MILLIMAN WHITE PAPER

Medicaid buy-in: Section 1332 Innovation Waivers, state options, and top ten considerations

Paul Houchens, FSA, MAAA
Christine Mytelka, FSA, MAAA
Susan Philip, MPP

As uncertainty and rising insurance premiums plague the individual market, some states are looking for ways to offer more comprehensive or lower-cost health insurance on the individual market, and to entice more of those currently uninsured to purchase coverage. One option currently garnering state attention is Medicaid buy-in.

A Medicaid buy-in option is different from Medicaid expansion efforts under the Patient Protection and Affordable Care Act (ACA). Under the ACA, states were permitted to expand Medicaid coverage to low-income adults, up to 138% of the federal poverty level (FPL). A Medicaid buy-in approach can build on a state's existing Medicaid program infrastructure and offer a Medicaid-like plan to specified residents.

Under a Medicaid buy-in proposal, the core target population would typically be those who are purchasing insurance using advanced premium tax credits (APTCs), or who are eligible for APTCs but uninsured. States have the flexibility to specify either a broader or narrower target group. A Medicaid buy-in may allow individuals not eligible for commercial group coverage to purchase a Medicaid-like plan. This type of proposal may allow a state to replace or augment the current insurance marketplace and ACA premium assistance structure under federal waiver authorities.

States could use their own funds and/or leverage federal funding to develop a buy-in program authorized by a Section 1332 State Innovation Waiver. A state's goals for a Medicaid buy-in through a 1332 Waiver could be further supported by a Section 1115 Demonstration Waiver or other Medicaid coverage changes. In this paper, we consider buy-in proposals that are "in the sweet spot": less ambitious than the single-payer proposals from New York[1] and California,[2] yet broader in scope than proposals limited to people with disabilities or the medically needy. Examples of legislative action exploring this middle range are in the sidebar "Recent interest in Medicaid buy-in." In general, these examples seek to create an alternative or additional consumer choice relative to the current qualified health plan options available through the insurance marketplaces. We will explore the opportunities at a high level and lay out key considerations for states as they weigh options to provide alternative coverage options to those who are seeking affordable coverage in the individual market and the currently uninsured.

Recent interest in Medicaid buy-In

In February 2018, **Maryland** introduced legislation to establish a task force to consider various options for making health insurance more affordable, including a Medicaid buy-in option.

In February 2018, **New Mexico** charged its Legislative Health and Human Services Committee with studying a Medicaid buy-in option to increase low-cost coverage options for its residents.

In June 2017, **Nevada** introduced a proposal, AB 374, to make available a Medicaid buy-in plan, called the Nevada Care Plan, to be sold alongside private insurance plans. Among its provisions, the bill directed the state to seek waivers to implement the program; to allow individuals who would not be eligible to enroll in Medicaid to buy in to the Nevada Care Plan; and to allow payments available through advanced premium tax credits (APTCs) and the cost-sharing reduction (CSR) program to be used toward the Nevada Care Plan. While the bill passed the legislature, and garnered national attention, it was vetoed by the governor on June 16, 2017.

In January 2017, **Minnesota** introduced SF 58 to allow for public options in the individual market, with reimbursement at Medicare payment levels.

A bill introduced in the U.S Congress—in both the House and Senate—called the "State Public Option Act" would allow states to develop a Medicaid buy-in program. The program would be eligible for an enhanced FMAP, with authorization to collect premiums and cost sharing as on the marketplace. In addition, "Medicaid Access Grants" would be available to states to increase provider reimbursement or otherwise support access, subject to approval from the HHS Secretary.

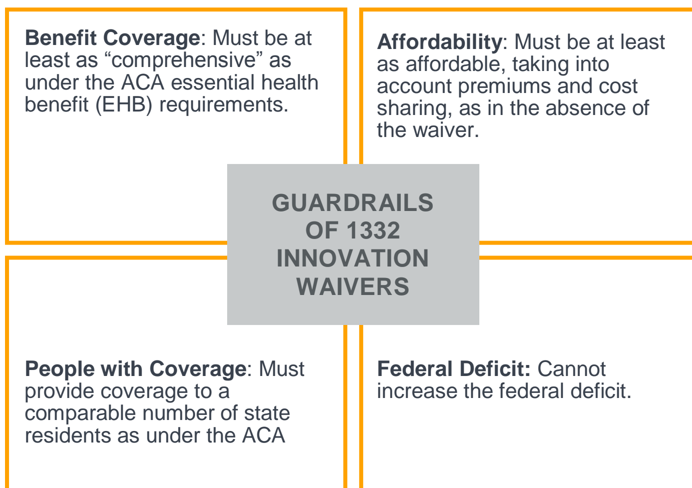
[1] The full text of New York Assembly Bill 4738 (February 2017) is available at http://nyassembly.gov/leg/?bn=A04738&term=2017. The full text of New York Senate Bill 4840 (March 2017) is available at http://nyassembly.gov/leg/?term=2017&bn=S04840.

[2] The full text of California SB 562 (March 2017) is available at https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB562.

Section 1332 State Innovation Waiver

Section 1332 State Innovation Waivers provide a flexible route for Medicaid buy-in. This policy option allows states to waive certain ACA requirements as long as the state's approach to coverage remains within four "guardrails," as illustrated in Figure 1.

FIGURE 1: GUARDRAILS OF 1332 INNOVATION WAIVERS



With an approved 1332 Waiver application meeting these four guardrails, states can modify or eliminate the employer mandate and the individual mandate. States can modify covered benefits or premium and cost-sharing approaches (likely a primary objective under a Medicaid buy-in).

As of March 2018, four states have received approval for a 1332 Waiver. Interestingly, none of the waivers approved to date is a Medicaid buy-in program. Hawaii's 1332 Waiver maintains stricter employer requirements that existed in the state prior to the ACA. Alaska, Minnesota, and Oregon have used the 1332 Waiver to stabilize their individual markets by establishing state-based reinsurance programs. These reinsurance programs are intended to reduce premiums in the individual market and improve affordability for consumers not qualifying for APTCs.[3] The focus of this paper is to examine the 1332 Waiver as a vehicle for Medicaid buy-in programs.

Under an approved 1332 Waiver, a state can receive federal "subsidy pass-through funding" of the total amount of the federal payments that would have been made had the waiver not been in effect. Depending on the waiver design, these payments could include APTCs, CSR subsidies, and small business tax credits, and could even reflect changes in income and payroll taxes resulting from changes in tax exclusions for employer-sponsored insurance.

Pass-through funding opportunities starting in 2018

Pass-through funding available for most states is anticipated to be higher starting in 2018 primarily due to:

- Elimination of the penalty associated with the individual mandate. Prior to 2019, any lost federal revenue due to a 1332 Waiver was counted against a waiver's pass-through funding. Now, states seeking to either waive the individual mandate or decrease uninsured (and potentially mandate penalty revenue) under a 1332 Waiver can safely assume no associated loss of federal revenue.
- Elimination of federal reimbursement for CSR subsidies. The lost federal revenue has been factored into higher premiums. Because APTC payments are based on premiums for the second-lowest-cost silver plan, increased premiums for these plans translates to higher APTC costs. Higher APTC costs translate to higher pass-through funding available, all else equal.

States considering a 1332 Waiver for Medicaid buy-in should address 10 key questions to guide the design of an approach that fits within the guardrails:

1. **What is the overall policy goal?** Is it to increase coverage? Reduce premium costs in the individual market? Improve affordability? Increase competition by creating another marketplace option (e.g., Medicaid buy-in plans could be sold alongside qualified health plans [QHPs] in the marketplace)? Pioneer adoption of value-based payment innovations or delivery system reform through the Medicaid program?
2. **How many people would either gain new coverage or shift their current coverage?** What is the target population? Up to what income level? How many insureds are likely to shift from individual insurance, purchased either on or off the marketplace? What is the current number of uninsured and what is their barrier to coverage (e.g., affordability, limited plan options, immigration status)? Should the state exclude individuals eligible for employer-based coverage to avoid "crowd-out"? For example, premium assistance in the marketplaces is only available to households without access to affordable employer-sponsored insurance.
3. **Should the Medicaid buy-in program be offered as one of several competing options on the marketplace or as the only option for those who are eligible?** Making the Medicaid buy-in the only option for eligible individuals might maximize enrollment and available federal subsidy pass-through funding, but is this feasible (or desirable)? The state should consider how the buy-in program might be perceived relative to the status quo (e.g., "winners/losers" analysis from the perspective of different types of potential subscribers and

[3] Please see http://us.milliman.com/insight/2017/Reinsurance-and-high-risk-pools-Past--present--and-future-role-in-the-individual-health-insurance-market/ for more information related to state-based reinsurance programs.

stakeholders: the young and healthy, those with chronic conditions, those with no subsidies, providers, insurers, etc.).

4. **How will the Medicaid buy-in program coordinate with the Medicaid program?** Has the state expanded Medicaid for low-income adults? If not, the state may first consider targeting this "gap" population. If it has, then the state may consider the population eligible for APTC or CSR payments. Would the buy-in program be administered as an extension of the Medicaid program for low-income adults, or as a standalone program? Managed care or fee-for-service? How will the program coordinate with the Children's Health Insurance Program (CHIP), for children of eligible buy-in members? Should there be an open enrollment period similar to marketplace coverage?
5. **What benefits would be covered?** Would all the Medicaid state plan benefits be covered or would only essential health benefits (EHBs) be covered? Would long-term services and supports (LTSS) be covered, dental benefits, or nonemergency transportation? Would there be a choice of plans offered, as with the metal levels on the marketplace?
6. **How would premiums be set and corresponding premium assistance determined?** Would the buy-in option be more affordable relative to the premium assistance currently available through the APTC program? Would premiums be set by the state (similar to a Medicaid managed care approach), or would rates be developed by carriers as in the marketplaces? Would premiums scale with income, with age, or with other factors such as plan selection? Would certain populations pay no premiums?
7. **What is the appropriate level of out-of-pocket costs?** How would cost sharing be structured—copays, premiums, deductibles? Would low-income individuals be eligible for reduced cost sharing similar to CSR subsidies?
8. **What federal dollars would be available?** As specified in the 1332 Waiver Application Checklist,[4] federal funds that would otherwise be spent in the absence of the waiver may be made available to the state in the form of pass-through funding. Depending on the scope of the waiver this may include APTC payments, CSR payments, and federal administrative costs relevant to the 1332 Waiver program. How much federal funding is available and what percentage of program costs can federal spending support?
9. **Provider reimbursement.** Will providers be paid at Medicaid reimbursement levels, or will a higher level of reimbursement (e.g., Medicare fee-for-service) be necessary to support access? What percentage of cost savings is available to the program from provider reimbursement differences between individual market coverage and the buy-in program? Would the buy-in program create potential "cost shifting" concerns for other payers?
10. **How will the program cover high-cost members such as the disabled or medically frail?** Disabled individuals cannot be charged higher premiums or cost sharing. However, states may cover these members outside the buy-in program, as long as benefits provided to them are at least as good as those available to nondisabled or medically frail individuals. States covering disabled members through an 1115 Demonstration Waiver or through state plan authority (Section 1932[a]) can free up federal subsidy pass-through payments for other members. For example, the State of Idaho recently proposed an 1115(d) Waiver for individuals with complex medical needs with income up to 400% FPL.[5] An 1115(d) Waiver was proposed to fund the extension of federal premium assistance to a portion of the gap population with income below 100% FPL.[6]

Section 1332 Innovation Waivers allow for a broad range of program options, limited primarily by available federal and state-based funding. Federal funding may be potentially supplemented by general revenue funds, provider assessments, employer assessments, premium revenue from members, or other sources.

To make the most effective use of federal pass-through funding, states may also consider accomplishing a part of the desired coverage expansion through Medicaid directly, either through a Medicaid state plan amendment or a Section 1115 Demonstration Waiver.

Section 1115 Demonstration Waiver

Under Section 1115 of the Social Security Act, the Secretary of the U.S. Department of Health and Human Services (HHS) has authority to waive certain federal healthcare program provisions, provided that the objectives of the program are being promoted. To obtain 1115 Medicaid Waiver approval, states must submit an application demonstrating budget neutrality and undergo negotiations with the Centers for Medicare and Medicaid Services (CMS). In the past, 1115 Waivers have been used for a wide range of state initiatives, including increasing eligibility limits for Medicaid, creating new eligibility categories for specific populations, advancing delivery system changes, testing pilot programs, applying cost-sharing and/or premium requirements, and, most recently, imposing work requirements. The 1115 Waivers are intended to be demonstrations and evaluations are

[4] CMS. Checklist for Section 1332 State Innovation Waiver Applications. Retrieved April 17, 2018, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Innovation-Waiver-Applications-5517-c.pdf.

[5] Idaho Health Care Plan. Retrieved April 17, 2018, from http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/1115%20WaiWai/IdahoHealthCarePlanSummary.pdf.

[6] Idaho Application for Section 1332 Waiver (November 1, 2017). Retrieved April 17, 2018, from http://healthandwelfare.idaho.gov/Portals/0/Medical/MedicaidCHIP/1115%20Waiver/Draft1332Application.pdf.

required to be submitted to CMS to assess the impacts of the program. As of March 2018, 36 states have 44 approved and 23 pending waiver applications.[7]

A state considering a Medicaid buy-in approach—that seeks to waive specific Medicaid provisions and use funds available through the Federal Medical Assistance Percentage (FMAP)—could apply for an 1115 Waiver. To the extent a state is *also* seeking to include individuals ineligible for Medicaid, it may also consider an *1115 Waiver in conjunction with a 1332 Waiver.* This approach may allow Medicaid dollars to support program changes, thus freeing up federal funds available through the 1332 Waiver—for example, to include populations in the individual market. As highlighted already, Idaho's proposed approach to target a small population through the 1115(d) Waiver would free up federal subsidy payments for other members. In addition, taking out certain high-needs population people from the individual market may help stabilize premiums.

At present, it is unclear how HHS would treat a joint waiver application (also sometimes called a "super waiver"). The 2015 Guidance on 1332 Waiver applications states that the HHS Secretary's assessment of the 1332 Waiver application will be separate from any other federal waiver application, including 1115 Waivers:

> [The assessment]…does not include the impact of changes contingent on other Federal determinations, including approval of Federal waivers pursuant to statutory provisions other than Section 1332. Therefore, the assessment would not take into account changes to Medicaid or CHIP that require separate Federal approval, such as changes in coverage or Federal Medicaid or CHIP spending that would result from a proposed Section 1115 demonstration, regardless of whether the Section 1115 demonstration proposal is submitted as part of a coordinated waiver application with a State Innovation Waiver. Savings accrued under either proposed or current Section 1115 Medicaid or CHIP demonstrations are not factored into the assessment of whether a proposed State Innovation Waiver meets the deficit neutrality requirement.[8]

However, the current administration may choose another alternative approach or issue alternative guidance, given its stated goal of providing states additional flexibility. Therefore, the question as to whether CMS will measure budget neutrality of a super waiver—by examining changes to federal expenditures across both Medicaid and the individual market, or separately—may not yet be fully settled. States should discuss the issue of budget neutrality with CMS early in the design stages of any super waiver.

Expanding Medicaid coverage for disabled working individuals

A state that is considering a 1332 Waiver may also consider implementing or revising its program for the working disabled to ensure coordination with the 1332 Waiver program. Programs for the working disabled were authorized under Section 4733 of the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999. These laws were passed to allow individuals with disabilities to work without jeopardizing income-based eligibility for Medicaid and other supports."[9] Section 201 of the law establishes a state plan buy-in option through which disabled individuals under age 65 can access Medicaid benefits, despite income that would otherwise make them ineligible. Income and resource standards for a Ticket to Work optional eligibility group are selected by the state, which also has the option of having no limits on income or assets at all. Eligible individuals either must be currently receiving Supplemental Security Income (SSI) or Social Security Disability Income (SSDI) benefits or have lost such benefits due to medical improvement, yet still have medically determinable impairments. Currently, 46 states have a program in place.[10]

A Ticket to Work program can function as a high-risk pool for many of the highest-need members, reducing the necessity for reinsurance or other risk mitigation in the general pool. In addition, because a Ticket to Work program can be implemented through a state plan amendment, it can be funded through the regular Medicaid matching process. To the extent that federal funding for the 1332 Waiver program is limited, implementing a Ticket to Work program could free up 1332 Waiver funding for other purposes, such as coverage expansion.

[7] Musumeci, M.B. et al. (March 2018). Section 1115 Medicaid Demonstration Waivers: The Current Landscape of Approved and Pending Waivers. Kaiser Family Foundation.

[8] HHS, CMS, & U.S. Department of the Treasury (December 2015). Waivers for State Innovation. Guidance. 45 CFR Part 155.

[9] Social Security Legislative Bulletin (December 3, 1999). Congress passes the Ticket to Work and Work Incentives Improvement Act of 1999. Retrieved April 17, 2018, from https://www.ssa.gov/legislation/legis_bulletin_120399.html.

[10] Medicaid.gov. Ticket to Work. Retrieved April 17, 2018, from https://www.medicaid.gov/medicaid/ltss/employmment/ticket-to-work/index.html.

Conclusion

Section 1332 State Innovation Waivers are a potentially appealing vehicle for increasing health insurance coverage through Medicaid buy-in. Through this approach, states are given broad flexibility to design programs that align with their goals and consider plan choice, eligibility, benefits, premiums, cost sharing, and provider reimbursement. Depending on the 1332 Waiver applications, most states are likely to have increased federal funding available starting in 2018, resulting from the premium increases that may follow elimination of individual mandate penalties and discontinuation of direct CSR payments. Increased 1332 Waiver federal pass-through funding can allow states greater scope for innovation and to provide coverage for their uninsured and under-insured residents. To the extent more funding is needed, it may be appropriate to consider a combined 1332 and 1115 "super waiver" approach. Designing a Medicaid buy-in program requires weighing all of these policy and financing considerations.

FOR MORE ON MILLIMAN'S PERSPECTIVE ON MEDICAID:

Visit milliman.com/medicaid-insight

Visit our blog at healthcaretownhall.com

Follow us on Twitter at twitter.com/millimanhealth

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

milliman.com

CONTACT

Paul Houchens
paul.houchens@milliman.com

Christine Mytelka
christine.mytelka@milliman.com

Susan Philip
susan.philip@milliman.com

© 2018 Milliman, Inc. All Rights Reserved. The materials in this document represent the opinion of the authors and are not representative of the views of Milliman, Inc. Milliman does not certify the information, nor does it guarantee the accuracy and completeness of such information. Use of such information is voluntary and should not be relied upon unless an independent review of its accuracy and completeness has been performed. Materials may not be reproduced without the express consent of Milliman.