

Medicaid Buy-In

Questions of Purpose and Design

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Medicaid Buy-In: Questions of Purpose and Design

During the summer of 2017, the state of Nevada confronted the possibility that several rural counties might not have any health insurers offering coverage on the Affordable Care Act’s (ACA) health insurance exchange. In response, the Nevada state legislature passed a bill to permit individuals not otherwise eligible for Medicaid to “buy into” that program. The bill also authorized the state to seek federal approval for those eligible for the ACA’s premium tax credits to use those credits to purchase insurance through the buy-in program. As this process unfolded, one of the state’s insurers stepped in to offer coverage in all of the counties, eliminating the original concern.

With the immediate problem resolved, and in light of the precedent-setting implications of such a new extension of Medicaid, the governor vetoed the bill. Yet this Nevada episode is notable as it marks one of the first in a recent round of attempts to use Medicaid as a platform for coverage expansion. Since then, various proposals to broaden the scope of the Medicaid program to include individuals who are not otherwise eligible have emerged in about [fifteen](#) states and in the Congress.

As advocates of coverage expansion look for opportunities, it stands to reason that many see the Medicaid program as a possible platform. Medicaid has expanded incrementally over the years and it has recently shown itself once again to be scalable, with the ACA expansion that has taken place so far in thirty-two states. With national enrollment of approximately seventy million, Medicaid is our largest health insurance program, covering one in five Americans. [Michael Sparer](#) has argued that, due to its flexibility, superior coverage characteristics, and more attractive cost structure, “Medicaid for More” trumps “Medicare for All” as a basis for coverage expansion.

Here we describe and compare the major categories of current proposals in the states and Congress and discuss

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some of the logistical and policy considerations. For our purposes, a “Medicaid buy-in” is any initiative that uses part of the structure of the Medicaid program to open coverage, for a fee, to populations not usually eligible for Medicaid. A buy-in may or may not involve the creation of a “public option,” a publicly operated insurance plan offered to individuals as an alternative and as a competitor to private plans in ACA exchanges. As we note below, buy-in proposals may be designed to serve other functions and may take many forms.

It should be noted that the idea of Medicaid as a platform is not completely new. Many states have long allowed certain populations — largely, but not exclusively, disabled adults and children — to buy into Medicaid. The incentive for allowing disabled populations to purchase Medicaid coverage would be to provide access to additional benefits not normally offered through private insurance and also, perhaps, to improve the commercial risk pool by removing potentially costly enrollees. County Medicaid plans have existed in a number of Western states for decades, and largely reflect the efforts of counties to proactively address their responsibility for healthcare for uninsured residents, which would otherwise take the form of uncompensated care. California and Texas have long had a number of county-financed Medicaid plans, and other areas such as Cook County and New York City have also created plans.

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Three Types of Buy-Ins

The current round of buy-in ideas can be roughly divided into three groups, depending on the problem they are trying to solve. The most incremental seek to expand eligibility to certain populations. Buy-in proposals in the middle and largest category are designed with the goal of stabilizing the individual market that, depending on the state context, can take many forms. Finally, the most ambitious proposals aspire to export the rate structure of Medicaid to a broader segment of the insurance market.

1

Increasing Eligibility: Buy-ins for Underserved Individuals

The most incremental approach to a Medicaid buy-in allows populations to enroll in Medicaid in a way that would have relatively little impact on the rest of the insurance market. As mentioned, many states have permitted disabled adults and children to buy into Medicaid or the Children’s Health Insurance Program (CHIP). Similarly, some states have covered certain immigrant populations under their Medicaid program, using state funds. In the 1990s, New Jersey permitted households below 350 percent of the federal poverty level (FPL) to buy into its Medicaid program. Several current buy-in proposals are similarly incremental. Oklahoma and Missouri have proposed allowing disabled populations to buy into Medicaid. New Jersey, whose current law contains a children’s buy-in program (currently not operational), has



legislation introduced that would expand children’s eligibility. Broader opportunities that would permit unsubsidized adults to purchase Medicaid plans could be helpful in states where they are essentially priced out of the market, a problem that is only increasing over time in the individual market.

2

Increasing Stability: Buy-ins for the Individual Market

Most of the current buy-in ideas are designed to stabilize or remedy weaknesses in the individual market. Some, like the Nevada proposal, have been motivated by concerns about the potential for a “bare county” or a failure of carrier participation. Yet a buy-in option can be useful not just as a backstop against a bare county but also for a closely related circumstance: uncompetitive rural areas where coverage is least affordable. While the buy-in would not improve competition, it could replace a more expensive plan with a cheaper one, which is helpful from the perspective of federal tax credits as well as unsubsidized individuals. Providers who may not ordinarily agree to Medicaid rates may see a net increase in revenue if such a plan improves take-up and reduces uncompensated care. In more competitive markets, a Medicaid-based public option could serve a certain segment of the eligible individual market population defined by income, geography, or health conditions in ways that could improve the stability of the rest of the individual market. The Basic Health Plans that currently exist in New York and Minnesota can be thought of as examples of this approach.

The optimal structure of a buy-in would be shaped by the policy goals and market environment in each state. In some states, the public option may take the form of a state-sponsored Qualified Health Plan (QHP), which would be available to the entire eligible population and may be intended to displace more expensive alternatives. In other states, the best opportunity may be to allow some or all of the individual market population to buy into an existing Medicaid program, or create another coverage option that is some type of mixture of Medicaid and a QHP. From a logistical perspective, creating a QHP is a simpler choice, but depending on local market conditions there may be reasons to prefer an alternative.



A recent analysis by [Manatt Health](#) assesses these financial and operational considerations for states. The [Urban Institute](#) has noted that the value of this solution may be limited, since many states with the worst marketplace problems will be unlikely to propose a buy-in because they haven't expanded Medicaid and may not have Medicaid Managed Care Organizations (MMCOs) in their state. MMCOs as part of a state's Medicaid program would make a buy-in more scalable, as health plans already have key infrastructure such as enrollment, clinical, and network functions. Another point to consider is whether a buy-in could be construed as a time-limited approach that could be phased out if it appeared that market conditions were improving.

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3

Increasing Affordability: Buy-ins that Go Beyond the Individual Market

The [State Public Option Act](#), a bill introduced last fall in the Congress, would allow states the choice to buy into a QHP that is provided by the state Medicaid program. The proposal highlighted the affordability advantages of Medicaid by focusing on the rate-setting aspect of a public option. This and some other proposals seek to create a public option tied to Medicaid rates that would be offered not only to the individual market but ultimately to a larger group of individuals and income levels. To the extent that this broader public option could be made available to other insurance market segments, such as state employee or employer plans, it could create a stepping stone to more global rate setting or potentially even a single-payer environment. For example, the current proposal in [Massachusetts](#) would create a Medicaid-like product that would ultimately be available to segments of the employer market, in this case participating employers of Medicaid-eligible employees.

Design Issues

There are numerous specific design issues that must be considered in the development of any type of Medicaid buy-in or public option, but there are also a few broader market considerations worth mentioning. States need to maintain a clear sense of the problem they are trying to solve by creating a new coverage option.

1. Eligibility

Probably the most important difference among the plans described above is the size of the affected population. The larger the population, the greater the potential to crowd out commercial rates, and the more opposition that can be expected from traditional healthcare stakeholders. A relatively incremental option may not be transformative, but it could fill a gap, such as undocumented or unsubsidized populations that have a high likelihood of being otherwise uninsured. The less the buy-in option crowds out commercial coverage, the smoother passage it is likely to have. However, this comes at the expense of having a greater impact on coverage, affordability, and system-wide cost trends.

2. Benefits

Another important issue affecting buy-in design would be the nature of the coverage that would be offered. Medicaid has vastly lower cost-sharing, which has been a motivation for the establishment of the Basic Health Program and also a draw for some states currently considering buy-ins, such as [New Mexico](#). Policymakers will also need to determine if the benefit package should be based on Medicaid, which offers a wider range of benefits, including features such as nonemergency transportation, or whether it should more closely approximate what is typically available in commercial coverage as specified by the ACA.

A public option that takes the form of a QHP would need to conform to ACA requirements and a version that was neither Medicaid nor a QHP would need to develop some unique set of benefits, maybe similar to the existing Basic Health Program. Even limited buy-in plans will need to assess whether there should be cost sharing and deductibles for newly eligible populations, and whether traditional benefits need to be altered. These choices, along with the structural choices about the nature of the buy-in, depend on whether the primary incentive is more about the lower rates or more about improving coverage and affordability for certain individuals.

3. Financing

A key consideration in the design of a Medicaid buy-in or public option is how enrollment is financed. A potential source of financing is the Advanced Premium Tax Credit (APTC) that is currently in use on the individual market; proposals that find ways to employ those credits will have a bigger potential reach. By creating a state plan that is literally a QHP, states may avoid the need to apply for a federal waiver. Buy-ins to existing Medicaid plans or other non-QHP options for people eligible for federal tax credits will probably require some type of waiver approval. However, in



states where the marketplace is functioning well, and the goal of a public option is to provide a lower-cost option for unsubsidized persons without disrupting the QHP marketplace, seeking waiver approval for use of APTCs may be seen as undesirable, as that would make the buy-in more of a threat to existing market participants. Other than reinsurance, there has not been much state activity to directly assist the unsubsidized, although this possibility was raised in the California legislature.

4. Rate Setting

The rate-setting process for health plans that contract with state Medicaid agencies is quite different than the commercial rate development process used by health plans on the ACA exchanges. A key design question for Medicaid buy-in proposals will be to determine the process by which rates are set.

Typically, in Medicaid, states establish premium rates for specific demographic, age, and geographic regions and use some form of risk adjustment to address selection bias across plans. One approach to rate setting would thus be to use the established rate categories. However, this approach may not be accurate if the buy-in population is either healthier or sicker than the underlying Medicaid population. This could be particularly likely in situations such as where the state has not expanded Medicaid and/or there are unsubsidized individuals enrolling in the plan.

The relative risk profile of the buy-in population will also have implications for the single-risk pool. If it is healthier than the rest of the individual market, keeping the buy-in population in the risk pool will be helpful to the market; if not, removing this population from the risk pool could be helpful. States will need actuarial modelling to assess the impact of various alternatives.

In the ACA exchanges, commercial plans propose rates to their respective state insurance departments, and there can be wide variation in rates among insurers — a key element in competitive markets. Relatedly, the approach to rate setting would also help to determine whether the buy-in or public option plan would be part of the single risk pool, which would probably be most likely if the new plan were a QHP. If the new

coverage options remove many lives from the single-risk pool, it will be important for policymakers to understand how that exodus will impact risk selection and premiums in the remaining ACA-compliant individual market. Risk adjustment also operates quite differently in these two market segments, and states will need to consider how any risk adjustment would work with a new coverage option, whether a buy-in, a QHP, or another new plan.

5. Healthcare Provider Rates and Participation

The potential opportunity to use lower Medicaid rates more broadly is a major motivating factor for most buy-in proposals. However, providers are adamant about not expanding the footprint of the Medicaid rate structure. The larger the program, the more likely that provider rates will drift away from Medicaid. For these reasons, the eligibility and rate issues are closely intertwined, particularly because states are not able to compel participation from providers. The buy-in design thus needs to consider whether to use standard Medicaid rates, and, if so, whether there will be enough participating providers to meet enrollee demand. A related issue pertains to drug prices, where it is unlikely that the discounted Medicaid drug prices will be extended to a broader population. These pressures can erode the affordability advantage of the new coverage option, as could differences in actuarial value that might affect utilization.

6. Regulatory Considerations

There are significant state and federal regulatory issues to be addressed in all of these potential scenarios. A basic issue underlying the feasibility of many of these plans concerns the ability to get an ACA section 1332 waiver to repurpose the tax credits. A Medicaid waiver may also be required. Depending on where the new coverage option sits, there will be many state regulatory issues, such as which agency establishes network adequacy, whether state insurance mandates apply, and how consumer complaints will be handled.

Conclusions

Given the positive financial results for marketplace carriers and a more stable enrollment population than some feared in the individual market, the threat of bare counties now seems less imminent. This improvement could slow momentum toward buy-ins that are designed largely to ensure market access, as policymakers may be inclined to avoid disruption if it does not seem to be strictly necessary. Yet, while the individual market may be on somewhat firmer footing at present, the future is by no means assured. State circumstances also vary significantly, and are apt to vary more

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in the future, given the range of responses to the elimination of the mandate and the threat of short-term and association health plans.

While the access option imperative for a Medicaid buy-in may have receded somewhat, the affordability motivation may be gaining currency. There is no question that the unsubsidized population is facing increasing challenges affording premiums, even for high-deductible plans. In addition, substantial cost sharing for those between 250 and 400 percent of the FPL may also create important affordability concerns and motivate different approaches to a buy-in.

Increasingly, the interest in improving affordability has expanded beyond the individual market. But the individual market can provide a useful springboard, as the acute affordability issues and the need for greater stability in this segment can be leveraged to establish a basis for broad expansion coverage options based on a lower rate structure. While the issue of universal coverage may be quite partisan, there is widespread support for increasing the affordability of healthcare. In this climate, policy proposals based on broadening the use of a Medicaid-like or even Medicare-like rate structure may receive an increasingly receptive audience.



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