State Health Policy Highlights

State Considerations for Medicaid Buy-In Proposals

Authored by Manatt Health

STATE Health & Value STRATEGIES

Driving Innovation Across States

A grantee of the Robert Wood Johnson Foundation

April 2019

Introduction

Lawmakers across the country are considering Medicaid buy-in or "public option" programs to stabilize the Affordable Care Act (ACA) insurance market and offer a coverage option that is more affordable and accessible than current options in the individual and employer markets. So far in the 2019 legislative session, more than 10 states have introduced legislation to study or implement a buy-in.[1] A new State Health and Value Strategies issue brief, *State Medicaid Buy-Ins: Key Questions to Consider*, explores the key questions that states will want to consider as they pursue design, and implementation of buy-in proposals. This State Health Policy Highlight provides a checklist summarizing the key questions, which are laid out in greater detail in the underlying issue brief.

Checklist of Key Questions

- ☐ **What problem(s) is the state trying to solve?**
  Buy-in models are not one-size-fits-all, selecting the "right" model will depend on state goals. An important first step for selecting a model and tailoring its features is to get very specific about and prioritize the state's policy goals, and to define the population(s) to which the new coverage option will be targeted. Example goals include increasing affordability, promoting insurer competition, and promoting health care initiatives that improve health outcomes, such as social determinants, population health, and/or delivery system reform.
- ☐ **What are the potential sources of buy-in cost-savings in the state?**
  Potential buy-in savings—which generate lower premiums—will vary depending on the status quo in the state market. Each state will have different dynamics and potential sources of savings under a buy-in program. Sources of savings may include provider payment rates, administrative efficiencies, leveraging state purchasing power, and long-term savings through investments in population health and delivery systems. The buy-in model selection and design should play to the state's strengths and opportunities for savings, balanced against the impact these sources of savings will have on other insurers' ability to negotiate, and compete, in the individual market, and on provider participation in the buy-in product.
- ☐ **What are the potential impacts of the buy-in on other insurance markets in the state?**
  The precise impact of the buy-in on other markets depends on the model selected, the risk profile of enrollees who choose to enroll in the buy-in, and existing insurer responses to the new entrant. As states design a buy-in product, they should consider these factors and engage with key stakeholders to understand their concerns and perspectives.
- ☐ **Does the state require, or would it be beneficial to pursue, a 1332 waiver for the buy-in?**
  States can design a buy-in without seeking an ACA Section 1332 State Innovation Waiver (1332 waiver).[2] However, a unique challenge of buy-in proposals is that most of the program savings for the *subsidized population* accrue to the federal government, as the administrator of premium tax credits, and not the state or consumers. Some buy-in models are more likely to require, or benefit from, 1332 waivers than others. If a state seeks to leverage federal dollars to achieve its coverage and affordability objectives (and reap the benefits of generating savings in the individual market), a 1332 waiver may be necessary.
- ☐ **Is the state well positioned to implement a buy-in?**
  Experience with Medicaid expansion and marketplace administration has pressure-tested many states' capacity to implement, and manage, complex health coverage programs, and to provide outreach to enrollees. A buy-in

program could be an appropriate extension of those operational strengths. States should evaluate whether they are positioned to implement a buy-in alongside other fiscal and administrative priorities, and which model is most appropriate based on their ability to take on fiscal and administrative risk.

- **What key steps should a state take to design and implement a buy-in?**
  States across the country are taking diverse paths on buy-in legislation, largely depending on who is leading the buy-in charge, with either a step-based approach (with a study bill followed by implementation/appropriation legislation), or one originating bill pre-approving introduction upon conclusion of a study. Given the potential financial and market impacts of a buy-in, analysis will be needed to inform design prior to implementation. Additionally, stakeholder engagement with consumers, providers, and insurers will help the state refine their goals (and therefore the buy-in design), and ensure stakeholder participation in the program. After legislative approval, the state will need to engage in implementation planning, including: administrative development; contracting with a partner insurer(s) or directly with providers; coordination with the Marketplace; and 1332 negotiations, if applicable.

Conclusion

Given the slim likelihood that health care reform initiatives that address coverage, access, and affordability will emerge at the federal level this year or next, state policymakers are taking matters into their own hands. Medicaid buy-in models are chief among the emerging state-based solutions. It is essential that states begin the buy-in design and implementation process by being explicit about their goals since they are critical for guiding design decisions. Beyond goal setting, states will need to consider how to fund the buy-in and will require sufficient "lead time" for a broad field of implementation tasks, including: product design, actuarial analysis, development of legislation, and frequent and robust communication with key stakeholders. All of these activities will position states to implement a successful buy-in program that provides a new, affordable health coverage option to state residents.

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

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

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

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

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

ABOUT MANATT HEALTH

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

Endnotes

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

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