

Medicaid Buy-In: State of Play

To: *Interested Parties*
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Re: *Medicaid Buy-in*



Key Highlights

- æ Medicaid Buy-in is generating excitement from both consumer groups and state governments interested in improving health insurance affordability and choice.
- æ States may explore Medicaid Buy-in for a variety of reasons, and each state's approach will likely be designed differently to meet the state's unique needs.
- æ Fourteen states are in various stages of exploring Medicaid Buy-in, through studies or legislation.

As states look for opportunities to control insurance costs, stabilize their insurance markets and provide consumers with more options, Medicaid Buy-in is emerging as a potential solution under consideration in many states.

The results of the recent midterm elections show that health care is top of mind for American voters. Forty-one percent of national voters in exit polls identified health care as the single most important issue facing the nation, outpacing both immigration and the economy.¹ With a divided federal government, meaningful federal action to expand coverage, including significant progress to modify the Affordable Care Act or action on the various proposals that would allow people to purchase Medicare coverage², is highly unlikely for the next two years. In the near-term, states will be the testing grounds for developing new ways to expand insurance coverage. Some state leaders are already looking for ways to improve health care affordability and choice. Because Medicaid is primarily state-run, it provides an option for states to explore in order to make health care coverage more affordable.

WHAT IS MEDICAID BUY-IN?

The term "Medicaid Buy-in" is used to describe differently structured proposals, but all would create a way for some people who are not currently eligible for Medicaid³ to purchase Medicaid or Medicaid-like coverage. Just as no two states have identical Medicaid programs, Medicaid buy-in proposals are likely to vary from state to state.

- æ Buy-in proposals aim to make available the relatively robust and affordable coverage Medicaid typically provides to people who don't otherwise qualify. The goal is not to change the Medicaid program for those already eligible and enrolled.
- æ In this context, Medicaid Buy-in should not be confused with existing programs in many states that allow individuals with disabilities to buy Medicaid coverage if their income or assets would otherwise make them ineligible for Medicaid coverage.⁴

MEDICAID BUY-IN IS AN APPEALING OPTION FOR CONSUMERS

Medicaid is no longer just a niche program for certain populations. It is a familiar source of affordable health care for many families and communities, providing health care coverage to 19% of the U.S. population.⁵ Medicaid has evolved to fit the diverse needs of different enrollees, including children, parents, those receiving long-term care, people with disabilities and childless adults. Medicaid provides comprehensive coverage of benefits tailored to different groups of enrollees in the program with minimal cost sharing.⁶ And Medicaid beneficiaries are generally satisfied with

their care, with Medicaid enrollees in a recent study rating their care a 7.9 on a scale of 0-10.⁷ People who became eligible for Medicaid under the Affordable Care Act's expansion rate their coverage even more highly than those enrolling in Marketplace coverage. A Commonwealth Fund study in 2016 found that 77 percent of adults with marketplace plans and 88 percent of those newly enrolled in Medicaid were very or somewhat satisfied with their health insurance.⁸ A recent poll found that 51% of respondents are in favor of Medicaid Buy-in plan, with only 9.6% opposed.⁹

MEDICAID BUY-IN IS AN APPEALING OPTION FOR STATE POLICYMAKERS

Medicaid Buy-in proposals can appeal to state policymakers for many different reasons. Medicaid is an efficient program, and while it occupies significant percentages of states' budgets, when controlled for enrollees' health status, Medicaid costs less than private insurance. Similarly, Medicaid's per enrollee costs have grown more slowly compared to other payers.¹⁰

Medicaid Buy-in proposals can be structured to help state policymakers achieve a range of goals and address varying priorities.

Increasing choice and competition:

In 2019, 35% of counties will have only one issuer offering coverage on the Marketplace.¹¹ Creating a way for consumers to purchase Medicaid coverage could generate more competition in areas with few issuers, giving consumers more choices, and reducing the risk of bare counties with no issuers offering coverage.

- æ More affordable coverage:** A coverage option built on the framework of the Medicaid program could provide a more affordable option by leveraging the administrative and marketing savings and lower per-enrollee costs of the program relative to commercial insurance.
- æ Minimizing churn and disruption:** People in the individual insurance market can experience “churn” as their income changes and they move between Medicaid and the private insurance market.¹² Depending on the way it is designed, a Medicaid Buy-in option could help minimize the disruption that consumers currently face when their circumstances change.
- æ State public option tool:** As polls register support¹³ for proposals to allow people to purchase Medicare coverage before age 65, pursuing Medicaid Buy-in gives state officials a way to respond to their constituents’ interest in additional public coverage choices, especially when federal policymakers are unlikely to enact this type of option.

MEDICAID BUY-IN DESIGN OPTIONS AND ISSUES

The different reasons a state may pursue a Medicaid Buy-In proposal will help to shape the way the proposal is structured. Every state’s Medicaid program is unique, and similarly, no two states are likely to have Buy-in proposals that are identical. Pursuing Buy-in gives states the flexibility to design a coverage option tailored to their unique needs, taking into consideration their existing markets, populations and delivery system. Some states, for example, may be well-positioned to leverage existing Medicaid Managed Care Organizations (MCOs) as a part of a Buy-in.

States thinking about creating a Medicaid Buy-in first need to answer a series of questions and explore the trade-offs. As discussed above, states may pursue a Medicaid Buy-In for varying reasons and to solve different problems. The policy design choices that a state ultimately makes should be guided by their top priority for pursuing a Medicaid Buy-in.

Mannatt Health, in partnership with the State Health & Value Strategies, has laid out two primary design options that states can consider for Medicaid Buy-in: a state sponsored product available on the state’s Marketplace or a Medicaid Buy-in outside of the Marketplace.¹⁴ Both of these options present different a series of complex and interrelated implementation decisions, including how rates and premiums are set, whether consumers can utilize premium tax credits when they purchase coverage, what benefits will be offered (and if consumers are purchasing ACA compliant Qualified Health Plans), and how to mitigate adverse selection or risk segmentation that could occur.

Policymakers must also carefully consider provider payment rates, and whether enrolling additional customers in plans that tend to pay lower rates will result in sufficient provider participation and access to care. A new coverage option that attracts people currently enrolled in commercial plans that typically pay higher rates could require a different approach than one that primarily attracts those who are currently uninsured. In most cases, states would need to receive permission from the federal government, in the form of a State Innovation Waiver, to allow people to use their tax credits to purchase Medicaid or Medicaid-like coverage on the Exchange.

SURVEY OF STATE INTEREST IN MEDICAID BUY-IN INITIATIVES

Momentum continues to build behind

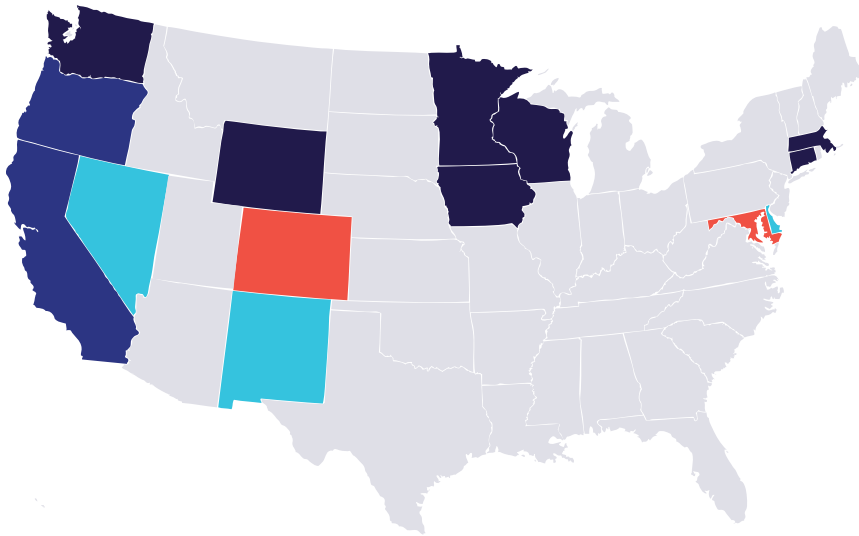
Medicaid Buy-in proposals in many different states. State are at different points in the policy development and political process, with some nearing completion of formal studies, while others are still broadly exploring the policy as one of many options to improve affordability and access. In other states, legislation has stalled but may be back on the agenda when state legislatures convene in 2019.

STATES CONDUCTING FORMAL MBI STUDIES

Nevada: Nevada became the first state legislature to pass legislation to create a Medicaid Buy-in in 2017, though Governor Brian Sandoval vetoed the bill. The proposal, referred to as “Sprinklecare” in honor of legislative champion Assemblyman Mike Sprinkle, brought the issue to national prominence. The legislation created a Nevada Care Plan, available for purchase on the state’s Health Insurance Exchange for all Nevadans not otherwise eligible for Medicaid. Consumers would have been permitted to use Advanced Premium Tax Credits (APTCs) and CSRs to purchase the coverage, and the coverage would have been the same as that available to other Medicaid enrollees not in managed care in the state, though would have excluded non-emergency medical transportation services. The legislation contemplated that many other policy design questions and details, including the premiums charged for the coverage, would be determined through the rulemaking process.¹⁵ The legislation moved quickly through the legislative process, from introduction to veto in approximately 3 months.¹⁶

While Sprinklecare itself was vetoed, Governor Sandoval signed legislation¹⁷ which instructed the Legislative Committee on Health to study a Medicaid

STATE MEDICAID BUY-IN TRACKER



Source: "State Efforts to Develop Medicaid Buy-in Programs", Heather Howard, *State Health and Value Strategies*; augmented by USofCare research.

STATES CONDUCTING FORMAL MBI STUDY	MBI STUDY LEGISLATION INTRODUCED/NOT ENACTED	OTHER STUDY ACTIVITY	MBI LEGISLATION INTRODUCED/NOT ENACTED
NEVADA NEW MEXICO DELAWARE	MARYLAND COLORADO	OREGON CALIFORNIA	MASSACHUSETTS MINNESOTA CONNECTICUT IOWA WASHINGTON WISCONSIN WYOMING

Buy-in option and produce a final report by September 1, 2018. As a part of this effort, Assemblyman Sprinkle, along with other key state officials, formed a Nevada Care Plan working group, which conducted a series of listening sessions with community groups across the state. Assemblyman Sprinkle presented the final report from the Nevada Care Plan working group to the state legislature on September 24th.¹⁸

Current Status: Study completed. As part of the report to the legislature, Assemblyman Sprinkle indicated that plans to utilize feedback from the working group and community listening sessions to draft more detailed legislation to establish a Nevada Care Plan.

New Mexico: Earlier this year, a bipartisan majority of the New Mexico state legislature passed a Memorial calling on the Legislative Health and Human Services Committee to study the potential for a Medicaid buy-in in

the state.¹⁹ Mannatt Health Strategies is conducting a two phase analysis of policy options. Mannatt expects to complete their work, which will include an actuarial analysis, by the end of 2018.²⁰ In the meantime, momentum for Medicaid buy-in in the state continues to build, with five different local councils and governments, representing roughly 50 percent of the states' overall population, passing resolutions in support of the initiative.²¹

Current Status: Study underway.

Delaware: In June 2018, Delaware approved a Senate Concurrent Resolution authorizing the creation of a Medicaid Buy-in Study Group to study allowing residents earning more than 138% of the FPL to purchase coverage through the Medicaid program.²² The group is co-chaired by majority members of the State House and Senate and consists of other legislative leaders along with representatives of the Department of Health and Human Services, the

Medical Society of Delaware, the Delaware Healthcare Association, and the insurance industry. When their study is completed, the report must be submitted to all members of the General Assembly and the Governor's office.

Current status: Study underway. The group has begun meeting, with three more sessions scheduled throughout the rest of 2018. The deadline for completion of the study is January 31, 2019.²³

STUDY LEGISLATION DID NOT ADVANCE

Maryland: Legislation was introduced in the state Assembly to create a Task Force to make recommendations about the feasibility of a Medicaid Buy-in.²⁴ The state Senate amended companion legislation to instead create a Maryland Health Insurance Coverage Protection Commission, which, among other duties, would make recommendations on the feasibility of a Medicaid Buy-in.²⁵ Neither version of the legislation was enacted.

Colorado: Legislation²⁶ to require the state's Department of Health Care Policy and Financing and the Division of Insurance to study three options for health care coverage, including a Medicaid Buy-in, was introduced but not enacted. Local advocates have also been exploring the implications of an off-exchange Medicaid Buy-In for the state.

OTHER STUDY ACTIVITY:

Oregon: State legislators are examining several Medicaid Buy-in options as a part of the state's Universal Access to Health Care work group. The work group is studying different conceptual proposals, including three different approaches to buy-in: one that would make Medicaid available off-Exchange for purchase by those who are not eligible, an option to allow consumers eligible for premium

tax credits to use those tax credits to purchase coverage, and one that would align provider networks in Medicaid and the Marketplace to enhance care continuity.²⁷ The Workgroup will submit a set of recommendations to the House Interim Committee on Health Care this fall, which will be considered for potential legislation in 2019.²⁸

Current Status: Work group process ongoing.

California: The state legislature recently enacted legislation²⁹ that will require the state’s newly established Council on Health Care Delivery Systems to prepare a feasibility analysis on a public health insurance plan option to increase competition and choice for health care consumers. This feasibility analysis is required to include an actuarial and economic analysis of a public insurance plan and is due to the Legislature and the Governor on or before October 1, 2021. While this law does not specifically require that the public option studied be structured as a Medicaid buy-in, it establishes a formal process through which policymakers can consider pathways to creating a public option.

Current status: Not started. The state statute creating the Council on Health Care Delivery Systems becomes effective on January 1, 2019.

MBI LEGISLATION INTRODUCED BUT NOT ENACTED

Massachusetts: The Massachusetts Senate passed wide ranging health care legislation³⁰ in November 2017, which included a provision allowing for employers and individuals to buy into the state’s MassHealth plan as part of a larger effort to address health care affordability. This bill also called on

the state’s Office of Medicaid to issue a report by October, 1 2018 discussing whether or not an expanded plan will be implemented. Companion state House legislation, Bill H.4617,³¹ introduced late in June 2018, did not include a MassHealth buy-in program, and business leaders and insurance providers expressed discomfort with the idea of a public option for fear of hurting private insurance markets and raising state costs.³² Efforts to reconcile the House and Senate proposals were ultimately unsuccessful.³³

Minnesota: In early 2017, bills were introduced in the Minnesota House³⁴ and Senate³⁵ calling for state legislators to expand access to MinnesotaCare, the state’s basic health program (BHP)³⁶, to all Minnesota residents regardless of income. Supported by Gov. Mark Dayton, the MinnesotaCare buy-in would be funded through monthly premiums paid by enrollees, limiting the financial burden on taxpayers.³⁷ MinnesotaCare would offer a Gold and Silver plan through the state’s health insurance marketplace, MNsure, and all health plans currently offering managed care services for Medicaid and the BHP would also be required to provide at least one buy-in option for consumers.³⁸ To alleviate concerns from Minnesota hospitals and doctors about receiving lower payments for their services from those on MinnesotaCare plans, they would instead be reimbursed at federal Medicare rates, which are typically higher than those for Medicaid.³⁹

Minnesota’s proposal underwent a detailed actuarial analysis, allowing proponents to estimate average premiums and potential savings for families across the state.⁴⁰ However, the Republican-controlled legislature adjourned without holding a hearing or

advancing the bill.

A poll taken shortly before the midterm election found that 70% of Minnesota likely voters support proposals to allow people to buy into public programs.⁴¹

Connecticut: Legislation⁴² to create a Medicaid public option called the “Husky E plan” available to people not otherwise eligible for Medicaid was introduced in the General Assembly but did not advance. Husky E would have included Affordable Care Act Essential Health Benefits, and the legislation directed state officials to study whether to apply for a waiver to allow consumers to utilize premium tax credits and cost sharing reductions to purchase this coverage. Husky E would be funded by premiums assessed based on the results of an actuarial analysis, with excess funding over plan cost used to increase provider reimbursement rates.

Iowa: Legislation introduced in the state Senate⁴³ would have created “Healthy Iowans for a Public Option” for those not otherwise eligible for Medicaid and without affordable employer insurance was introduced in January 2018 and did not advance. The coverage would have been available on the state’s Exchange and people could use premium tax credits and cost sharing reductions, and would be administered through the Iowa Medicaid Enterprise.⁴⁴ A separate section of the legislation would have terminated the state’s Medicaid managed care contracts.

Washington: Legislation⁴⁵ to create the Apple health public option was introduced in the state Senate, but did not advance. The legislation required the Apple Health option to be offered by managed care plans, and directed the health authority to increase rates for providers participating in both Apple

Health and the Apple Health public option. All essential health benefits would be covered, including reproductive care, and coverage would be actuarially equivalent to a silver Exchange plan. The legislation also instructed state officials to explore regional risk pools or purchasing options with Oregon and California.

Wisconsin: Legislation to create a Medicaid Buy-in was introduced in both the Assembly⁴⁶ and Senate⁴⁷ in 2017 but did not advance. The proposals would have allowed people earning too much to be eligible for the state’s Badgercare Plus or childless adult demonstration to purchase this coverage. The legislation stipulated that coverage would have an actuarial value of at least 87%, with a premium similar to the average paid by the state to managed care. The legislation also directed the state Department of Health Services to implement mechanisms to minimize adverse selection, negative impacts on premiums in the individual and group insurance markets, and to minimize the state’s financial risk, but does not provide additional details on what mechanisms the state could employ to achieve these goals.

Wyoming: Legislation was introduced in the state Senate⁴⁸ in February 2018 to create a Medicaid buy-in as part of a larger health reform package. The program would have been open to all adults not currently eligible for Medicaid. Premiums for the program would have been set by the Department of Health, which could also impose limited cost-sharing requirements, and was envisioned as a budget neutral reform option. The same legislation would have expanded Medicaid coverage under the Affordable Care Act. This legislation was defeated by a margin of 7-23 shortly after its introduction.

LOOKING AHEAD

Many of these states will likely take a fresh look at this policy. Several newly elected governors endorsed Medicaid buy-in as part of their campaigns, and their victories will add new energy and enthusiasm to efforts already underway in their state.

- æ New Mexico Governor-elect Michelle Lujan-Grisham made Medicaid buy-in a key component of her Health Action Plan, committing to implementing a buy-in if elected.⁴⁹
- æ “IllinoisCares” is a central part of Illinois governor-elect J.B. Pritzker’s health care platform.⁵⁰ His proposal would allow Illinois residents to pay premiums to purchase Medicaid coverage, and would allow those eligible to use premium tax credits.
- æ Minnesota Governor-elect Tim Walz publicly endorsed the MinnesotaCare buy-in on the campaign trail,⁵¹ and the issue will likely remain on the state’s agenda when the Legislature convenes next year due to the proposal’s widespread popularity among Minnesotans. Additionally, Minnesota faces a significant health care fiscal cliff in 2019, with the upcoming expiration of the state’s provider tax and reinsurance funding, which will require the state’s elected leaders to tackle health care in some way.
- æ Wisconsin Governor-elect Tony Evers has indicated he supports “BadgerCare for All” legislation.⁵²

CONCLUSION

As the continues to demand significant changes in the health care system-- and the federal government remains gridlocked-- interest in Medicaid Buy-in as a possible option will continue to grow. State policymakers are showing a healthy appreciation for the complex series of policy decisions that developing a Medicaid Buy-in entails, having learned the lesson of the original Sprinklecare, which advanced quickly through the legislative process without answers to important questions. Even if one state successfully enacts legislation to create a Buy-in, each state will still need to perform its own careful due diligence to make sure that their approach to Buy-in best meets their state’s unique needs and appropriately addresses the problem they are trying to solve.

ENDNOTES

- 1 CNN exit poll results can be found here: <https://www.cnn.com/election/2018/exit-polls/national-results>
- 2 For an overview of major public-option plans introduced at the federal level, see <https://tcf.org/content/commentary/comparison-health-reform-legislation-creating-public-plans/?agreed=1>
- 3 Medicaid eligibility is generally based on income and/or category. See <https://www.macpac.gov/medicaid-101/eligibility/>
- 4 For more information on these Buy-in programs, see <https://www.acl.gov/news-and-events/acl-blog/medicaid-buy-opens-doors-employment-people-disabilities> and <https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities?currentTimeframe=0&sort-Model=%7B%22colld%22:%22Location%22:%22sort%22:%22asc%22%7D>
- 5 <http://files.kff.org/attachment/fact-sheet-medicaid-state-US>.
- 6 For a breakdown of benefits covered by Medicaid specific to certain populations, see https://kaiserfamilyfoundation.files.wordpress.com/2018/04/9025-02-figure_5.png
- 7 <https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2643347>
- 8 The full study can be found here: https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2016_may_1879_collins_americans_experience_aca_marketplace_feb_april_2016_tb.pdf
- 9 Boston University/ Harvard University poll conducted September 12-26, 2018. https://scholar.harvard.edu/files/medicare_medicaid_press_release_.pdf
- 10 <https://www.kff.org/report-section/medicaid-spending-growth-compared-to-other-payers-issue-brief/>
- 11 <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/Final-2019-County-Coverage-Map.pdf>
- 12 <https://www.nejm.org/doi/full/10.1056/NEJMp1304170>
- 13 <https://kaiserfamilyfoundation.files.wordpress.com/2017/11/9121-aca-figure-10.png>
- 14 More detail on the Mannatt/ SHVS strategies is available at <https://www.manatt.com/getattachment/fd64ec7f-de6f-448c-8579-7f37b185fcc3/attachment.aspx>
- 15 <https://ldi.upenn.edu/brief/state-efforts-close-health-coverage-gap>
- 16 <https://www.leg.state.nv.us/App/NELIS/REL/79th2017/Bill/5393/Overview>
- 17 https://www.leg.state.nv.us/Session/79th2017/Bills/SB/SB394_EN.pdf
- 18 A summary of the work group's process and findings available on the Nevada state legislature's website: <https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/13179>
- 19 <http://www.sos.state.nm.us/uploads/files/SM3-2018.pdf>
- 20 "Evaluating Medicaid Buy-in Options for New Mexico" Mannatt Health Strategies, LLC. September 2018. <https://www.nmlegis.gov/handouts/LHHS%20092618%20Item%2010%20New%20Mexico%20Buy-in%20Options.pdf> Accessed November 5, 2018.
- 21 <https://www.publicnewsservice.org/2018-10-03/health-issues/grassroots-advocacy-for-medicaid-buy-in-builds-in-nm/a64189-1>
- 22 <http://legis.delaware.gov/json/BillDetail/GenerateHtmlDocument?legislationId=26806&legislationTypeId=3&docTypeId=2&legislationName=SCR70>
- 23 Study Group membership and meeting schedule is available at <https://legis.delaware.gov/TaskForceDetail?taskForceId=402>
- 24 <http://mgaleg.maryland.gov/2018RS/bills/hb/hb1312f.pdf>
- 25 <http://mgaleg.maryland.gov/2018RS/bills/sb/sb0878t.pdf>
- 26 https://leg.colorado.gov/sites/default/files/documents/2018A/bills/2018a_1384_ren.pdf
- 27 <https://www.oregonlegislature.gov/salinas/HealthCareDocuments/Medicaid%20Buy-In%20Straw%20Proposals%20-%20Discussion%20Purposes%20Only%20-%20draft%20-%20Sept.%2020.pdf>
- 28 Workgroup Work Plan: <https://www.oregonlegislature.gov/salinas/HealthCareDocuments/House%20Committee%20on%20Health%20Care%20-%20%20Work%20Group%20Work%20Plan.pdf>
- 29 https://leginfo.ca.gov/faces/billTextClient.xhtml?bill_id=20170180AB2472
- 30 <https://malegislature.gov/Bills/190/S2211>
- 31 <https://malegislature.gov/Bills/190/H4617/Amendments/House>
- 32 <https://commonwealthmagazine.org/opinion/business-groups-raise-concerns-about-health-bills/>
- 33 <https://www.bizjournals.com/boston/news/2018/08/01/legislators-fail-to-come-together-on-health-care.html>
- 34 HF 92, <https://www.revisor.mn.gov/bills/bill.php?f=HF92&y=2017&ssn=0&b=house>
- 35 SF 58, <https://www.revisor.mn.gov/bills/bill.php?f=SF58&y=2017&ssn=0&b=senate>
- 36 <https://mn.gov/dhs/people-we-serve/adults/health-care/health-care-programs/programs-and-services/minnesotacare.jsp>
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- 38 <https://www.healthaffairs.org/doi/10.1377/hblog20170802.061367/full/>
- 39 <http://www.startribune.com/dayton-proposes-major-buy-in-expansion-for-minnesotacare/475541923/>
- 40 https://mn.gov/gov-stat/pdf/2017_02_02_MinnesotaCare_Buy-In_Fact_Sheet_FINAL.pdf
- 41 https://www.apmrresearchlab.org/stories/2018/09/16/mpn-news-star-tribune-minnesota-poll-walz-leads-governors-race-especially-young-voters-women#h1.policy_preferences_health_care_and_gas_tax
- 42 <https://www.cga.ct.gov/2018/TOB/h/2018HB-05463-R00-HB.htm>
- 43 <https://www.legis.iowa.gov/docs/publications/LGI/87/SF2035.pdf>
- 44 <https://dhs.iowa.gov/ime/about/abouttime>
- 45 <http://lawfilesexet.leg.wa.gov/Biennium/2017-18/Htm/Bills/Senate%20Bills/5984.htm>
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- 48 <https://www.wyoleg.gov/Legislation/2018/SF0088>
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- 50 <https://www.jbpritzker.com/illinois-cares/>
- 51 <https://www.mprnews.org/story/2018/08/28/tim-walz-jeff-johnson-debate-at-minnesota-state-fair-governor-race-2018-election>
- 52 <http://wicheose.org/healthcare/>