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The Implications of a Medicaid Buy-In Proposal

John Holahan and Linda J. Blumberg

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In Brief

Legislation to permit marketplace enrollees the option of buying into Medicaid has been introduced by Senator Brian Schatz. The intent is to provide states with an option that, should they take it, would ensure access to affordable marketplace coverage options. In addition, the policy might increase competition in the marketplaces and lead to lower premiums. There would be many differences between the Medicaid buy-in and existing Medicaid programs that would have to be addressed. These include differences in populations covered, benefits, and cost sharing requirements. States that have declined to expand Medicaid eligibility under the ACA are the least likely to adopt a Medicaid buy in, and many of these have low insurer marketplace participation and high and fast increasing marketplace premiums. In some other states, Medicaid managed care organizations already offer qualified health plans in the marketplaces, so this type of proposal would have little effect. But there are several states that have expanded Medicaid, have few marketplace insurers, and high premiums in marketplaces. In these states, a Medicaid buy-in program could be quite valuable.

Introduction

In August 2017, Senator Brian Schatz proposed a new Medicaid buy-in program for people enrolling in nongroup insurance coverage through the Affordable Care Act (ACA) marketplaces.[1] Public support for Medicaid is high, as seen in the opposition to Medicaid cuts in recent ACA repeal proposals. A Medicaid buy-in would permit states to offer marketplace enrollees a public fee-for-service plan or Medicaid-participating managed care plans. Competition from Medicaid options should increase plan choice and provide lower-premium options. This proposal avoids some of the complexities of a Medicare buy-in approach,[2] but it faces its own challenges.

Important Differences Between a Medicaid Buy-In Program and Current Medicaid Programs

Benefits Covered.

This Medicaid buy-in proposal should be understood as providing a marketplace public plan option developed through state Medicaid programs. Although the bill does not reference benefits specifically, we anticipate that the plan offered would be distinct from the insurance package current Medicaid enrollees have. Medicaid has a set of mandatory and optional benefits, and each state determines which optional benefits are covered. The Medicaid buy-in plan for marketplace enrollees would likely cover the 10 essential benefits required by the Affordable Care Act. States' current Medicaid programs may be more or less generous than ACA-compliant coverage. Thus, marketplace enrollees would probably not be buying into existing Medicaid plans, but into state-developed plans that would operate alongside current Medicaid offerings. These new plans could be fee-for-service plans created by the state, plans offered by managed care organizations (MCOs) providing insurance to Medicaid beneficiaries, or a combination of the two.

Premium Payments and Out-of-Pocket Requirements.

Medicaid currently does not require enrollees to make premium contributions or out-of-pocket payments toward health services they use except under waiver programs, which can have nominal premiums for higher-income beneficiaries. By contrast, Medicaid buy-in options in the marketplaces would offer cost-sharing reduction plans (with 94 percent, 87 percent, or 73 percent actuarial value, depending upon enrollee income) and 70 percent actuarial value plans to people with incomes above 250 percent of the federal poverty level (FPL). In principle, they could also offer plans with actuarial values of 60, 80, or 90 percent, consistent with other marketplace plans. Buy-in enrollees would be required to make income-related premium contributions. State Medicaid agencies would take on the new responsibilities of developing plans consistent with commercial options, setting actuarially fair premiums, and collecting those premiums. States have some of this capacity with state employee plans, but much of what would be needed for a buy-in would be new and different for Medicaid agencies.

Financing.

Medicaid programs are funded jointly by federal and state governments. The federal government pays states for 50 to 75 percent of traditional Medicaid program expenditures, depending upon state per capita personal income (the federal government contributes higher percentages of expenditures in low-income states), and the state pays the rest. Higher federal matching percentages are paid for people enrolled under the Medicaid expansion and for children in the Children's Health Insurance Program (CHIP). Under the proposed Medicaid buy-in program, the costs of insurance would be paid by households through premiums and by the federal government through premium tax credits. But states could bear the financial risk if premiums for the buy-in products are set too low. For example, in a state constructing a fee-for-service plan as a buy-in product, if premium collections (including federal premium tax credits) fall below actual expenditures on covered services, the state would be financially liable for the excess expenditures, unless other policies are put in place to cover them. States may be unwilling to take on such risk, and if they are, they would have incentives to set premiums high to reduce that risk. States with Medicaid MCOs operating in all or part of the state could require those MCOs to offer buy-in products, thus shifting the financial risk to the MCOs. But if MCOs object to such a requirement and are unwilling to participate, the state risks losing MCO participation for traditional Medicaid beneficiaries.

Challenges of Implementing a Medicaid Buy-In Program

Insufficient Political Support.

Medicaid buy-in would work differently in different states, if it is implemented at all. The 19 states that have chosen not to expand Medicaid eligibility under the ACA are unlikely to adopt a Medicaid buy-in for people above the poverty level. In fact, nonexpansion states mostly overlap with the set of states that have few insurers and high premiums. Table 1 shows data on the 19 states, including the insurers with the broadest participation in each state. These insurers participate in the most rating regions in a given state. Also shown are the number of insurers in the state, the average lowest-cost silver plan premium, and the average 2016–2017 percent change in lowest-cost silver premiums. We focus on 2017 insurer participation and premium changes because 2018 premiums are distorted by the adjustment of silver premiums to account for the termination of federal reimbursements for cost-sharing reductions. Some states (e.g., Florida, Georgia, Texas, and Virginia) have several competing insurers and relatively low premiums and premium growth. Most of the remaining 15 states have few insurers and much higher premiums and premium growth. For example, in 10 of the 19 nonexpansion states, 100 percent of the state population lives in markets with one or two insurers. In 13 of the 19 states, the lowest-cost marketplace premium exceeds the national average. But since these high-premium states declined to expand Medicaid coverage to people with incomes below 138 percent of FPL, they are unlikely to adopt a Medicaid buy-in, particularly if they face financial risk in doing so.

Some Medicaid expansion states, including Arizona, West Virginia, Pennsylvania, and Maryland, also have high marketplace premiums and/or premium growth, at least in some areas. These states may be the most likely to take advantage of, and benefit from, a Medicaid buy-in program. They all have relatively little marketplace competition in addition to high premiums. Their willingness to expand Medicaid to lower-income people leaves a political opening for further expansion to marketplace enrollees.

Reliance on Fee-for-Service versus Managed Care.

Some state Medicaid programs rely exclusively on fee-for-service, some have contracts with MCOs to provide coverage to nonelderly beneficiaries, and some use a combination (fee-for-service for some populations and managed care for others). In 2017, 36 states (including the District of Columbia) had managed care plans for at least some of their Medicaid populations; the remaining states were fee-for-service.[3] States where Medicaid MCOs cover all areas and are willing to participate in a buy-in program would face the least effort and financial risk. Some of these MCOs are already offering coverage through the marketplaces, so their transition to a Medicaid buy-in program would not be onerous. However, the buy-in would have little noticeable effect in areas where Medicaid MCOs are already in the marketplace. These insurers would set premiums as they saw fit and comply with any additional regulations (e.g., payment rate rules for primary care providers), and the MCOs would bear the risk of any underpricing that could occur. But some MCOs currently providing Medicaid coverage may be unwilling to participate.

Lack of Marketplace Participation by Many Medicaid MCOs.

Many more insurers offer Medicaid MCOs than participate in the ACA's marketplaces. Large national insurers (e.g., Anthem, Aetna, Humana, and UnitedHealthcare) and local Blue Cross insurers participate in Medicaid in many states but often do not participate in the marketplaces. National and regional Medicaid Managed Care Organizations (e.g., Centene, Molina, and CareSource) do not always participate in every marketplace market in which they offer Medicaid plans. It is important to understand why some insurers participate in Medicaid but not in the marketplaces. Medicaid MCOs may be unwilling to take on the financial risk of the marketplace population. They may feel that their inexperience in setting and collecting premiums would bring significant new costs. They may be unwilling to enter a market where constantly changing federal regulations and policies make the number and average health care needs of enrollees highly uncertain. They may not want to work within the marketplace regulatory environment or

Table 1. Insurer Participation, Average Lowest-Cost Silver Premiums, and Premium Change in Nonexpansion States

State	Dominant Insurers	Number of Insurers Participating in Marketplace, 2017[a]	State Average Lowest-Cost Silver Monthly Premium, 2017	State Average Percent Change in Lowest-Cost Silver Premium, 2016–2017	Percent of Population With Only One or Two Marketplace Insurers, 2017
US Average	**N/A**	**N/A**	**$342**	**21.2%**	**34.0%**
Alabama	Blue Cross Blue Shield of Alabama	1	$435	51.3%	100.0%
Florida	Blue Cross Blue Shield of Florida Celtic Insurance Company (Centene)	6	$323	14.1%	33.8%
Georgia	Blue Cross Blue Shield Healthcare Plan of Georgia	5	$312	10.6%	36.0%
Idaho	Blue Cross of Idaho	4	$344	26.8%	0.0%
Kansas	BlueCross and BlueShield of Kansas City	3	$362	50.5%	100.0%
Maine	Anthem Health Plans of ME (Anthem BCBS) Harvard Pilgrim HealthCare	3	$371	19.5%	0.0%
Mississippi	Humana Insurance Company Ambetter of Magnolia	2	$327	23.7%	100.0%
Missouri	Blue Cross and Blue Shield of Kansas City	4	$365	19.8%	81.7%
Nebraska	Medica Insurance Company	2	$464	45.1%	100.0%
North Carolina	Blue Cross and Blue Shield of NC	2	$517	40.0%	100.0%
Oklahoma	Blue Cross Blue Shield of Oklahoma	1	$495	73.6%	100.0%
South Carolina	Blue Cross and Blue Shield of South Carolina	1	$389	29.7%	100.0%
South Dakota	Avera Health Plans Sanford Health Plan	2	$430	36.0%	100.0%
Tennessee	BlueCross BlueShield of Tennessee	3	$433	56.9%	100.0%
Texas	Blue Cross Blue Shield of Texas Celtic Insurance Company Molina HealthCare of Texas	10	$279	10.6%	8.7%
Utah	SelectHealth	3	$308	33.9%	18.0%
Virginia	CareFirst BlueChoice Anthem HealthKeepers	11	$309	10.2%	2.7%
Wisconsin	Anthem BCBS Medica Health Plans of Wisconsin Molina HealthCare of Wisconsin	15	$350	20.9%	3.5%
Wyoming	Blue Cross Blue Shield of Wyoming	1	$494	8.9%	100.0%

Notes: ACA = Affordable Care Act; AV = actuarial value; FPL = federal poverty level; NA = not applicable.

[a] Authors' calculations using data from Healthcare.gov public use files and relevant state-based marketplace websites.

abide by marketplace rules that create more intense price competition. Smaller Medicaid MCOs may not have the network capacity to expand. A Medicaid buy-in program would have many of the same complications. Theoretically, states could compel their Medicaid MCOs to participate in the marketplace by making it a condition of Medicaid participation. But this runs the risk of losing at least some participants of the current program.

Issues in Fee-for-Service States.

States where Medicaid is only fee-for-service, states where at least some regions do not have MCOs, and states where MCOs are not willing to provide a buy-in product in at least some areas would have to develop a Medicaid-based fee-for-service qualified health plan to make a buy-in program work. Although some of the development and operation of such a plan could be contracted out (e.g., to actuarial firms or firms that provide insurance administrative services), this effort would require investment of state personnel and finances. And as noted earlier, these states would bear the financial risk of underpricing these buy-in products relative to incurred claims net of possible risk adjustment with any other plans participating in the marketplaces. To limit this financial exposure and minimize risk, the state would have a strong incentive to set high buy-in premiums, at least in the early years of the program. But doing so could make the new plan uncompetitive in the marketplace (if there are private plan competitors) and could defeat the purpose of improving the availability of affordable coverage options for people ineligible for premium tax credits.

Like a Medicaid MCO, a fee-for-service Medicaid plan would compete as a qualified health plan on the marketplaces. If there were no other competitors, the fee-for-service plan would be considered the second-lowest-cost plan, and individuals would not have to pay any more to obtain Medicaid coverage. If there were competitors and the Medicaid plan was one of the two lowest-cost options, individuals could enroll at no additional cost above the ACA-specified percent-of-income requirements. If the Medicaid premiums in a competitive marketplace were above the benchmark, individuals would have to pay the difference to be in Medicaid instead of the first- or second-lowest-cost silver plan.

Increasing Primary Care Physician Payment Rates.

The Schatz Medicaid buy-in proposal would require fee-for-service or MCO plans to reimburse providers for primary care services at least at Medicare rates. The bill does not specify whether these higher fees would also apply to each participating state's traditional Medicaid population or only to its ACA expansion population, and this distinction would have cost consequences for states. A plan with higher primary care fees may have difficulty competing against other insurers in the marketplace. In states where the buy-in plan is the only option, it obviously would not face competition. But if there are competitors, they may have narrower networks and lower provider payment rates than Medicaid does. Where Medicaid MCOs are already operating in a state's marketplace, a Medicaid buy-in plan could require that those MCOs develop a higher-priced option to meet the primary care payment rule, essentially creating a plan to compete against itself.

Broader Provider Payment Rate Issues.

Provider participation in Medicaid buy-in plans is inextricably tied to the payment rates offered by such plans. In some areas, Medicaid managed care organizations likely would be unable to expand their capacity to accommodate marketplace enrollees without paying higher reimbursement rates to physicians in specialties other than primary care, and state fee-for-service Medicaid programs may find it difficult to increase physician participation. The same may be true for hospital participation, although virtually all hospitals currently participate in their states' Medicaid programs. Inpatient payment rates for Medicaid are very close to those for Medicare, so we would not expect hospital participation to hinder expanded Medicaid enrollment.[4] And where Medicaid MCOs already participate in marketplaces, they often offer the lowest-premium plans, suggesting that their payment rates fall below those of other insurers.

Limited access to some types of specialists is already a significant problem for Medicaid beneficiaries in some areas of the country; analysts attribute this to low provider payment rates.[5] Expanding Medicaid plan enrollment to the marketplace population could cause similar access problems for this higher-income group. Increasing reimbursement beyond the primary care requirement could mitigate this problem, but it would lead to higher federal costs for the subsidized population and higher premiums for people ineligible for subsidies than might be anticipated under a Medicaid buy-in. In addition, it may be difficult to pay higher provider payment rates through Medicaid for marketplace enrollees without extending those increases for the Medicaid-eligible population as well; this would increase government costs further, but it could reduce historic access problems significantly.

Conclusion

For many states, a Medicaid buy-in program would be a major change from the current Medicaid program. The covered population, benefits, and cost-sharing requirements would be quite different, and would require the states that do not now have Medicaid MCOs participating in the marketplaces to take on new responsibilities. The buy-in is not likely to make much of a difference in states with competitive markets, particularly in states where marketplaces already offer qualified health plans from Medicaid MCOs (e.g., New York, Massachusetts, Ohio, Michigan, and

California). And the 19 states that have so far declined to expand Medicaid eligibility under the ACA are unlikely to adopt a buy-in option for people with incomes above 138 percent of FPL, especially given the potential financial exposure if a state underpriced a fee-for-service Medicaid plan. But a Medicaid buy-in option could help, offering additional insurance choice at reasonable premiums, in Medicaid expansion states with few insurers and high premiums (e.g., Alaska, Pennsylvania, Maryland, and Arizona). And the approach would be especially fruitful in states with Medicaid MCOs that are not currently offering qualified health plans in the marketplace. But to integrate these plans into the marketplaces, we must first understand why they are not participating now and develop policies, such as state-based reinsurance for high health care risks, assistance with premium determination and collection, and joint marketing and enrollment assistance that could make participation more attractive for these insurers.

NOTES

1 State Public Option Act, S 2001, 115th Cong, 1st Sess (2017).

2 Blumberg LJ, Holahan J. Designing a Medicare buy-in and a public plan marketplace option. Washington: Urban Institute; 2016. https://www.urban.org/research/publication/designing-medicare-buy-and-public-plan-marketplace-option-policy-options-and-considerations.

3 Medicaid Managed Care Market Tracker: total Medicaid MCOs. Kaiser Family Foundation website. https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Accessed January 4, 2018. Data from March 2017.

4 Selden TM, Karaca Z, Keenan P, White C, Kronick R. The growing difference between public and private payment rates for inpatient hospital care. *Health Aff*. 2015;34(12):2147–2150. https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2015.0706.

5 Felland LE, Lechner AE, Sommers A. *Improving Access to Specialty Care for Medicaid Patients: Policy Issues and Options*. New York: Commonwealth Fund; 2013. http://www.commonwealthfund.org/~/media/files/publications/fund-report/2013/jun/1691_felland_improving_access_specialty_care_medicaid_v2.pdf.

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ABOUT THE AUTHORS & ACKNOWLEDGMENTS

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