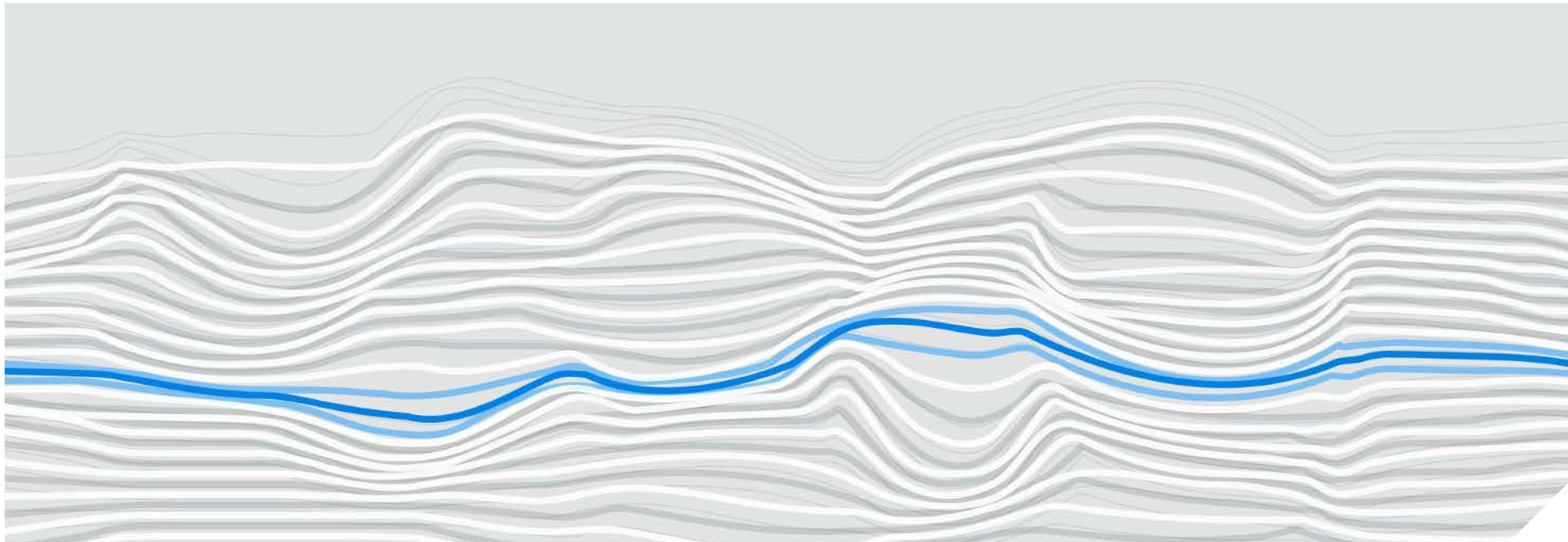
Milliman

Medicaid Buy-In

Exploring state options to offer more comprehensive or lower-cost health insurance

Christine Mytelka, FSA, MAAA
Susan Philip, MPP

16 JULY 2019



Outline

- **Medicaid buy-in defined**
- State objectives
  - Address individual market issues
  - Reduce uninsured
- Recent state and federal guidance
- Design options for states' consideration
- Caveats and limitations

Medicaid buy-in

Broadly refers to an approach in which a state allows for the development of an health insurance plan to help cover those who remain uninsured and/or find current health insurance options to be unaffordable

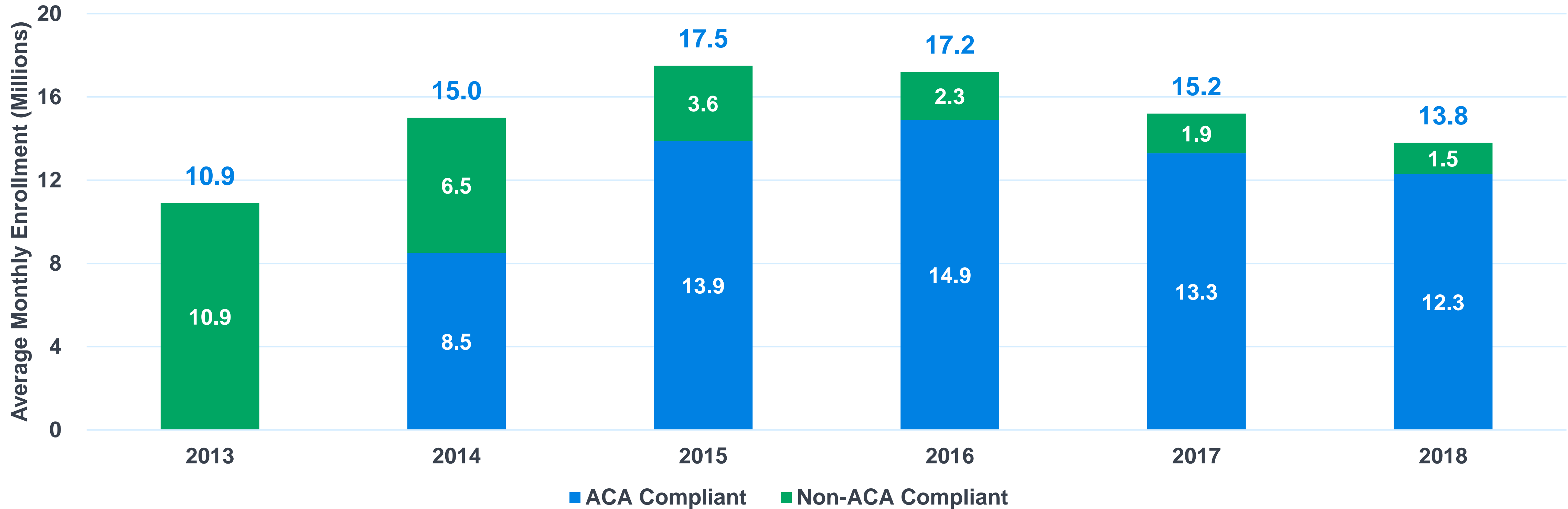
- Typically offered to those not eligible for Medicaid
- Can be offered along side QHPs in the same risk pool, or separate
- Can have Medicaid-like plan design, QHP-like plan designs, or other
- Can leverage Medicaid participating insurers and provider network or QHP participating insurers and network
- **Many variations**

Outline

- Medicaid buy-in defined
- **State objectives**
  - **Address individual market issues**
  - **Reduce uninsured**
- Recent state and federal guidance
- Design options for states' consideration
- Caveats and limitations

Limited enrollment gains

Comprehensive non-group enrollment



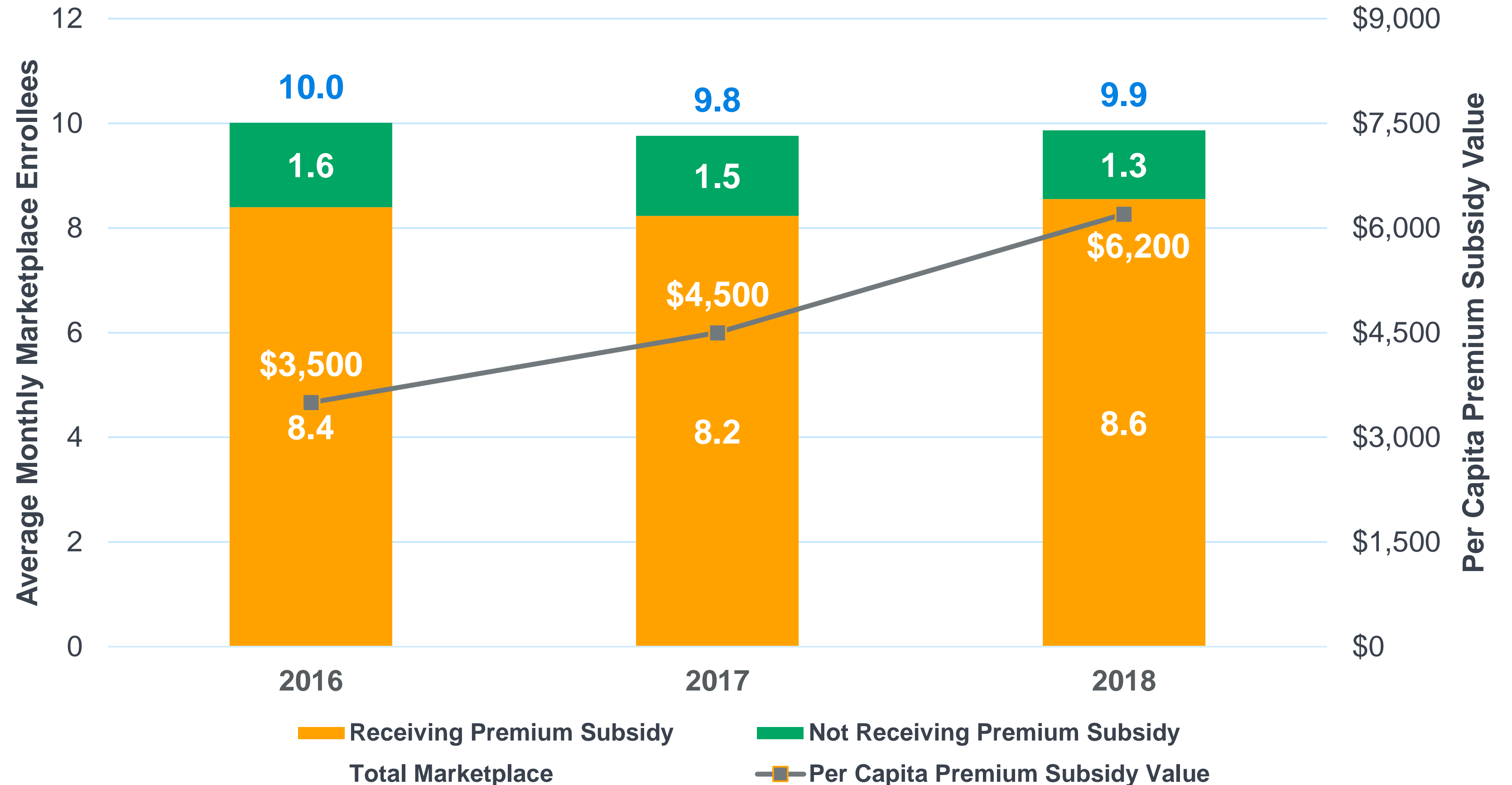
Sources

1. 2013 through 2017 Commercial Medical Loss Ratio Data
2. HHS Risk Adjustment Program State-Specific Data
3. CY 2018 Statutory statement enrollment data
4. Effectuated enrollment reports through 2018
5. Supplemental Health Care Exhibit data from 2017 and 2018

Affordability for those without subsidies

Premium assistance provided through the marketplace

- In 2018, the 8.6 million marketplace enrollees receiving premium assistance are estimated to receive an average of **$6,200** in annual premium assistance
- National estimated premium assistance expenditures of **$53 billion**

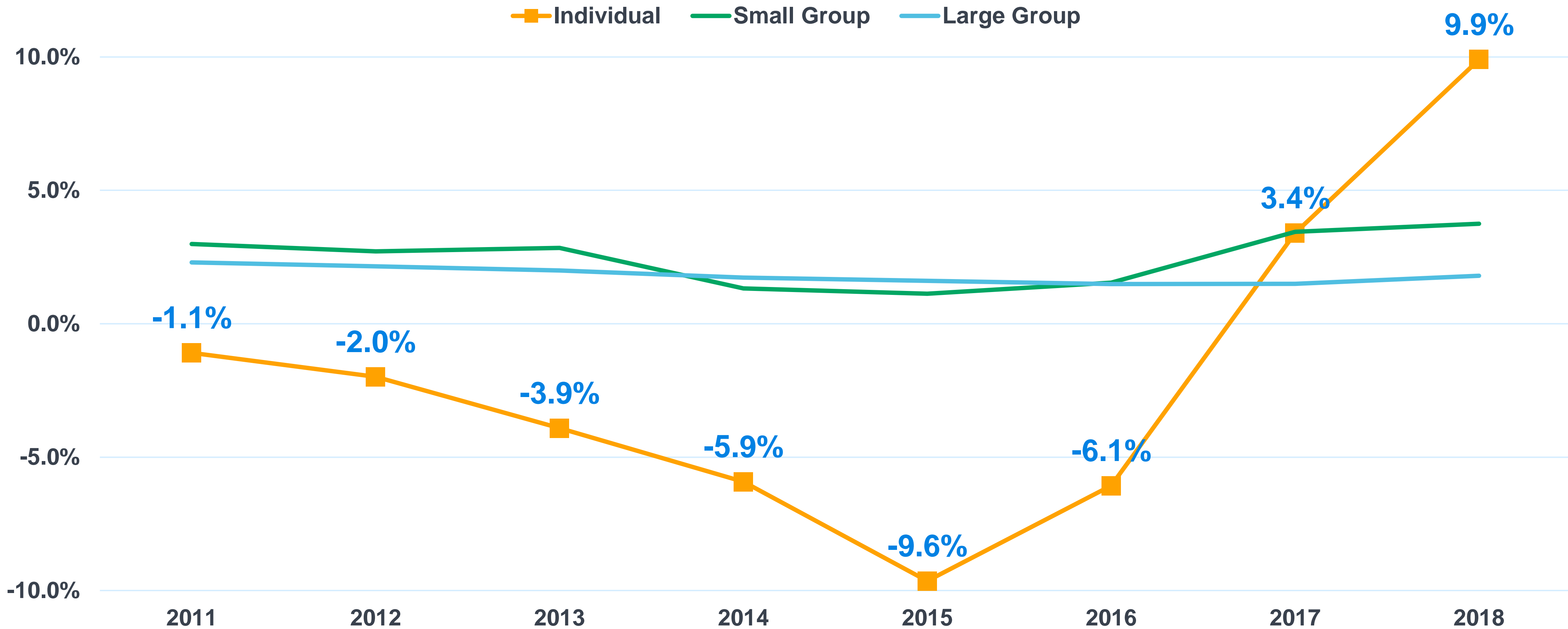


Notes

1. Values rounded.
2. Source: http://www.milliman.com/insight/2018/2018-summary-of-individual-market-enrollment-and-Affordable-Care-Act-subsidies/

Volatility

Commercial health insurance underwriting margins



Notes

1. CY2011 through CY2017 results based on Commercial MLR Data released by CMS, adjusted for actual risk corridor and risk adjustment payments received.
2. CY 2018 results estimated based on changes in reported medical loss ratio between NAIC 2017 and 2018 Supplemental Health Care Exhibit, Part 1..

Key observations given coverage and enrollment trends

Individual market

- Enrollment gains relative to 2013 limited
- Affordability major concern for non-subsidized individual market enrollees
- Volatile market in terms of insurer participation and profitability
- Premium subsidy value has increased significantly with premium trends (higher available pass-through funding)

Medicaid

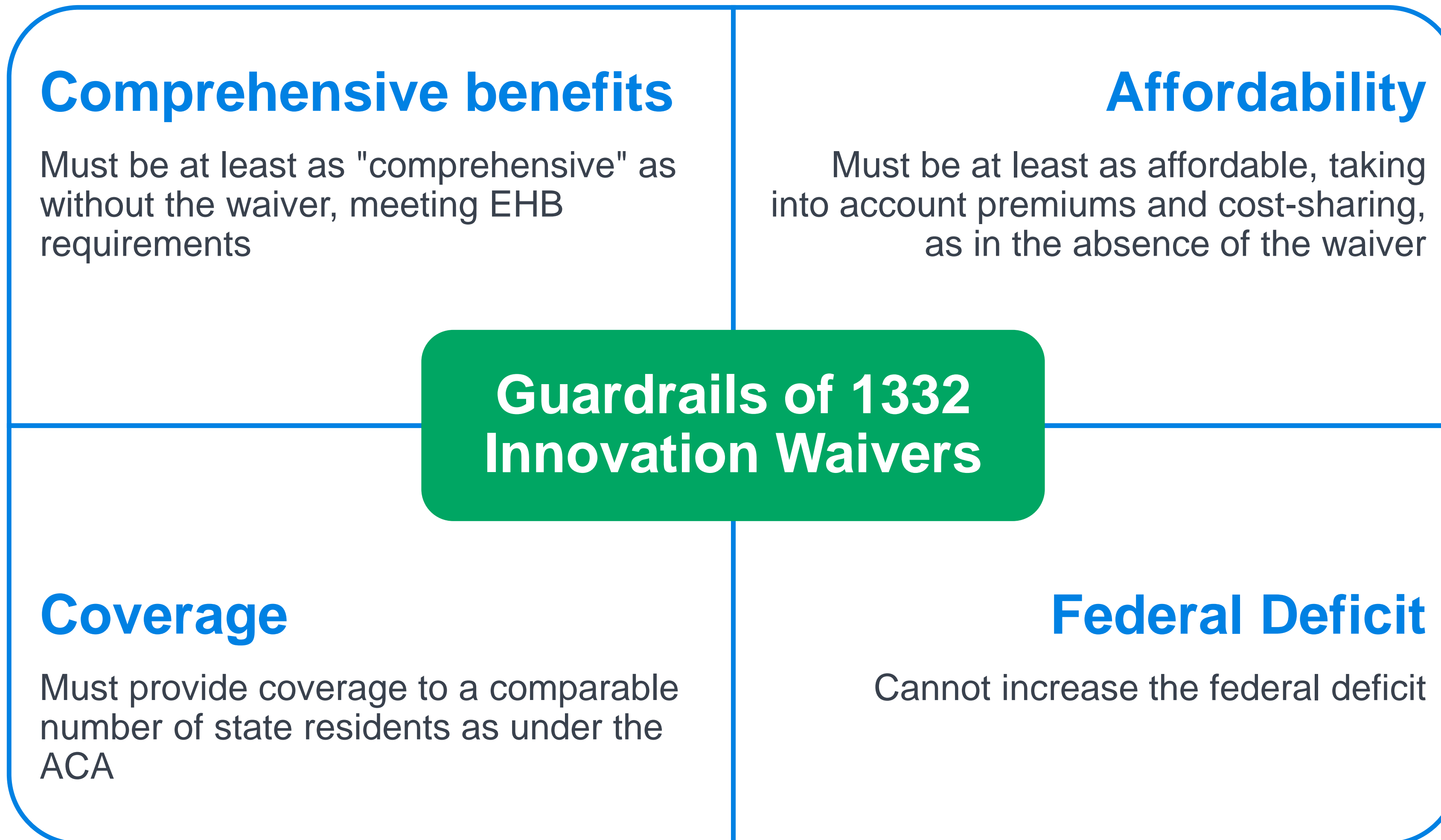
- Responsible for majority of insurance coverage gains since 2013
- Medicaid managed care market more stable (actuarial soundness requirements)
- Potential for common MCOs to serve existing and 'buy-in' populations
- Leverage state purchasing power, control provider reimbursement
- Potential administrative efficiencies, alignment across programs
- Population health managed through contracting requirements

Outline

- Medicaid buy-in defined
- State objectives
  - Address individual market issues
  - Reduce uninsured
- **Recent state and federal guidance**
- Design options for states’ consideration
- Caveats and limitations

1332 Waiver: Recent federal guidance

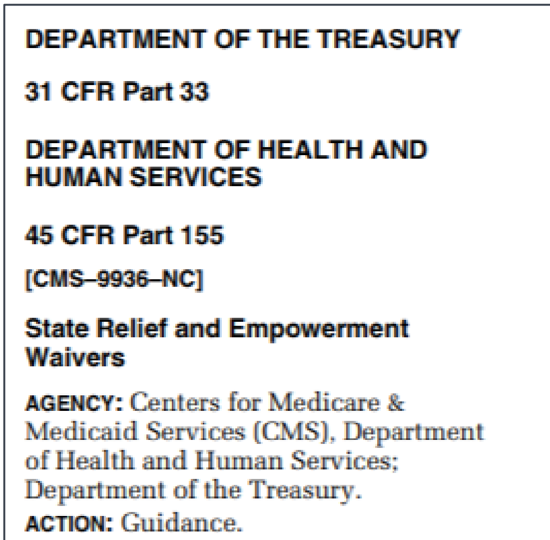
Guardrails still exist but loosening of restrictions to provide states more flexibility



- **Aggregate**: New guidance focuses on “aggregate” effects of waiver rather than requiring guardrails be met for specific sub-populations.
- **Benefit coverage**: Dependent on EHB-benchmark plan.
- **Number of state residents**: New guidance focuses on ***availability*** of coverage rather than coverage being provided.

1332 Waiver: Recent federal guidance

Waiver concepts and guidance leave room for interpretation



DEPARTMENT OF THE TREASURY

31 CFR Part 33

DEPARTMENT OF HEALTH AND HUMAN SERVICES

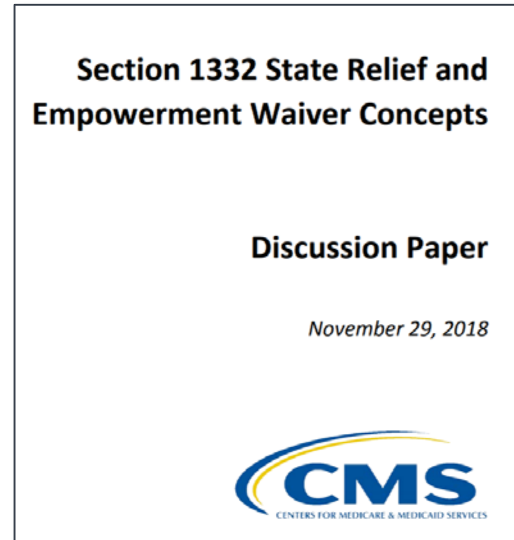
45 CFR Part 155

[CMS–9936–NC]

State Relief and Empowerment Waivers

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services; Department of the Treasury.

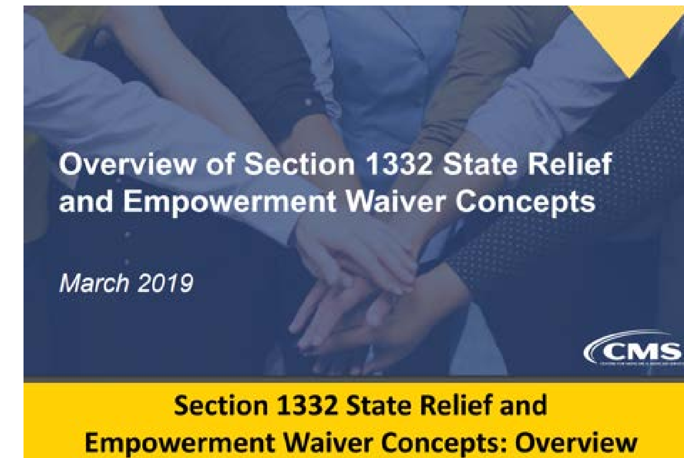
ACTION: Guidance.



- Emphasis on using private market coverage
- Encouraging state innovation
- “Support and empower those in need”
- Promote consumer-driven health care

Four waiver concepts (illustrations)

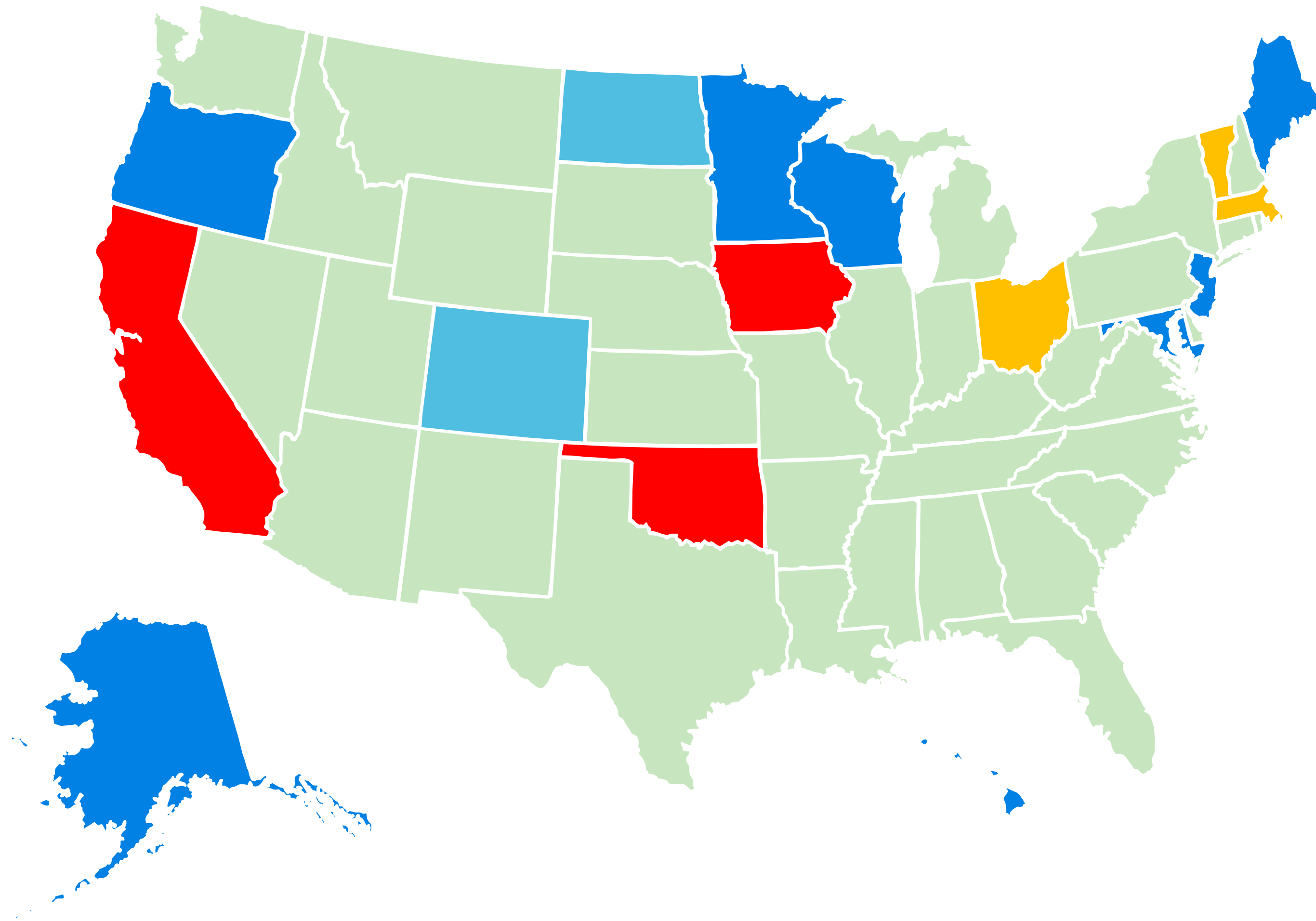
- Restructure premium assistance (APTCs)
- Support non-QHPs (e.g. catastrophic)
- Health Expense Account
- Risk stabilization



Sources

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF
https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf
https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/03122019-State-Relief-Empowerment.pdf

1332 Waiver activity

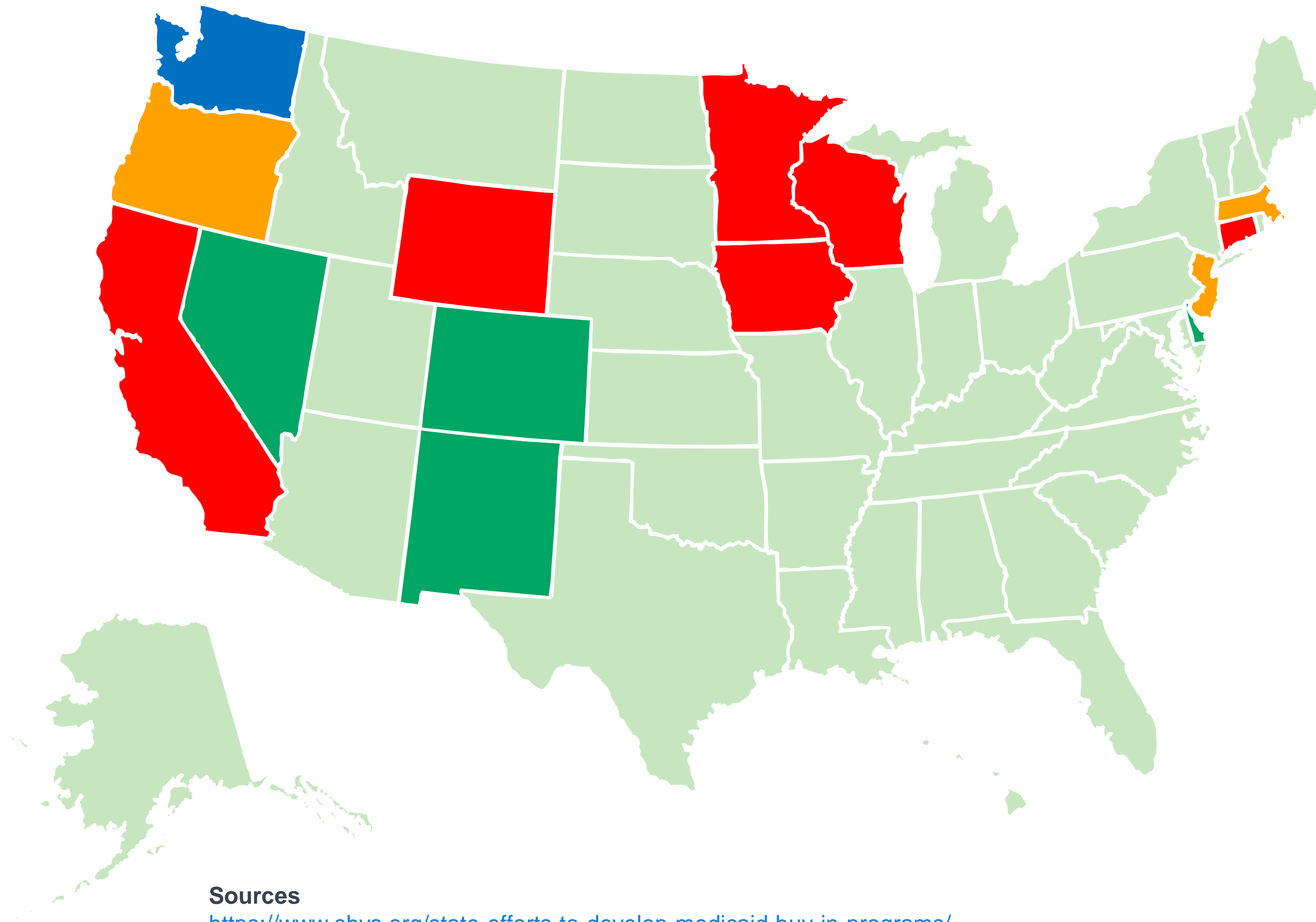


	Approved: Oregon, Alaska, Hawaii, Minnesota, Wisconsin, Maine, New Jersey, Maryland
	Pending: Colorado, North Dakota
	Request deemed incomplete: Ohio, Vermont, Massachusetts
	Withdrawn: California, Oklahoma, Iowa

- States seeking to address market stability and affordability through reinsurance programs.
- Approved and pending waivers focus on using pass-through funding for reinsurance programs

Source
https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

Medicaid buy-in state activity



(blue)	Public option/Medicaid buy-in legislation passed: Washington
(orange)	Medicare buy-in legislation introduced / not enacted: Massachusetts, New Jersey, Oregon
(green)	States conducting formal study: Colorado, Delaware, Nevada, New Mexico
(red)	Other activity: California, Minnesota, Connecticut, Iowa, Wisconsin, Wyoming

Washington state public option

- To start January 2021
- Private insurers
- Goals: simpler, more affordable (lower premiums and deductibles)
- Reimbursement capped at 160% Medicare
- At least 135% Medicare for primary care
- Subsidies for up to 500% FPL
- Does not use waiver

Sources

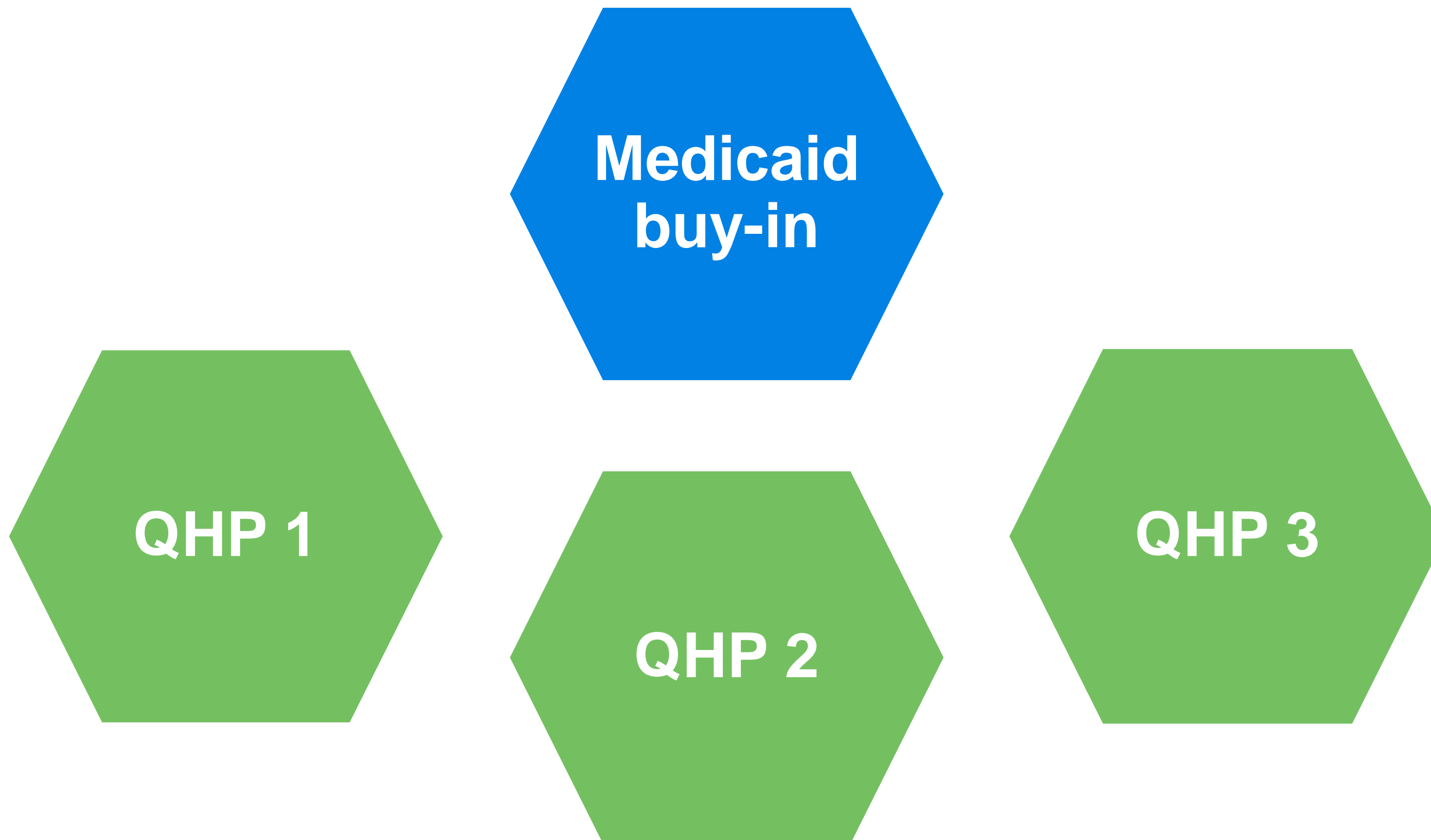
https://www.shvs.org/state-efforts-to-develop-medicaid-buy-in-programs/
https://unitedstatesofcare.org/wp-content/uploads/2018/12/MBI-Memo.pdf
http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf

Outline

- Medicaid buy-in defined
- State objectives
  - Address individual market issues
  - Reduce uninsured
- Recent state and federal guidance
- **Design options for states' consideration**
- Caveats and limitations

Relationship to Medicaid buy-in to the marketplace

Alongside QHPs, same risk pool

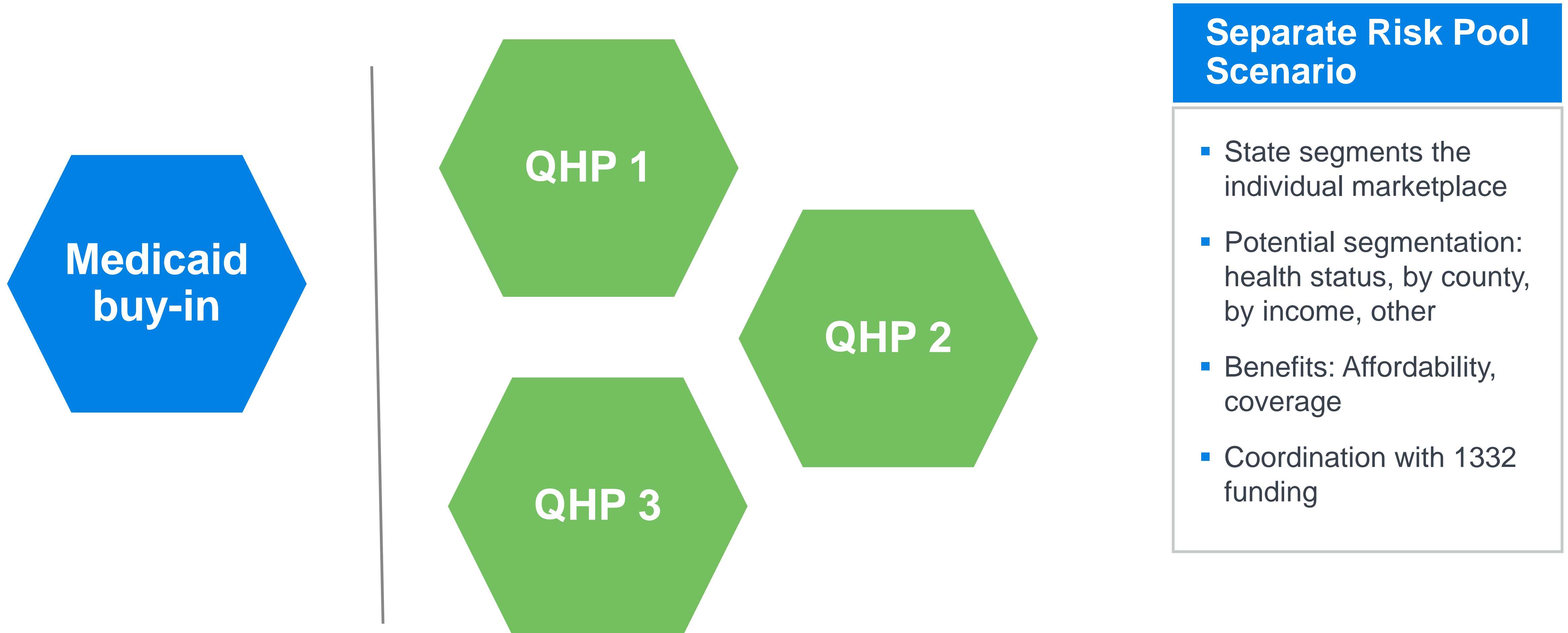


Same Risk Pool Scenario

- State allows insurers to develop and sell a Medicaid-like product with intermediate level of benefits, cost sharing and reimbursement
- State offers the product on the Marketplace along side other QHPs in the marketplace
- **Benefits**: Choice, affordability, coverage
- **Risks**: provider cost shifting, crowd out, level playing field, reduced APTCs

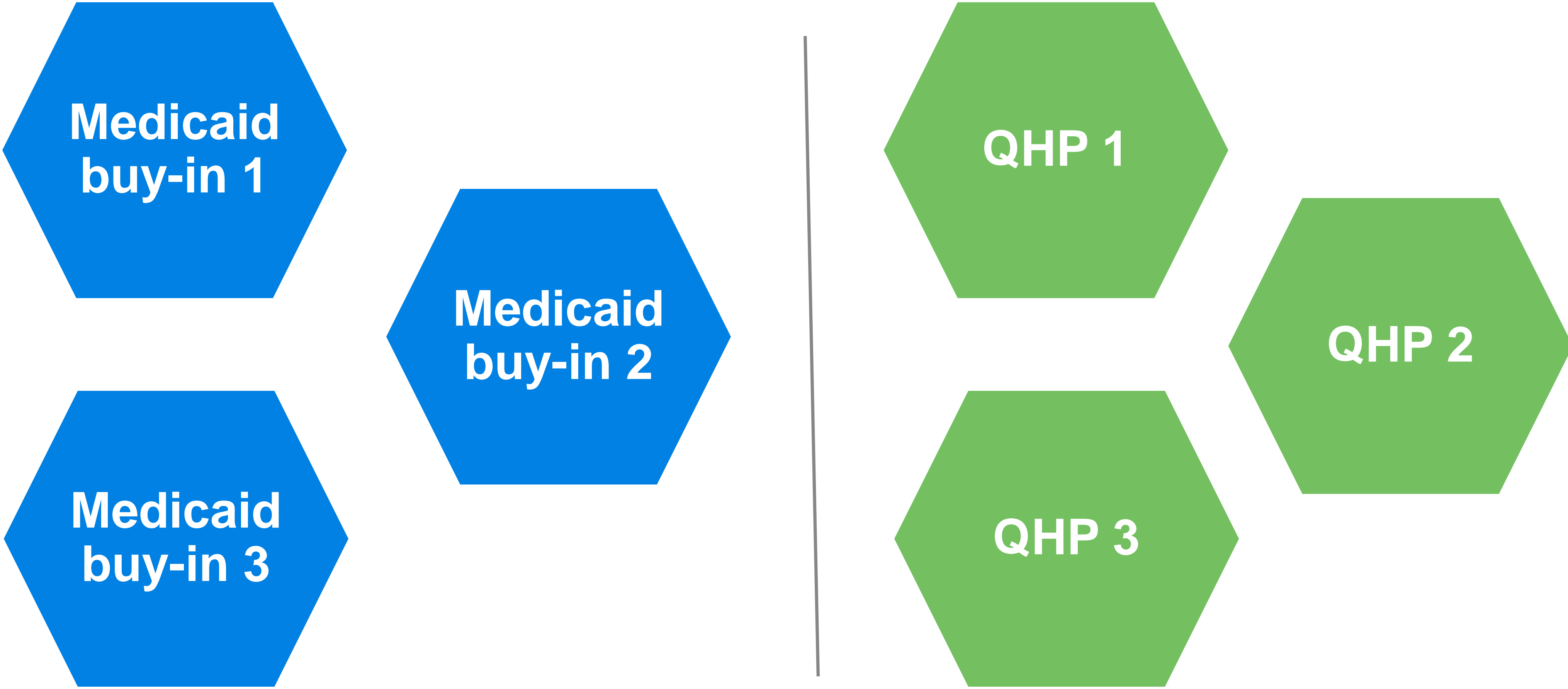
Relationship to Medicaid buy-in to the marketplace

Separate risk pool



Relationship to Medicaid buy-in to the marketplace

Separate risk pool



Design option: Targeted population

States can choose to offer buy-in to broader populations

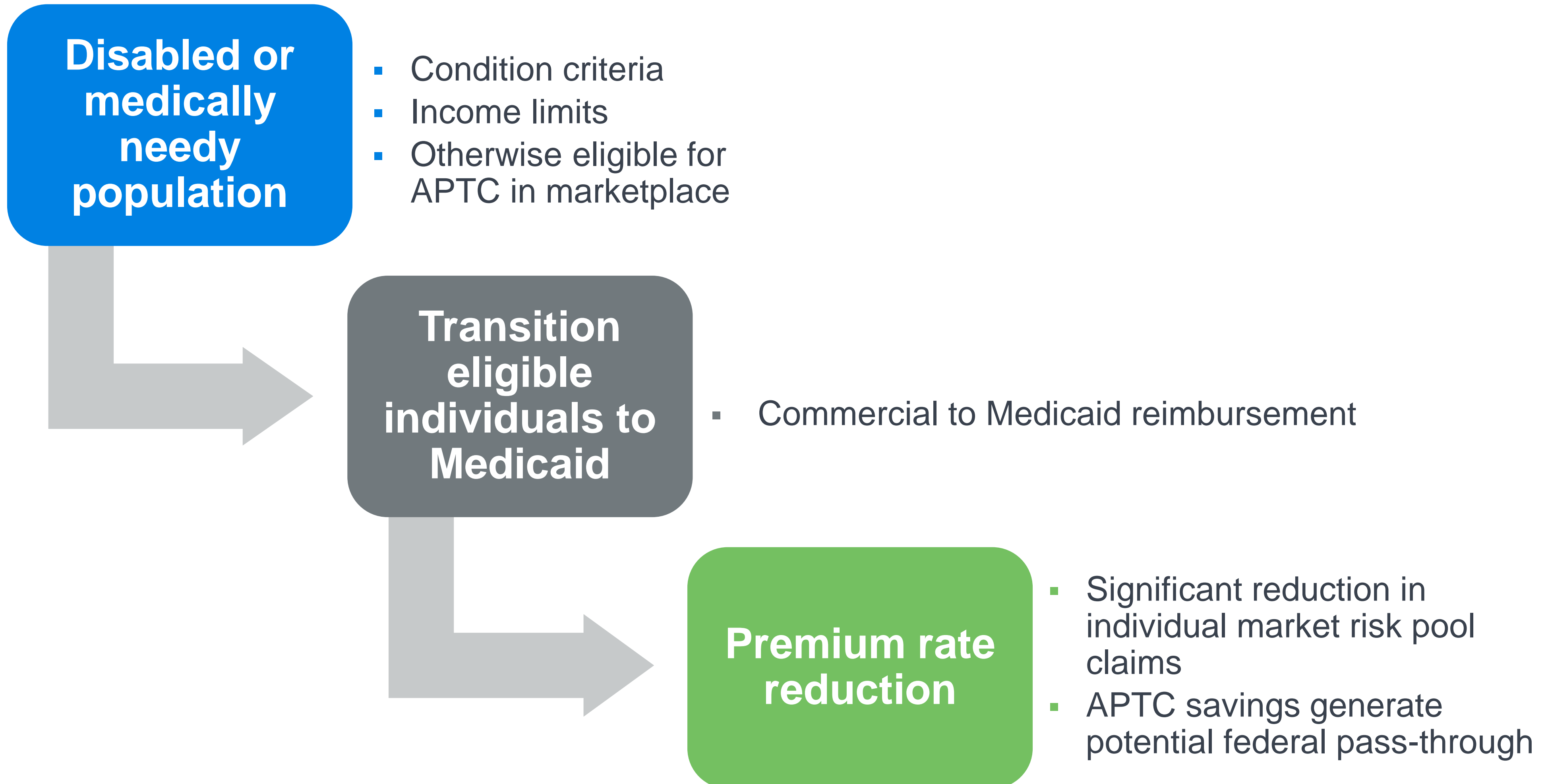
- Potential eligibility conditions (mix and match)
  - By health status
  - By geography/county
  - By income
    - Gap only
    - Higher income, such as 200% FPL, 250% FPL, or even 400% FPL
- Limit to individuals without affordable employer coverage
- Coordination with CHIP

Removing higher cost populations improves ACA marketplace affordability

Broader eligibility may crowd out commercial markets

Design option: Targeted population

States can target the buy-in option to the disabled or medically-needy



Design options: Benefits, premiums, and cost sharing

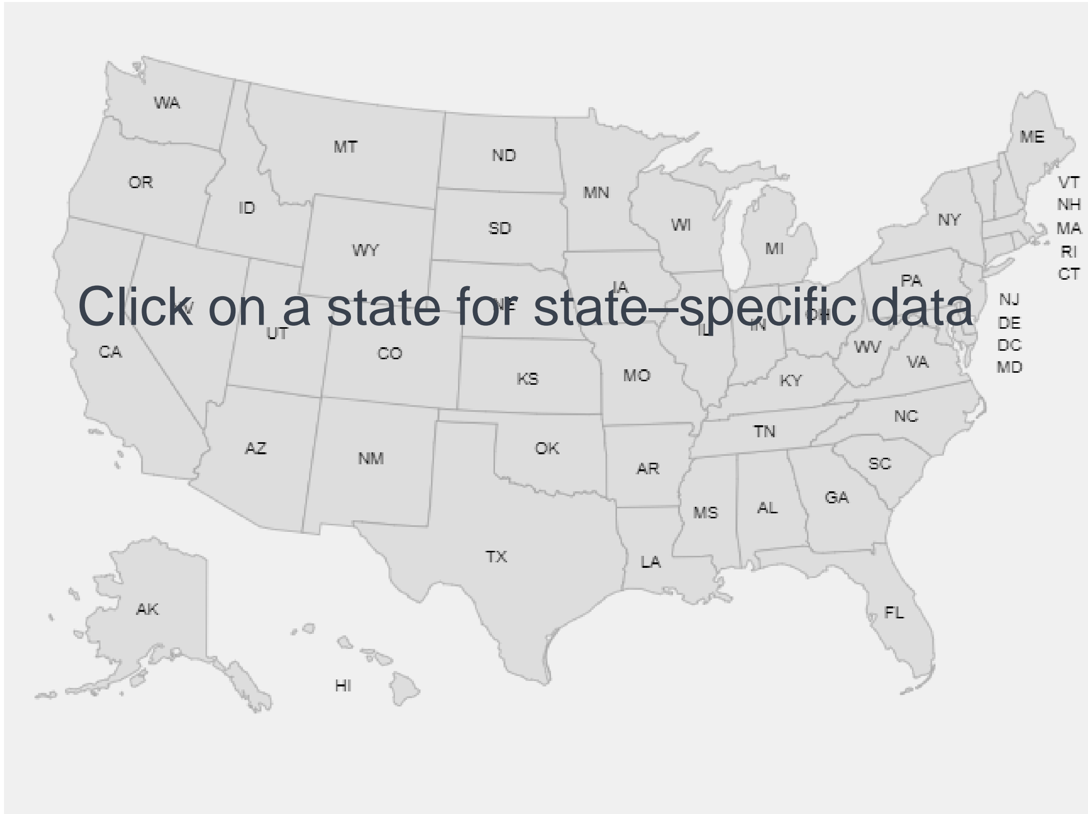
- Benefits
  - 1332: At least as comprehensive as ACA marketplace
  - Add anything? Expanded SUD, dental, non-emergency transportation, community LTSS, other
- Monthly premium and cost sharing
  - 1332: At least as affordable as ACA marketplace
  - 1332 waiver concept A: State-specific premium assistance
  - Premium structure can be simplified, or vary by age, income, etc.
  - Cost sharing can be made more appropriate to target population
- Open enrollment period or flexible
- Payment models and provider reimbursement

Plan design generosity may be limited by available funding

Consider impact on various groups: young, old, healthy, smokers, those with or without subsidies, providers, insurers

1332 Waiver feasibility: How much funding can we get?

Individual market enrollment and subsidy information



PREMIUM SUBSIDIES WILL BENEFIT QUALIFYING INDIVIDUALS IN THE STATE OF INDIANA BY $394 MILLION IN 2018.

FIGURE 2: INDIANA HEALTH INSURANCE MARKETPLACE ENROLLMENT

	2016	2017	2018
Individual Marketplace Enrollment	153,000	139,000	137,000
Individuals Receiving a Premium Subsidy	124,000	102,000	96,000
Individuals Receiving CSR Plan	69,000	65,000	59,000

Note: Values reflect estimated average monthly effectuated enrollment. Please see the methodology paper for more information on the estimate methodology.

FIGURE 3: SUMMARY OF AFFORDABLE CARE ACT SUBSIDIES

ANNUAL AVERAGE VALUES	2016	2017	2018
Individual Marketplace Premium	$5,000	$5,200	$6,000
Combined Premium/CSR Subsidy	$3,700	$3,900	$4,100

Note: Individual marketplace premium reflects gross premium for premium subsidy-eligible individuals prior to federal financial assistance. Premium and CSR subsidy values reflect twelve month effectuated enrollment period per APTC enrollee.

Source
http://www.milliman.com/insight/2018/2018-summary-of-individual-market-enrollment-and-Affordable-Care-Act-subsidies/

Thank you

Christine Mytelka, FSA, MAAA
Christine.Mytelka@milliman.com
Susan Philip, MPP
Susan.Philip@milliman.com