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Evolving Public Option/Medicaid Buy-In Models and Considerations

Maryland Health Insurance Coverage Protection Commission

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Agenda

- Policy Context and State Goals
- Evolving State Option Models
- 1332 Waiver Considerations
- Creating a Legislative Package

Characteristics of the Remaining Uninsured

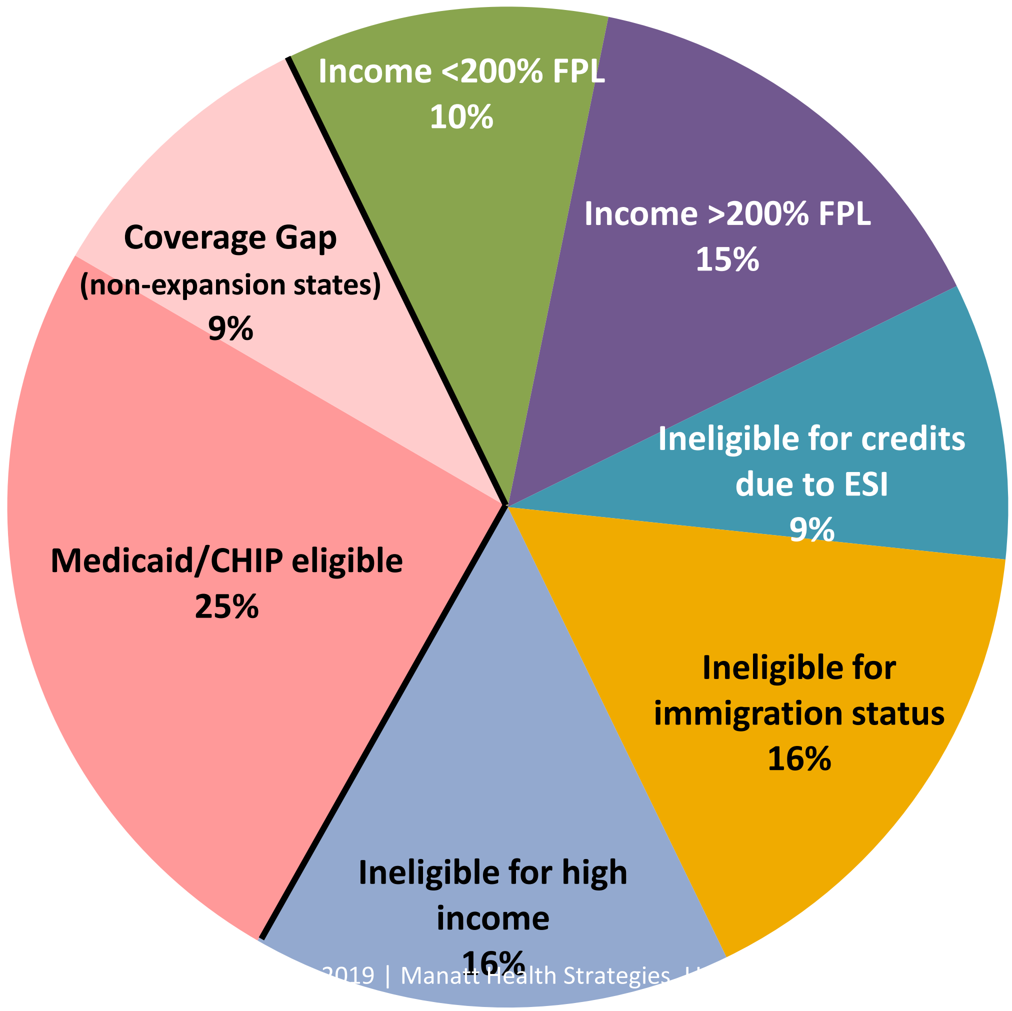
In 2017, 30 million non-elderly Americans remained uninsured

To continue expanding coverage, federal and state policymakers should consider the characteristics of the remaining uninsured when designing interventions

Program Eligibility for the Remaining Uninsured, Nationally

Medicaid Eligible

34% (10.3 M) of the currently uninsured are eligible for Medicaid/CHIP, in states that have and have not expanded Medicaid



Marketplace Eligible

25% are eligible for tax credits, but do not participate on the Marketplace

An additional 41% are ineligible for tax credits

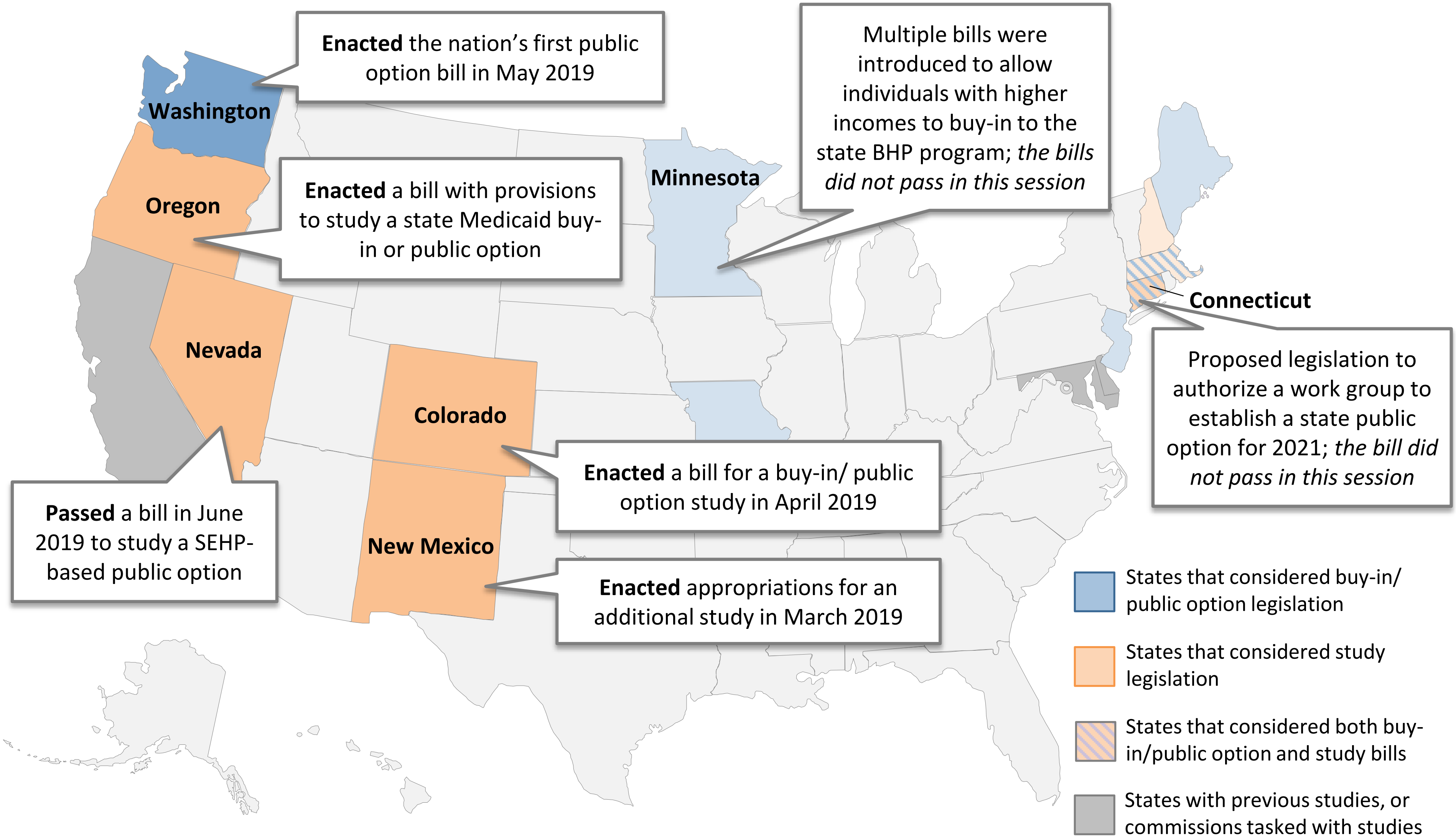
Adapted from the Urban Institute, [Characteristics of the Remaining Uninsured: An Update], July 2018

State Affordability Goals

Each state has specific market dynamics and health policy goals to consider when choosing affordability and cost-containment policies

- Reduced premiums to make purchasing coverage more affordable
- Reduced cost-sharing (deductibles, co-insurance, etc.) to make coverage more attractive and care more affordable
- Access for the uninsured and unsubsidized
- Strengthening the Marketplace by attracting customers and maintaining a balanced risk pool
- Increasing state purchasing power across programs
- Promoting healthcare initiatives that improve health outcomes and result in long-term savings
- Curtailing overall healthcare costs

The State of Play for Buy-in/Public Option Proposals



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Definition of “Medicaid Buy-in”

The concept of Medicaid buy-in is evolving, encompassing the original Medicaid-based proposals and extending to other programs through which **states can leverage government bargaining power to offer a more affordable coverage option**, like state employee health plans or a Basic Health Program

States are also increasingly interested in state-sponsored plans, or “public options,” offered on the Marketplace in partnership with an existing insurer(s)

"State Options": Evolving Models

Off-Market Buy-in	On Marketplace Public Option	Basic Health Program Buy-In
The State makes Medicaid-*like* coverage available to consumers who are not eligible for Medicaid; coverage offered as an off-market, state-administered buy-in plan	The State offers a state-sponsored qualified health plan (QHP) on the Marketplace and may also offer a plan in the individual market to those who do not qualify for the Marketplace (e.g., for immigration status); potentially in partnership with an existing managed care plan	The State offers a Basic Health Program (BHP) to individuals with incomes below 200% of the federal poverty line (FPL) who are not Medicaid-eligible, and could redesign and expand plans to individuals with higher income eligibility, allowing them a choice to buy-in to the program

Potential Sources of State Option Savings

Model selection and design should play to the state's strengths and potential for buy-in savings, balanced against potential stakeholder impact

Savings sources may include:

- Provider payment rates
- Administrative efficiencies
- State purchasing power
- Long-term savings through investments in population health and delivery systems

Financing can be:

- Self-sustaining (financed only through enrollee premium contributions)
- Subsidized with state dollars
- Funded through federal savings obtained under a 1332 waiver
- Some combination of these three funding sources

Case Study: Washington State's First-in-the-Nation Public Option

The goal of Washington's public option is to increase affordability and choice for unsubsidized customers priced out of the market

- Under the law, Washington Health Care Authority will **contract with one or more insurers to provide state-sponsored plans**, known as "Cascade Care," on the state Marketplace for plan year 2021; the law also institutes standardized plans for all insurers on the Marketplace

- Cascade Care plans will be subject to an **aggregate reimbursement cap of 160% of Medicare rates**, with reimbursement floors for:
    - Primary care physician at <135% of Medicare
    - Rural hospitals at <101% of Medicare allowable costs
    - *Exceptions:* If the cap will raise premiums; if plans can achieve 10% premium reductions through other means; and/or plans are unable to form adequate networks given the reimbursement restrictions

- The study also commissioned studies on the potential impact of future **provider tying and state subsidies** for those <500% FPL

- The three state agencies— Washington Health Benefit Exchange (HBE), Health Care Authority (HCA), and Office of the Insurance Commissioner (OIC)—are working closely on all aspects of implementation

- The plans are projected to **reduce premiums by 5-10%**

State Dynamics

- This year, 14 of 39 counties have only one insurer offering plans on the Marketplace
- 2019 average benchmark premiums are $381/month; below the national average
- Only 65% of Marketplace participants receive subsidies; one of the lowest rates in the nation

Case Study: New Mexico: Studying Multiple Options

In 2018, New Mexico led the nation in the study of buy-in models, and performed a quantitative analysis of a Targeted Buy-in model

- Under previous legislation, New Mexico commissioned a study “to ensure health care coverage is expanded to low-income, uninsured residents.” The study outlined four basic buy-in options:
  1. **Targeted Medicaid Buy-In**
  2. Qualified Health Plan (QHP) Public Option
  3. Basic Health Program (BHP)
  4. Medicaid Buy-In for All

State Dynamics

- New Mexico has a small Marketplace population, and benchmark premiums lower than the national average ($365 vs. $477) in 2019
- 82% of Marketplace enrollees receive subsidies and 34% of New Mexicans were on Medicaid in 2017, the highest proportion in the country

What’s Next?

- New Mexico is engaged in re-strategizing after Targeted Buy-in legislation did not pass; the Governor, advocates, and key legislators remain supportive of buy-in as a 2020 legislative priority
- Funding for additional study was appropriated in 2019

Targeted Buy-In Study Results

- Specially targeted people ineligible for federal subsidies (e.g., immigration status or family glitch)
- Premiums reduction of 15-28% relative to the average and lowest-cost premiums in the Marketplace (est. $377-$403/monthly)
- Projected total enrollment from 7,000-16,000
- State costs ranging from $12 million to $48 million for state subsidies for low-income enrollees

Case Study: Colorado's State Option Study

In May, Colorado enacted HB 19-1004 to study a "state option for health care coverage" before November 2019

- **Coverage.** All state residents will be eligible; the plan will be available in all counties on- and off- the Marketplace
- **Benefits.** As a QHP, the State Option will cover all Essential Health Benefits and mandate "many" preventive care, primary care, and behavioral health care services be provided pre-deductible
- **Administration.** Offered through existing insurers; and carriers of a certain (unspecified) size will be required to offer the option
- **Savings.** Carriers will be requiring to achieve a 85% medical loss ratio (up from the current 80% obligation), use all prescription drug rebates and other compensation paid by drug manufacturers to reduce premiums, and cap facility reimbursements at 175%-225% of Medicare
- **Financing.** The State Option will be self-funded, but the report recommends applying for a 1332 waiver for federal pass-through funding
- **Premiums.** State analysis estimated a 9% to 18% premium decrease, compared to expected 2022 rates

State Dynamics

- In 2018, 16 of 64 (25%) of counties only had one insurer offering plans on the Marketplace
- 2019 average benchmark premiums are $488/month; above the national average ($477/month); in rural parts of the state premiums are over 40% higher
- 74% of Marketplace enrollees receive subsidies
- A recently-passed reinsurance program is expected to decrease premiums by 18% across the state

Public comment will be accepted until October 25; and the final due to the legislature on November 15

Emerging Lessons and Themes Across States

- Specific state dynamics will influence the option design choice
- Provider responses will depend on reimbursement rates and the option's enrollee population
- Stakeholders must balance priorities—target population (by income, uninsured, immigration status, etc.), premium vs. cost-sharing affordability, eligibility, etc.—and some concessions may be required
- Designs often impact subsidized and unsubsidized populations differently
- Concerns about the state risk and effects on the remaining population; particularly without federal waiver funding
- Combining reforms can help meet multiple goals, but a legislative package may make it harder to achieve consensus from multiple stakeholders

Meeting the 1332 Requirements

The 2015 guidance established strict standards for applying the guardrails; In 2018, the Departments of Health and Human Service and Treasury relaxed some of these standards, Administration has discretion not to approve waiver that meet all of the guardrails

Guardrails

1 *Scope of Coverage*

The waiver must provide coverage to at least as many people as the ACA would provide without the waiver

2 *Comprehensive Coverage*

The waiver must provide coverage that is at least as "comprehensive" as coverage offered through the Marketplace

3 *Affordability*

The waiver must provide "coverage and cost-sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as Marketplace coverage

4 *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

Other Requirements

CMS and the Treasury Department will require contingency language indicating that state will not implement policy in absence of a waiver

The state must indicate a waivable policy provision of the ACA to receive pass-through funding

The State Option Cannot Solve Everything

- It is important to understand that a state option is **not a panacea**
- It is **not a one-size-fits-all model** for providing universal coverage and increasing affordability
- It may **not be the simplest way to address high out-of-pocket costs** or high premiums in the existing insurance market
- It **may not change behavior** among people who are currently eligible for other programs but do not seek coverage

- States may have a range of goals, some of which might be in conflict
- Meeting multiple goals—even when goals do not directly conflict—can be a challenge; prioritization is key
- State policymakers will need to understand and account for divergent stakeholder perspectives (e.g., advocates, insurers, providers)

Combining Policies for A Health Reform Package

States can consider combining policies to meet a diverse set of health policy goals and states may design a legislative package that mitigates risks to other populations

State-Based Marketplace
Offers the state more flexibility

Standardized Plans
Can help address cost-sharing affordability

Individual Mandate
Will continue to promote access and attract healthy risk into the market

Reinsurance
Can further reduce premiums across the Marketplace

Agency Coordination
May increase enrollment and continuity among churn populations

State Subsidies*
Can increase available design and promote affordability for target populations

State Options
(Buy-In/Public Option)

**Savings from other policies could be used to fund subsidies*

Key Questions for Maryland

- What problem(s) is Maryland trying to solve? Is the buy-in an effective strategy to address that problem(s)?
- Who remains uninsured in Maryland and how will that influence policy design?
- What are the potential sources of cost-savings in the state?
- What existing infrastructure is the most natural fit for a state option?
- What are the potential impacts of a state option on other insurance markets in Maryland?
- Does the state require, or would it be beneficial to pursue, a 1332 waiver
- Is Maryland well positioned to implement a state option?

Any questions?

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Thank you!

About Manatt Health

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Biography

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Education

- Georgetown University, M.P.P., Public Policy, 1999.
- Princeton University, A.B., Politics, 1996.

About

Ms. Brooks-LaSure has more than 15 years of experience in health policy analysis and strategic consulting. She helped shepherd House healthcare reform bill development and negotiated with the Senate and the Obama Administration on the Affordable Care Act (ACA). As an Administration policy official, she also executed coverage and insurance reform provisions during the ACA's implementation. Her work centers on providing policy analysis and strategic advice to the full gamut of healthcare stakeholders across both the private and public sectors. Her areas of policy focus include marketplaces, insurance reforms, employer coverage, Medicare Advantage and Part D.

Prior to Manatt, Ms. Brooks-LaSure served as deputy director for policy and regulation at the Center for Consumer Information and Insurance Oversight (CCIIO), Centers for Medicare and Medicaid Services (CMS). Ms. Brooks-LaSure came to CCIIO from the HHS Office of Health Reform where she was director of coverage policy. In that role, she advised senior leadership at the White House and HHS on policy options and negotiated policy agreements between HHS offices and agencies, as well as with the White House, Office of Management and Budget (OMB), and Treasury and Labor Departments. Ms. Brooks-LaSure also served on the Democratic professional staff for the U.S. House of Representatives Ways and Means Committee.