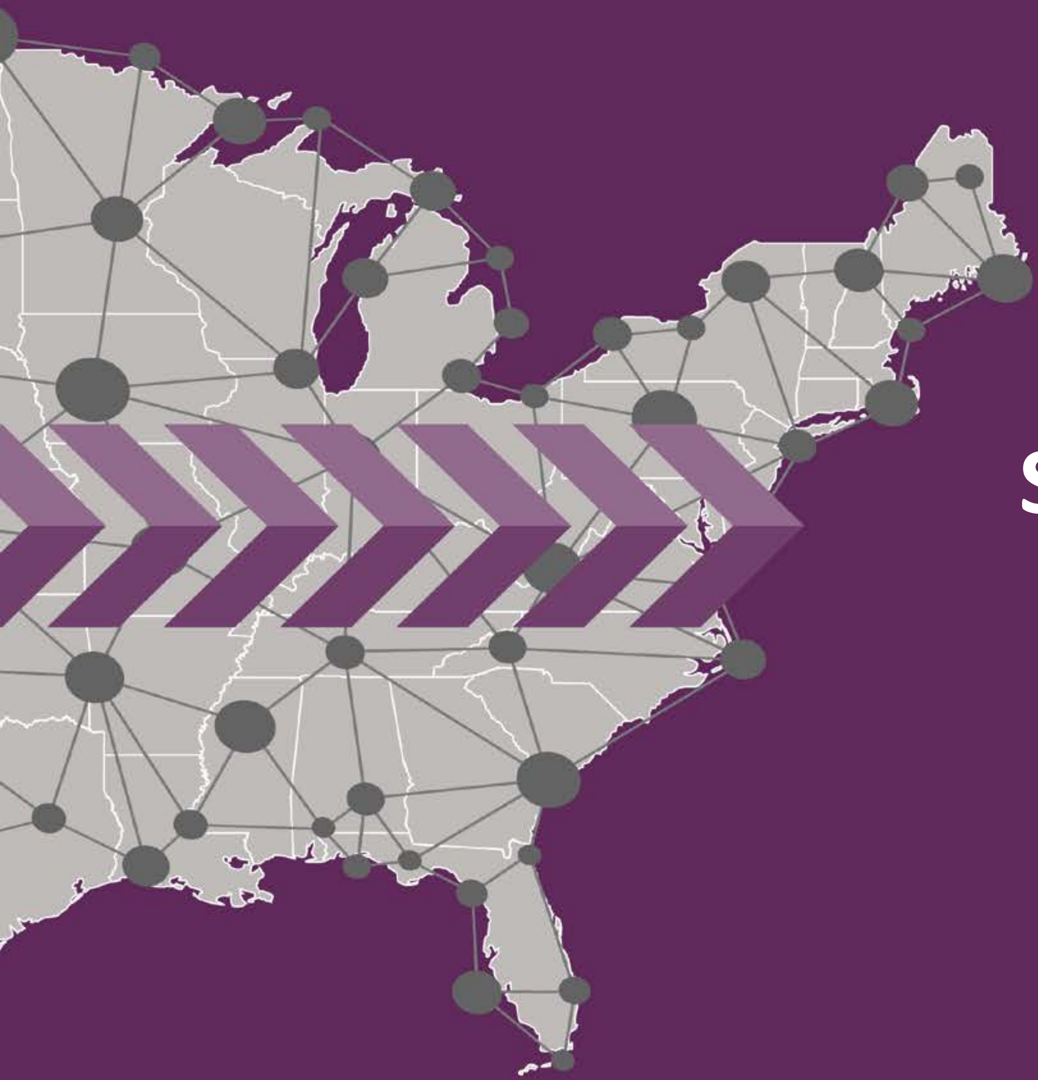

Medicaid Buy-In: State Options, Design Considerations and 1332 Implications

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STATE Health & Value STRATEGIES | *Driving Innovation Across States*

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About Manatt Health

Patricia Boozang and Chiquita Brooks La-Sure with Manatt, Phelps & Phillips, LLP prepared this presentation. Manatt Health, a division of Manatt, Phelps & Phillips, LLP, is an integrated legal and consulting practice with over 90 professionals in nine locations across the country. Manatt Health supports states, providers, and insurers with understanding and navigating the complex and rapidly evolving health care policy and regulatory landscape. Manatt Health brings deep subject matter expertise to its clients, helping them expand coverage, increase access, and create new ways of organizing, paying for, and delivering care. For more information, visit www.manatt.com/ManattHealth.aspx

Today's Objectives

- Discuss states' goals for developing Medicaid buy-in proposals, and how they impact product design
- Review the primary models for state-administered Medicaid buy-in proposals, and the administrative considerations and authorities needed for each model
- Discuss the implications of Section 1332 waiver deficit neutrality and pass-through funding

Background

Medicaid Buy-In: Defined

- A state proposal to provide healthcare coverage to individuals with incomes above the current state Medicaid eligibility level by leveraging Medicaid in some way – such as using the following to offer a more affordable or accessible coverage option in the state:
  - Medicaid provider network
  - Medicaid reimbursement
  - Medicaid infrastructure
  - Medicaid-like benefits

State Goals for Medicaid Buy-In

Access and Competition

Affordability

Market Alignment Between Medicaid and Marketplace

Single Payer Glide Path

- 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)

A state may need to obtain a 1332 waiver depending on its goals and Medicaid buy-in design

Overview of 1332 Waiver Requirements

Section 1332 of the ACA allows states to apply for an innovation waiver to provide residents access to high-quality, affordable health insurance as an alternative (in whole or in part) to standard marketplace coverage if it **complies with guardrails protecting consumers and ensuring deficit neutrality**

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 Exchange.

3 *Affordability*

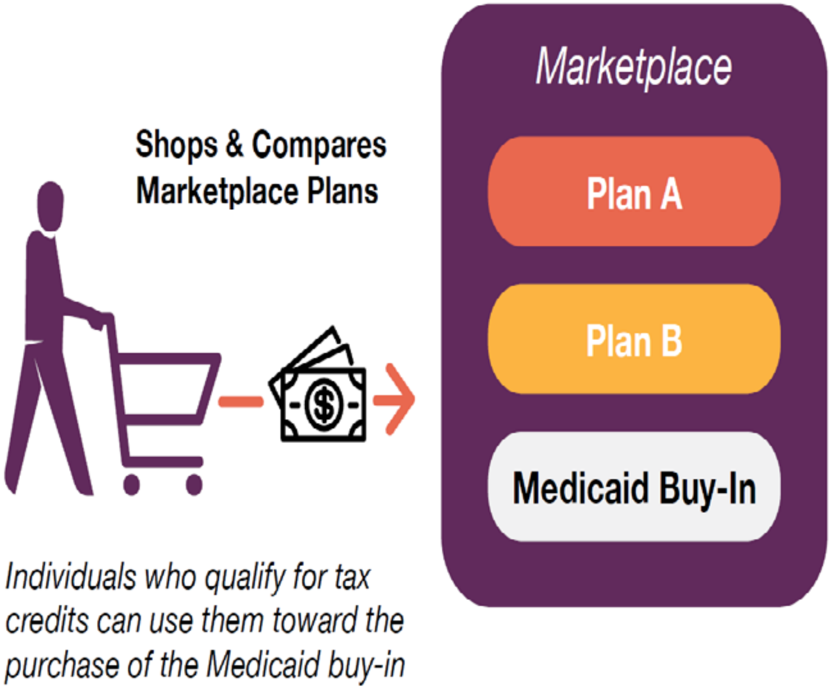
The waiver must provide "coverage and cost sharing protections against excessive out-of-pocket" spending that is at least as "affordable" as Exchange coverage.

4 *Federal Deficit*

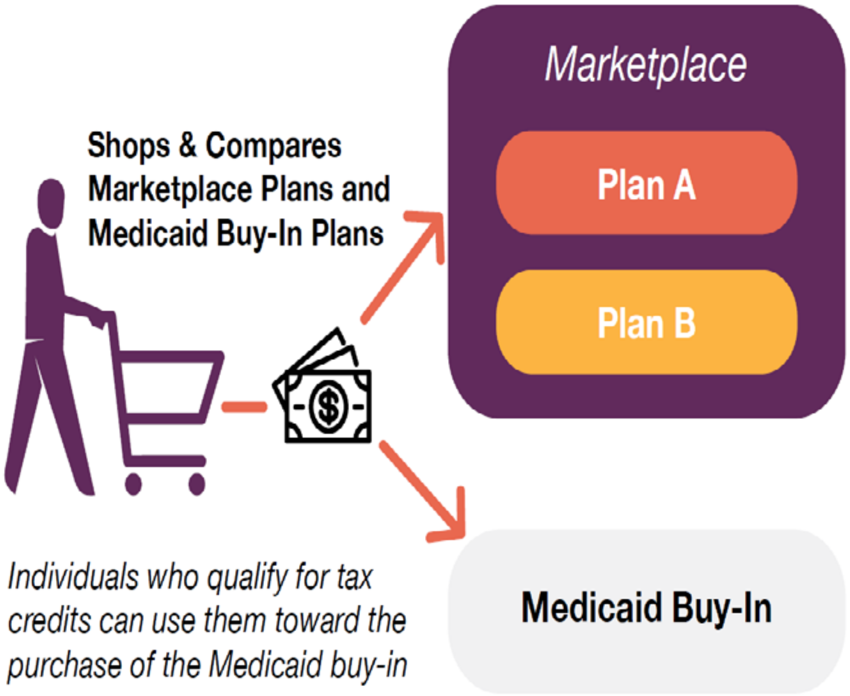
The waiver must not increase the federal deficit including all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue.

Primary Models for Medicaid Buy-In

Model 1: State-Sponsored Product on the Marketplace



Model 2: Medicaid Buy-In Outside of the Marketplace



Model 1: State-Sponsored Product on the Marketplace

Key Model 1 Features

- State designs a product to meet Marketplace standards and qualify for advance premium tax credits (APTCs)
- State procures the product through its Medicaid managed care plans
- State may set the provider rates as part of product design
- State aligns eligibility with Marketplace coverage

Model 1: Operational Considerations and Implementation Authority

- **1332 Waiver Considerations**
  - Obtaining a 1332 waiver may not be necessary to implement this model if the state's plan meets all the requirements to be certified as a qualified health plan (QHP) in order to receive APTCs
  - If a state wants to "stand in the shoes of the issuer," or receive tax credits directly, a 1332 waiver may be necessary; risk adjustment is an additional complexity if the state-sponsored product is not a certified QHP
- **Agency collaboration** between the state Medicaid agency and state insurance department is essential for successful implementation

Model 2: Medicaid Buy-In Outside of the Marketplace

Key Model 2 Features

- A state would create a Medicaid buy-in product outside the Marketplace for people with incomes above Medicaid eligibility levels
- Benefits in this buy-in model could be similar to Medicaid or Marketplace, but with rates, premiums and cost-sharing set by the state
- Structured to allow consumers to use their APTCs to purchase the buy-in product
- The product would not be subject to private insurance rating requirements and would not be considered individual insurance coverage
- Eligibility levels above Medicaid and could mirror Marketplace eligibility

Model 2: Operational Considerations and Implementation Authority

- **Impact on Marketplace Coverage**
  - The buy-in may result in Marketplace destabilization if enrollees leave the Marketplace and insurers increase premiums in response
  - Mitigation strategies are available, including limiting enrollment to certain populations
- **Impact on Marketplace Risk Pool is Complex**
  - If the buy-in attracts a sicker population, it improves the individual market risk pool (and lowers premiums in the individual market), but it could put the state at financial risk to care for a sicker population
  - If the buy-in attracts a healthier population, the state might achieve more savings, but it could negatively impact the individual market risk and premiums
- **Requires a 1332 waiver** to allow individuals to use APTCs to purchase a non-QHP product

1332 Deficit Neutrality and Pass-Through Funding

Deficit Neutrality

- In order to obtain a 1332 waiver, a state must demonstrate deficit neutrality, meaning the waiver will not increase the federal deficit
- Federal savings from any reductions in APTCs (e.g. due to lower premiums in the Marketplace) are measured against any increase in federal spending (e.g., due to higher Marketplace utilization and/or enrollment) or decrease in federal revenues (e.g., lower user fees paid to the federally facilitated Marketplace)
- The Centers for Medicare and Medicaid Services (CMS) conducts the following evaluation to determine whether the waiver meets deficit neutrality:

Federal Spending
Pre-1332

−

Federal Spending
Under 1332

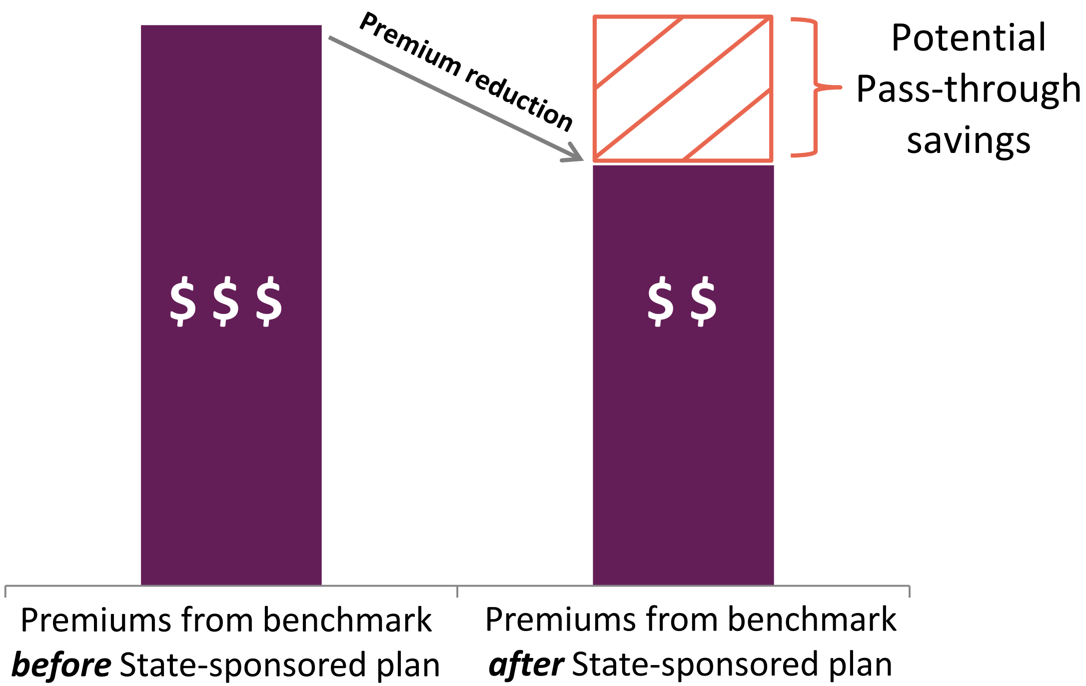
=

Federal Savings:
Pass-through funding available to States

Pass-Through Funding: Model 1

If a State-sponsored product **on the Marketplace** has a lower premium than plans in the current market, it would reduce the benchmark for tax credit subsidies, thus reducing federal costs

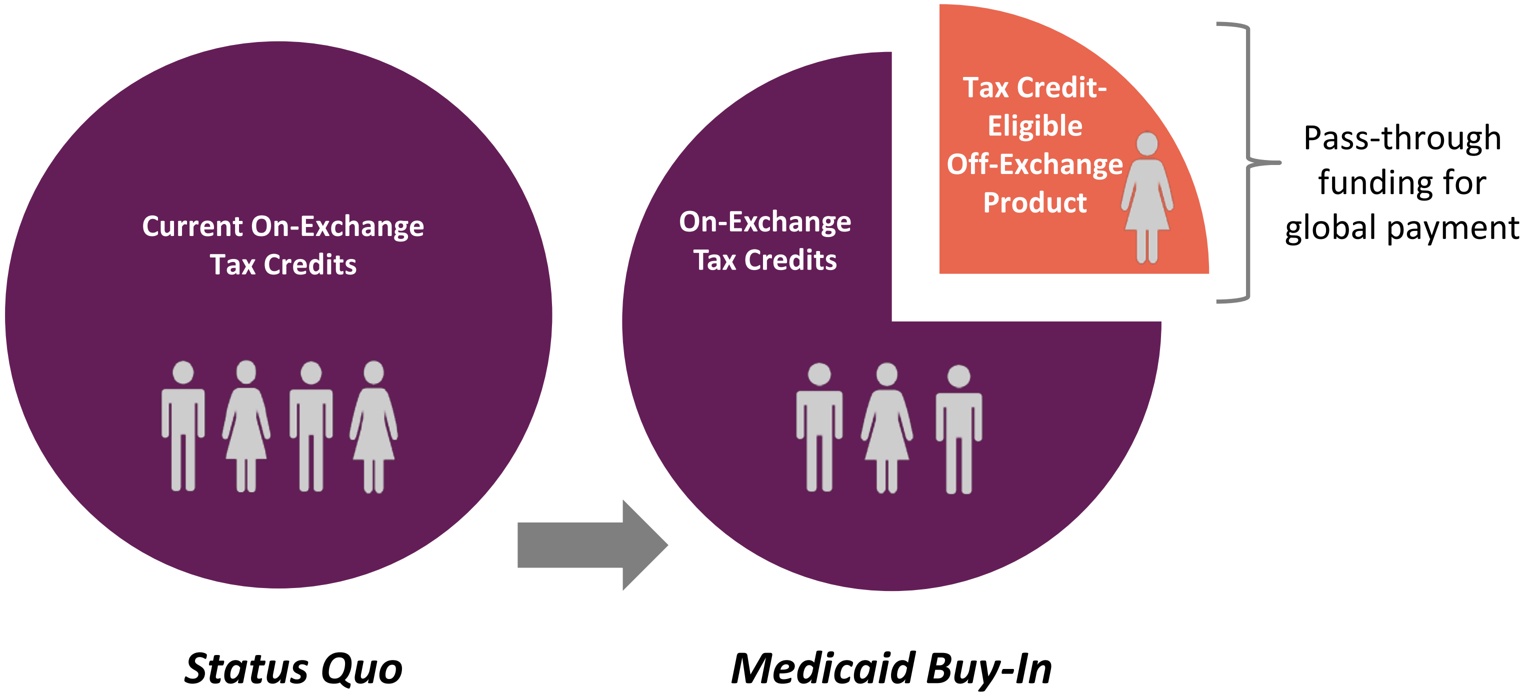
Under a 1332 waiver, the state could receive as pass-through funding the value of those savings



Pass-Through Global Payment: Model 2

A Medicaid buy-in **outside the Marketplace** would lower the number of individuals receiving tax credit subsidies on the Marketplace. The state would receive that funding as a global payment

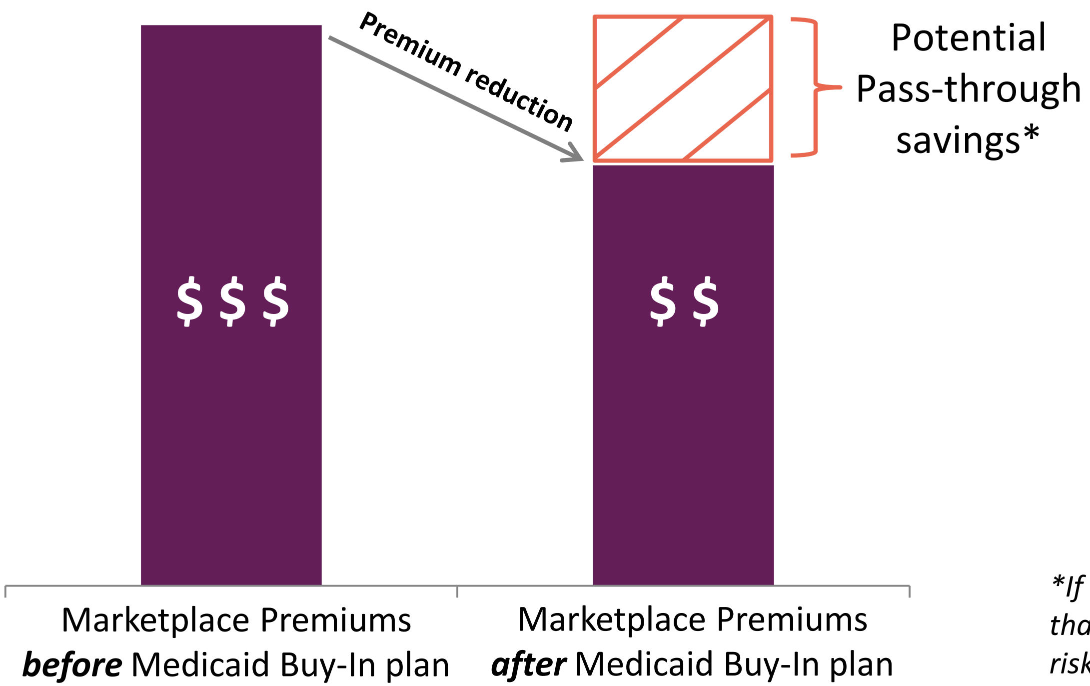
If the cost of the product was less than the value of the global payment, the state would be able to use those savings for the buy-in program



Pass-Through Savings Calculations: Model 2

Additionally, if the buy-in attracts a higher risk population than in the Marketplace, it could lower premiums in the individual market, thus lowering federal APTC costs

The state could be eligible for those pass-through savings



**If buy-in risk is higher than individual market risk, it would reduce savings gain to the state*

Q&A

Appendix

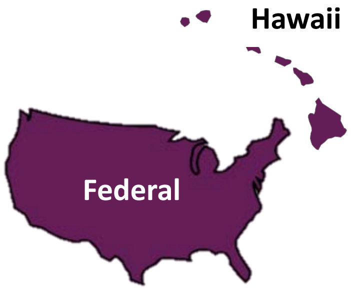
State Initiatives

In April 2018, legislation was reintroduced to allow individuals with incomes above 201% FPL to purchase a MinnesotaCare-like product on the Marketplace

Legislation passed the state Senate in November 2017 to provide a new coverage option for all residents, including those with employer-sponsored insurance

The legislature authorized a study on a Medicaid buy-in proposal to lower costs and expand coverage for residents, including those earning less than 200% FPL

A plan to allowing residents to purchase Nevada Care Plan with APTC and CSRs was vetoed by the Governor in June 2017. A work group has been formed to explore additional options



In October 2017, the State Public Option Act was introduced by Senators Schatz and Lujan to create a Medicaid buy-in is designated as a QHP, treated as the second-lowest-cost silver plan, and eligible for APTCs. No further action has been taken

Thank You

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