new coverage product. Premium pricing, cost-sharing levels, benefit design and network breadth are all critical factors in consumers' decision-making and therefore in assessing the buy-in's potential impact on existing markets. Additional considerations relating to the impact on the individual market risk pool are summarized in Figures 3 and 4.

Enrollee Health Status. A key factor for buy-in programs, particularly those offered in a separate risk pool, is who chooses to enroll. A targeted buy-in will have a defined population that is eligible to enroll in buy-in coverage, making the health status of enrollees somewhat more predictable. For example, in an age-based buy-in (e.g., one open to individuals between 50 and 64 years of age), policymakers and analysts will have a better sense of the costs of the population relative to the general Marketplace population (in this case, those costs are likely to be higher). However, most buy-in models assume voluntary enrollment, meaning consumers have the choice to select buy-in coverage. If premiums for the buy-in coverage are lower than those for other coverage options, the buy-in plan may be a popular choice for healthier, already insured individuals. This trend could be exacerbated by differences in cost-sharing obligations; for example, if out-of-pocket obligations are higher in the Medicare buy-in than in Marketplace coverage, individuals with complex and/or chronic conditions may decide against enrolling in the Medicare buy-in options. For public options available more broadly, the impact on the individual market is more contingent on whether the option attracts the healthy uninsured. Other Marketplace insurers may also be concerned if public option enrollees are disproportionately healthy and moving out of existing products.[29]

Marketplace and Risk Pool Participation. The risk pool for buy-in coverage can also have a significant impact on the overall market. A public option buy-in plan that is offered on the Marketplace and in the individual market risk pool can positively impact the market by providing a stable coverage option, potentially increasing competition and attracting new consumers. Buy-in product pricing is a key factor, however, as a buy-in plan that is significantly lower-cost than other options on the market may have the effect of driving away other plan offerors who are unable to compete with a public plan, thereby reducing competition and consumer choice.

Offering a buy-in off the Marketplace and outside the individual market risk pool can impact the existing markets in different ways, depending on which consumers choose to purchase buy-in coverage. If healthier individuals move from the current market to the separate buy-in risk pool, the overall health status of the remaining individual market risk pool will be impacted and premiums for those remaining will likely increase. Similarly, if less healthy current enrollees decide to purchase buy-in coverage outside the individual market risk pool, premiums for those remaining in the individual market would likely go down.

Risk stabilization initiatives could be included in any of the buy-in designs to help minimize the impact on the existing market. For example, legislation creating a Medicare-based buy-in program could include stabilization policies for the broader market, like reinstituting the national reinsurance program or providing enhanced funding for risk adjustment programs.

In light of the wide range of potential impacts of a buy-in program on existing markets, particularly the individual market, it will be critical for policymakers and stakeholders to analyze the likely size and characteristics of the buy-in enrollee population in the context of its current market enrollment, and to be mindful of unintended consequences of buy-in design decisions. If existing markets are negatively impacted by a buy-in, then its implementation may lead to uneven benefits across populations and may undermine the overall goals of a buy-in.

Figure 3. Potential Buy-In Model Risk Pool Placement

		Coverage Risk Pool	
		Separate	**Individual Market**
Federally-Sponsored	**Targeted Age-Based Medicare Buy-In**	✓ Medicare or new buy-in pool	
	Medicare-Based Public Option		✓
State-Sponsored	**State Medicaid Buy-In**	✓ New buy-in pool, outside Medicaid pool	
	Medicaid-Based Public Option		✓
	Basic Health Program	✓ BHP risk pool	

Figure 4. Potential Impacts of Buy-In on Individual Market, Based on Program Features

<table>
<tr><th colspan="2"></th><th colspan="2">Population Enrolled in Buy-In Coverage</th></tr>
<tr><th colspan="2"></th><th>Buy-in attracts enrollees who were previously uninsured</th><th>Buy-in attracts enrollees who were previously enrolled in Marketplace coverage</th></tr>
<tr><td rowspan="2">Risk Pool for Buy-In Enrollees</td><td>In the individual market risk pool (e.g., public option models)</td><td>If buy-in attracts healthier enrollees: The overall status of the risk pool and stability of the market would improve, due to the influx of healthy new enrollees.
If buy-in attracts less healthy enrollees: The risk pool and market would be impacted negatively, due to the influx of sicker, more expensive new enrollees.</td><td>If buy-in attracts healthier enrollees: Since enrollees are already included in the risk pool, the impact would be limited, unless existing plans leave the market in response to a new entrant.
If buy-in attracts less healthy enrollees: The impact to the overall risk pool would be limited because of risk adjustment. (These enrollees could impact buy-in costs if coverage is more expensive than anticipated; and may impact state costs depending on state buy-in designs and financing.)</td></tr>
<tr><td>In a separate risk pool (e.g., targeted Medicare buy-in, state Medicaid buy-in)</td><td>Limited impact to the individual market, no matter the health status of buy-in enrollees.
Note, however, program costs (and potentially state costs) would be impacted if the buy-in attracted less healthy enrollees than anticipated.</td><td>If buy-in attracts healthier enrollees: The Marketplace risk pool would be hurt, given the migration of healthier enrollees away from the individual market risk pool to a new risk pool; it could be further impacted if existing plans exit the market as a result.
If buy-in attracts less healthy enrollees: The existing risk pool would be improved, given the migration of less healthy enrollees away from the individual market risk pool to a new risk pool. (These enrollees could impact costs, as above.)</td></tr>
</table>

Conclusion

There are merits and limitations to federal- and state-sponsored buy-in approaches. A Medicare-based buy-in option has some clear advantages, such as streamlined authority and administrative support at the federal agency level. Additionally, given the role the federal government plays in subsidizing coverage under the ACA—and that many of the savings produced by reforms like buy-in accrue to the federal government as a result—a Medicare-based buy-in program may be easier to rationalize. As a major funder of healthcare coverage and administrator of subsidies under the ACA, the federal government is a natural platform for offering a buy-in program. Further, a Medicare-based buy-in could also serve as a nationally standardized option, available across states to improve coverage, access and affordability. Implementation of the Medicare buy-in models discussed in this paper—particularly the targeted buy-in that expands eligibility to the existing Medicare program—would require federal legislation, as there is no current authority for the federal administration to implement such a program on its own, and securing such legislation would be challenging with a divided government at the federal level. Nonetheless, there are several active buy-in bills; and in an environment of "Medicare for All," discussions of how to leverage the Medicare program to reform healthcare coverage and improve access to care are likely to persist through the next Congress and into the 2020 presidential campaign.

A state-based approach also has its advantages: states can move forward without federal legislation or even federal authorization (though, as noted above, with some limitations on the ability for the state to redeploy savings). The health and stability of the Marketplaces vary among the states, and states may be better positioned to tailor a buy-in program to their particular needs and address gaps in local healthcare systems. But states often have limited resources and capacity to take on the financial and administrative responsibility of a new coverage option. And while state-based approaches may drive innovation, which could then spread, at least in the short term a state-based approach is likely to increase the already widening variations in access to coverage across states. Federal legislative support for state-based innovations with additional authority, funding or interaction with existing federal programs (as described in Boxes 7 and 8) may be a pragmatic way to move government-sponsored health reforms forward in the short term, and could serve as an example for future collaborative national reform.

Appendix: Federal Medicare-Based Buy-In Proposals

Several bills introduced in the last legislative cycle offer examples of how congressional action could create Medicare-based buy-in programs. Notably, some of these proposals also include system-wide reforms that seek to improve the functioning of the public options they propose.

Targeted Medicare Buy-In Proposals

- **Medicare at 55 Act** (Introduced by Senator Debbie Stabenow, D-Michigan): Would allow residents over 55 to buy into Medicare Parts A, B and D, and gives enrollees the option to pay an additional fee for Medicare Advantage (Part C) coverage. Enrollees would contribute a premium, calculated to cover benefit and overhead costs, which would be deposited into the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The plan would utilize the Medicare enrollment period with Marketplace application support for enrollees using ACA subsidies. Providers would be reimbursed at Medicare rates.
- **Medicare Buy-In and Health Care Stabilization Act of 2017** (Introduced by Representative Brian Higgins, D-New York): Would permit residents over 50 who meet traditional Medicare requirements (other than age) to enroll in the Medicare program, with variable premium contributions based on geography. (As will the Medicare at 55 Act, enrollees would also have an opportunity to buy into Medicare Advantage plan coverage.) Premiums would be calculated to minimize financial risk to the existing Medicare program and deposited to a newly created trust fund dedicated to the buy-in program. Enrollment would take place through the Marketplace during the open enrollment period, with subsidies based on the silver-level plan. Employers would also be permitted to purchase coverage for employees. The bill would also allow HHS to negotiate drug prices in Medicare Part D, increase cost-sharing reductions and actuarial value for silver-level plans for all Marketplace enrollees earning up to 400% of the FPL and reestablish the national reinsurance program.

Medicare Public Option Proposals

- **Medicare-X Choice Act** (Introduced by Senator Michael Bennet, D-Colorado/Representative Brian Higgins, D-New York): Would offer silver and gold-level public options for ACA-eligible individuals and small groups under Marketplace benefit, premium design, cost-sharing and rating rules. The plan would be offered initially in regions with one issuer and/or relatively high costs, with a full national rollout in subsequent years. Provider participation would be tied to Medicare network participation, and the plan would use Medicare rates, with a 25% rate increase in rural areas, with HHS-negotiated rates for new, non-Medicare services. The bill would also permit HHS to negotiate drug prices in Medicare and the Medicare-X program and authorizes a nationwide reinsurance program.
- **The Consumer Health Options and Insurance Competition Enhancement (CHOICE) Act** (Introduced by Representative Jan Schakowsky, D-Illinois/ Senator Sheldon Whitehouse, D-Rhode Island): Would offer a Medicare-based public plan to all ACA-eligible individuals and small groups purchasing coverage on the Marketplaces, at bronze, silver and gold metal levels, under existing

Marketplace rules. The provider network would include Medicare and Medicaid providers, unless an opt-out is granted. Reimbursement rates would be negotiated by the HHS Secretary, with Medicare rates as the default. The plan would be self-sustained through premiums contributions and would have a new, separate account in the U.S. Treasury.

- **Choose Medicare Act** (Introduced by Senator Jeff Merkley, D-Oregon/Representative Cedric Richmond, D-Louisiana): Would offer a Medicare-based plan ("Medicare Part E") to all residents not eligible for other government programs. The plan would be offered to individuals and to large and small groups on the Marketplace, with ACA-defined and Medicare Parts A, B and D benefit coverage with cost-sharing at the gold level. Medicare providers would be tied to participate in the new plan; rates would be newly negotiated, but set to no lower than current Medicare rates. The bill also includes reforms to other health programs, including changing Marketplace the benchmark and cost-sharing reduction calculations to gold-level plans; extending ACA rating rules to the large group market; expanding federal tax credits to individuals earning up to 600% of the FPL; providing funding for a three-year national reinsurance program; instituting a $6,700 indexed annual out-of-pocket cap to the current Medicare program; and allowing for drug pricing negotiations in Medicare.

[1] CMS. 2018 Average Effectuated Enrollment Data. September 2018.

[2] CDC National Center for Health Statistics. Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, January–March 2018. August 2018.

[3] Kamal, R., Cox, C., et al. How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans Are Affecting 2019 Premiums. Kaiser Family Foundation. October 2018.

[4] The average deductible is based on data from 39 states with federally-facilitated or state partnership Marketplaces. For more information, see Kaiser Family Foundation. Cost-Sharing for Plans Offered in the Federal Marketplace for 2019. December 2018.

[5] Fehr, R., Cox, C., Levitt, L. Insurer Participation on ACA Marketplaces, 2014-2019. Kaiser Family Foundation. November 2018.

[6] Riffkin, R. Americans With Government Health Plans Most Satisfied. Gallup. November 2015.

[7] Norton, M., DiJulio, B., Brodie, M. Medicare and Medicaid at 50. Kaiser Family Foundation. July 2015.

[8] Kaiser Family Foundation. Data Note: 10 Charts About Public Opinion on Medicaid. June 2017.

[9] Ross, C. An Obamacare Win: No 'Bare Counties' for Health Insurance Next Year. Public Broadcasting Service. August 2017. For more information, see Lucia, K., Hoadley, J., et al. Stepping Into the Breach: How States and Insurers Worked Together to Prevent Bare Counties for 2018. Robert Wood Johnson Foundation/Urban Institute. November 2017. Fehr, R., Cox, C., Levitt, L. Insurer Participation on ACA Marketplaces, 2014-2019.

[10] Profit margins will vary by buy-in design and tax obligations will differ by state. Medicare Advantage plans are not subject to state premium taxes—they are explicitly pre-empted by federal statute—and the ACA "health insurance provider fee" does not apply to nonprofit plans if 80% of their business is Medicare or Medicaid. 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).

[11] For more information see: Riley, T., Cousart, C. Health Care Is Local: Impact of Income and Geography on Premiums and Premium Support. National Academy of State Health Policy. June 2017; Blumberg, L. and Holahan, J. High Premiums in Nongroup Insurance Markets: Identifying Causes and Possible Remedies and Holahan, J., Wengle, E., et al. What Explains the 21 Percent Increase in 2017 Marketplace Premiums, and Why Do Increases Vary Across the Country? Urban Institute. January 2017.

[12] For more information see: Holahan, J., Skopec, L., et al. Why Does Medicare Advantage Work Better Than Marketplaces? Urban Institute. January 2018; Holahan, L., Blumberg, L., et al. What's Behind 2018 and 2019 Marketplace Insurer Participation and Pricing Decisions? Urban Institute. January 2019.

[13] Buy-in models that leverage state employee coverage programs are also under consideration in some states; however, this paper does not discuss those programs in detail.

[14] Kaiser Family Foundation. Health Insurance Coverage of the Total Population: 2017. 2017; CMS. National Health Expenditure Data, 2017.

[15] Some of the existing Medicare-based buy-in proposals also look to combine a buy-in program with other Medicare cost-reduction initiatives, such as achieving savings by allowing the federal government to negotiate drug prices in Medicare, and combining this Medicare purchasing power with that of the buy-in program.

[16] In the event enrollment is allowed through the federal or state-based Marketplaces, the Marketplaces would provide eligibility and enrollment functions regardless of whether the buy-in is designed to be part of the individual market or the Marketplace risk pool.

[17] Essential health benefits include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and management of chronic diseases; and pediatric services, including oral and vision care.

[18] In 2013, the Congressional Budget Office (CBO) estimated that adding a public plan to the Marketplace with self-sustaining premiums and provider reimbursement set at Medicare plus 5% would reduce the federal budget deficit by $158 billion through 2023. For more detail, see: CBO. Options for Reducing the Deficit: 2014 to 2023. November 2013.

[19] Some states currently operate buy-in programs with their Children's Health Insurance Program (CHIP) and states could choose to implement buy-in programs with that program. Medicaid has a broader reach than CHIP, in the vast majority of states, is a logical platform for advancing reforms for broader populations.

[20] The Patient Protection and Affordable Care Act, H.R. 3590. § 1332 (2010).

[21] At a state's request, the Secretary of the HHS has authority to waive certain Medicaid rules through a Section 1115 waiver as an "experiment" or "demonstration," so long as the waiver supports the objectives of the Medicaid program and is budget neutral to the federal government.

[22] For more information see: Boozang, B., Brooks-LaSure, C. Medicaid Buy-In: State Options, Design Considerations and 1332 Implications. Manatt Health/Robert Wood Johnson Foundation. May 2018.

[23] Individuals affected by the "family glitch" are those whose family is offered employer insurance and the employee's premium amount is "affordable" (i.e., less than 9.56% of income), which prevents other members from receiving subsidies, regardless of the additional premium cost of family coverage.

[24] For more information see: Boozang, P., Brooks-LaSure, C., et al. Evaluating Medicaid Buy-In Options for New Mexico. Manatt Health. December 2018; Brooks-LaSure, C., Grady, A., et al. Quantitative Evaluation of a Targeted Medicaid Buy-In for New Mexico. Manatt Health. January 2019.

[25] For more information see: Brooks-LaSure, C., Guyer, J., et al. Strategies for an Affordable Medicaid Buy-In Option in Colorado. Manatt Health. December 2018.

[26] The Patient Protection and Affordable Care Act, H.R. 3590. § 1331 (2010).

[27] Tolbert, J., Antonisse, L. Improving the Affordability of Coverage Through the Basic Health Program in Minnesota and New York. Kaiser Family Foundation. December 2016.

[28] Boccuti, C., Fields, C., et al. Primary Care Physicians Accepting Medicare: A Snapshot. Kaiser Family Foundation. October 2015.

[29] Enrollees attracted to the public option buy-in model based on its position as the lowest-cost coverage option are more likely to be young and healthy. Alternatively, customers looking for stability or an expanded provider network (particularly in the Medicare-based public option buy-in) may be more likely to have health conditions.

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