Medicaid Buy-In

Exploring state options to offer more comprehensive or lower-cost health insurance

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DECEMBER 19, 2018

Presenters

Paul Houchens, FSA, MAAA

- Evaluates health care reform proposals from the prospective of numerous sectors of the healthcare industry, including: State Medicaid agencies, employers, health insurers, and other state agencies.
- Assisted states in analyzing or projecting insurance market changes as a result of the Affordable Care Act. Completed an actuarial certification for a state's Section 1332 State Innovation Waiver.
- Consults for state Medicaid agencies, including capitation rate development, financial projections, risk adjustment, financial reporting, and encounter data quality improvement.

Christine Mytelka, FSA, MAAA

- Provides actuarial support and consulting services to state Medicaid agencies and Medicaid health plans.
- Leads in-depth analytic support for the State of Indiana's Medicaid program, including Medicaid managed care services, Medicaid forecast and budget development, and specific program support.
- Models program and policy changes, working with state budget agency and legislative fiscal analysts. Has expertise with alternative Medicaid expansion issues and 1115 waiver budget neutrality.

Susan Philip, MPP

- Work with states and supporting entities to conduct analysis and design of payment and delivery system reform proposals
- Consult at the state level on strategies to align payment policy with delivery system reform initiatives
- Work with health systems and providers on care and risk management strategies to better leverage people, processes, and systems to conduct population health management.

Outline

- Webinar objectives
- Coverage trends
- Recent state and federal activities
- Options for states' consideration
- Caveats and limitations

Objectives

1. What is the current state of coverage in the U.S.?
2. What are states considering to increase coverage rates, affordability, and/or comprehensiveness of coverage?
3. What options are available for states, especially through the 1332 State Innovation Waiver?
4. How can a Medicaid buy-in approach work and what should states consider to move forward with this option?

Medicaid buy-in

Broadly refers to an approach in which a state allows for the development of an health insurance plan to help cover those who remain uninsured and/or find current health insurance options to be unaffordable

- Typically offered to those not eligible for Medicaid
- Can be offered along side QHPs in the same risk pool, or separate
- Can have Medicaid-like plan design, QHP-like plan designs, or other
- Can leverage Medicaid participating insurers and provider network or QHP participating insurers and network
- *Many variations!*

Outline

- Webinar objectives
- Coverage trends
  - Individual market enrollment and premium trends
  - Medicaid enrollment trends
- Recent state and federal activities
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Comprehensive non-group enrollment

Average Monthly Enrollment (Millions)

	2013	2014	2015	2016	2017	2018
ACA Compliant		8.5	13.9	14.9	13.3	12.5
Non-ACA Compliant	10.9	6.5	3.6	2.3	1.7	1.2
Total Non-Group	10.9	15.0	17.5	17.2	15.0	13.7

Sources

1. 2013 through 2016 Commercial Medical Loss Ratio Data
2. HHS Risk Adjustment Program State-Specific Data
3. Statutory statement enrollment data through 3Q2018
4. Effectuated enrollment reports through 2018
5. Supplemental Health Care Exhibit data from 2016 and 2017

ACA-compliant coverage

Average Monthly Enrollment

	2014	2015	2016	2017	2018
On-Marketplace	5.5	9.1	10.0	9.8	9.9
Off-Marketplace	3.0	4.8	4.9	3.5	2.6
Total	8.5	13.9	14.9	13.3	12.5

Sources

1. HHS Risk Adjustment Program State-Specific Data
2. HHS Effectuated Marketplace Enrollment Reports
3. Statutory statement enrollment data through 3Q2018
4. Effectuated enrollment reports through 2018
5. 2018 values are estimated

Premium assistance provided through the marketplace

- In 2018, the 8.6 million marketplace enrollees receiving premium assistance are estimated to receive an average of $6,200 in annual premium assistance
- National estimated premium assistance expenditures of $53 billion

Average Monthly Marketplace Enrollees

12
10
8
6
4
2
0

$9,000
$7,500
$6,000
$4,500
$3,000
$1,500
$0

Per Capita Premium Subsidy Value

	2016	2017	2018
Total Marketplace	10.0	9.8	9.9
Not Receiving Premium Subsidy	1.6	1.5	1.3
Receiving Premium Subsidy	8.4	8.2	8.6
Per Capita Premium Subsidy Value	$3,500	$4,500	$6,200

Receiving Premium Subsidy
Not Receiving Premium Subsidy
Total Marketplace
Per Capita Premium Subsidy Value

Notes

1. **Values rounded.**
2. **Source: http://www.milliman.com/insight/2018/2018-summary-of-individual-market-enrollment-and-Affordable-Care-Act-subsidies/**

Marketplace Premium Trends 2014 through 2019
2nd Lowest Cost Silver Plan, 40 Year Old (Non-Subsidized)

- Chart illustrates range of monthly premiums from 2014 to 2019 (marker denotes 2019 premiums)
  - Reflects major city in each state
  - 2019 premium rates in 23 states slightly lower than 2018

$900
$800
$700
$600
$500
$400
$300
$200
$100
$0

$686
$201

2019

MN HI TN NM AZ OK OR KY UT IL KS MI MD ID NV DC TX OH CO GA VA CA IA AL MT MO SD WV FL SC NE ND MA WA DE NH RI MN PA AR NC LA WI NJ CT IN NY WY MS VT AK

New Jersey instituted state-based reinsurance program for 2019, decreasing premium rates from $411 in 2018 to $348 in 2019.

Source: https://www.kff.org/health-costs/issue-brief/tracking-2019-premium-changes-on-aca-exchanges/

Commercial health insurance underwriting margins

Individual | Small Group | Large Group

10%
5%
0%
-5%
-10%

	2011	2012	2013	2014	2015	2016	2017	2018
Individual	-1.1%	-2.0%	-3.9%	-5.9%	-9.6%	-6.1%	2.5%	9.0%

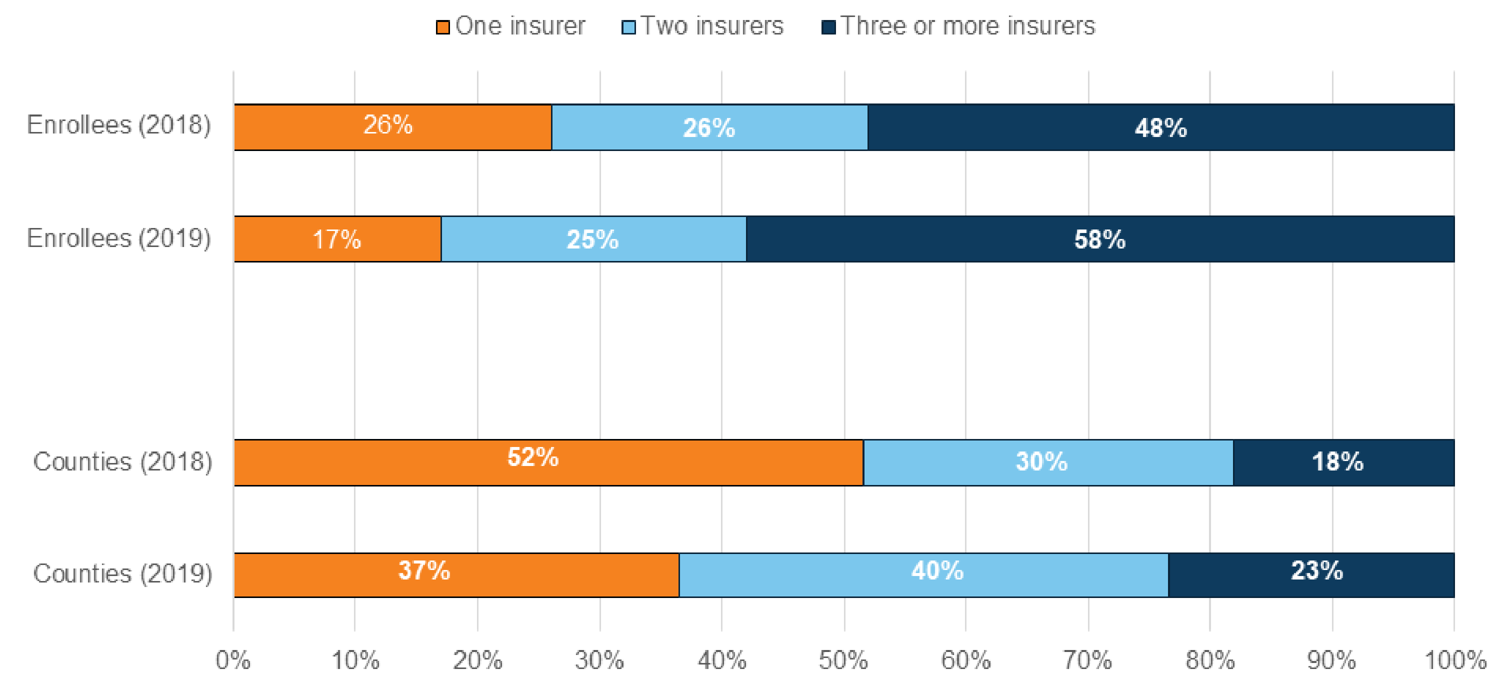
Notes:

1. CY2011 through CY2016 results based on Commercial MLR Data released by CMS, adjusted for actual risk corridor and risk adjustment payments received.
2. CY2017 results based on NAIC Supplemental Health Care Exhibit Life and Health Industry Exhibit, Part 1. Values do not exclude insurers not filing with NAIC.
3. CY 2018 results estimated based on changes in reported medical loss ratio between NAIC 2018Q3 and 2017Q3 Health Industry Exhibit of Premiums, Enrollment and Utilization.

Insurance marketplace competition

- With insurers profitable in the individual market, insurer participation in the marketplaces has increased from 2018 to 2019

Figure 1



Source: Kaiser Family Foundation analysis of data from the 2019 QHP Landscape file released by healthcare.gov on October 24, 2018. Note: For states that do not use healthcare.gov in 2019, insurer participation is estimated based on information gathered from state rate filings. Enrollment is based on 2018 plan selections. 2019 columns may not sum to 100 due to rounding.

Case study: Are out-of-pocket premiums responsible for low marketplace enrollment?

Metal Level

Silver

Example Age and Income

40-year-old with income of $25,000 (207% of poverty)

% Change in Lowest-Cost Monthly Premium, 2017-2018

-100% 6%

Oklahoma , OK

Monthly Premium After Tax Credit for the Lowest-Cost Silver Plan for a 40-year-old with income of $25,000 (207% of poverty)

2017: **$134** 2018: **$0**

$ Change: ($134)
% Change: -100%

Shelby , TN

Monthly Premium After Tax Credit for the Lowest-Cost Silver Plan for a 40-year-old with income of $25,000 (207% of poverty)

2017: **$123** 2018: **$0**

$ Change: ($123)
% Change: -100%

Source: https://www.kff.org/health-reform/issue-brief/how-premiums-are-changing-in-2018/

Further background on Oklahoma premium changes: https://www.ok.gov/health2/documents/CY2018%20Marketplace%20Premium%20Analysis_final.pdf.

	Oklahoma	Tennessee
% of Consumers with $0 Silver Plan Available for a Single 21 Year Old, 200% FPL / 64 Year Old, 400% FPL	38%	66%
2017 FFM Selections	146,300	234,100
2018 FFM Selections	140,200	228,600
Percentage Change in Selections	(4.2%)	(2.3%)

Notes
1. Consumers defined based on 2017 FFM selections in each county reported by CMS.
2. FFM selections rounded to the nearest hundred.

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Medicaid Enrollment Growth under the ACA

	Sep-18	Sep-13
Non-Expansion States	21.7	19.8
Expansion States	51.3	37.7
Total	73.0	57.5

0 10 20 30 40 50 60 70 80

National Monthly Medicaid and CHIP Enrollees (Millions)

Notes

1. Enrollment data source: https://data.medicaid.gov/. September 2013 enrollment data for Connecticut and Maine obtained from third-party sources.
2. September 2018 enrollment does not reflect retro-active eligibility.

Medicaid Enrollment Growth in Expansion States

2013 to 2018 Medicaid and CHIP Enrollment Trends - Expansion States

2013 to 2018 Medicaid Enrollment Change

120%
100%
80%
60%
40%
20%
0%
-20%

36.1% Average growth

VT DC DE IL NY HI MI MN MA PA OH IN CT ND NJ IA AZ LA NH MD WV OR CA WA AR NM RI CO AK MT NV KY

Notes

1. Enrollment growth measured based on September 2013 to September 2018 Medicaid and CHIP enrollment change.
2. Enrollment data source: https://data.medicaid.gov/. September 2013 enrollment data for Connecticut obtained from third-party source.
3. September 2018 enrollment does not reflect retro-active eligibility.

Key observations given coverage and enrollment trends

- Individual market
  - Affordability major concern for non-subsidized individual market enrollees
  - Enrollment gains relative to 2013 limited
  - Volatile market in terms of insurer participation and profitability
  - Premium subsidy value has increased significantly with premium trends (higher available pass-through funding)
  - Consumers not taking advantage of $0 net premium coverage opportunities
- Medicaid
  - Responsible for majority of insurance coverage gains since 2013
  - Medicaid expansion states have experienced significant enrollment increases
  - Medicaid managed care market more stable (actuarial soundness requirements, state procurement of managed care entities)
  - Potential for common MCOs to serve existing and ‘buy-in’ populations

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1332 Waiver: recent federal guidance

Guardrails still exist but loosening of restrictions to provide states more flexibility

Guardrails of 1332 Innovation Waivers

Comprehensiveness of benefits: Must be at least as "comprehensive" as without the waiver, meeting EHB requirements

Affordability: Must be at least as affordable, taking into account premiums and cost-sharing, as in the absence of the waiver

Number of State Residents with Coverage: Must provide coverage to a comparable number of state residents as under the ACA

Federal Deficit: Cannot increase the federal deficit

- New guidance focuses on “aggregate” effects of waiver rather than requiring guardrails be met for specific sub-populations.
- Benefit coverage: Dependent on EHB-benchmark plan. States can select from 50+ benchmark plans used in 2017 plan year.
- Affordability: “For example, a waiver that makes coverage slightly more affordable for some people but much less affordable for a comparable number of people would be less likely to be granted than a waiver that makes coverage substantially more affordable for some people without making others substantially worse off.”
- Number of state residents: New guidance focuses on *availability* of coverage rather than coverage being provided.

1332 Waiver: recent federal guidance

Waiver concepts and guidance leave room for interpretation

DEPARTMENT OF THE TREASURY

31 CFR Part 33

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 155

[CMS–9936–NC]

State Relief and Empowerment Waivers

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services; Department of the Treasury.

ACTION: Guidance.

Section 1332 State Relief and Empowerment Waiver Concepts

Discussion Paper

November 29, 2018

- Emphasis on using private market coverage
- Encouraging state innovation
- "Support and empower those in need"
- Promote consumer-driven health care

https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Waiver-Concepts-Guidance.PDF
https://www.govinfo.gov/content/pkg/FR-2018-10-24/pdf/2018-23182.pdf

1332 Waiver activity

	Approved: Oregon, Alaska, Hawaii, Minnesota, Wisconsin, Maine, New Jersey, Maryland
	Request deemed incomplete: Ohio, Vermont, Massachusetts
	Withdrawn: California, Oklahoma, Iowa

- States seeking to address market stability and affordability through reinsurance programs.
- Approved waivers focus on using pass-through funding for reinsurance programs

https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/

Medicaid buy-in state activity

https://unitedstatesofcare.org/wp-content/uploads/2018/12/MBI-Memo.pdf

Nevada (AB 374) 2017

Overview	Requires the Department of Health and Human Services, if authorized by federal law, to establish a health care plan for purchase by persons who are not otherwise eligible for Medicaid
Plan design	Nevada Care Plan was to be a Medicaid-like plan, except nonemergency transportation is excluded
Carriers	State to enter into contract with one or more insurer. Coverage through Silver State Health Insurance Exchange
Eligibility	Anyone not otherwise eligible for Medicaid
Subsidies	Allows individuals eligible for APTC and CSR to use it to purchase coverage through Nevada Care Plan
Waiver	State to seek necessary waiver authority; Would have likely sought 1332
Outcome	Vetoed, June 2017

https://www.leg.state.nv.us/App/NELIS/REL/79th2017/Bill/5393/Text

Minnesota (HF 92 and SF 58) 2017-2018

Overview	Human services commissioner required to seek federal waivers to permit individuals whose income is greater than the income eligibility limit to purchase coverage through a separate MinnesotaCare purchase option.
Plan design	Similar to Basic Health Plan option under Minnesota Care
Carriers	Managed care plans participating in MinnesotaCare. Health plans offering managed care services for Medicaid and the BHP would have been required to provide at least one buy-in option
Eligibility	All Minnesota residents, regardless of income
Subsidies	N/A
Waiver	Sought 1332 Waiver but did not receive approval to use pass-through funding for MinnesotaCare buy-in
Outcome	Not enacted in 2017. In April 2018 similar measure has been reintroduced (HF 4451), limited to those eligible for marketplace plans, with or without subsidies.

https://www.revisor.mn.gov/bills/bill.php?f=HF92&y=2017&ssn=0&b=house
https://mn.gov/gov-stat/pdf/2017_02_02_MinnesotaCare_Buy-In_Fact_Sheet_FINAL.pdf

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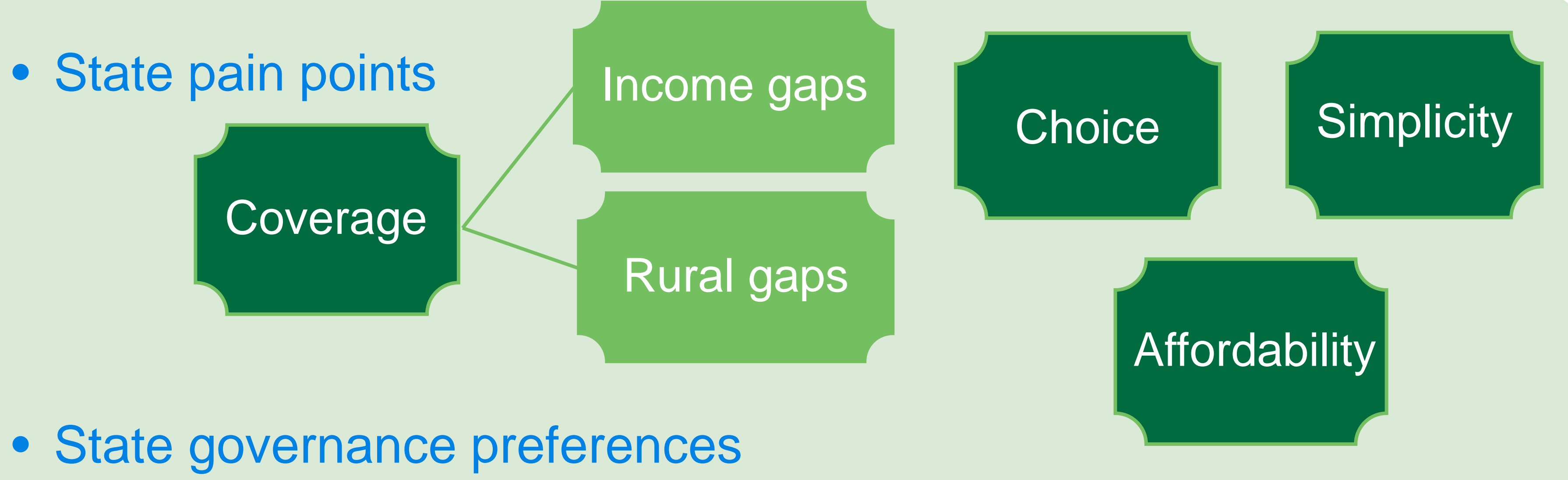
Selected options depend on context and policy objectives

Context and Objectives



Design Options

- Relationship of Medicaid option to the marketplace
- Chassis: Medicaid managed care and/or marketplace
- Targeted population
- Plan design, premiums, and cost sharing
- Provider network and payment models

Relationship to Medicaid buy-in to the marketplace

Alongside QHPs, same risk pool

Medicaid buy-in

QHP 1

QHP 2

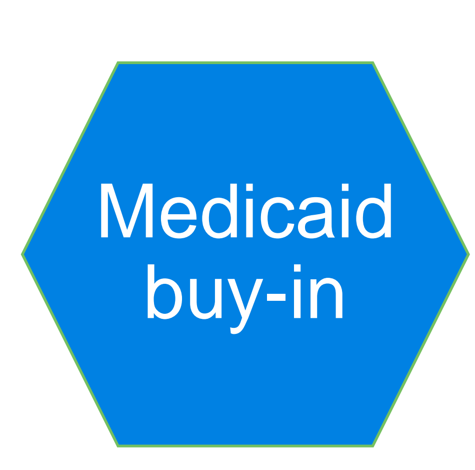
QHP 3

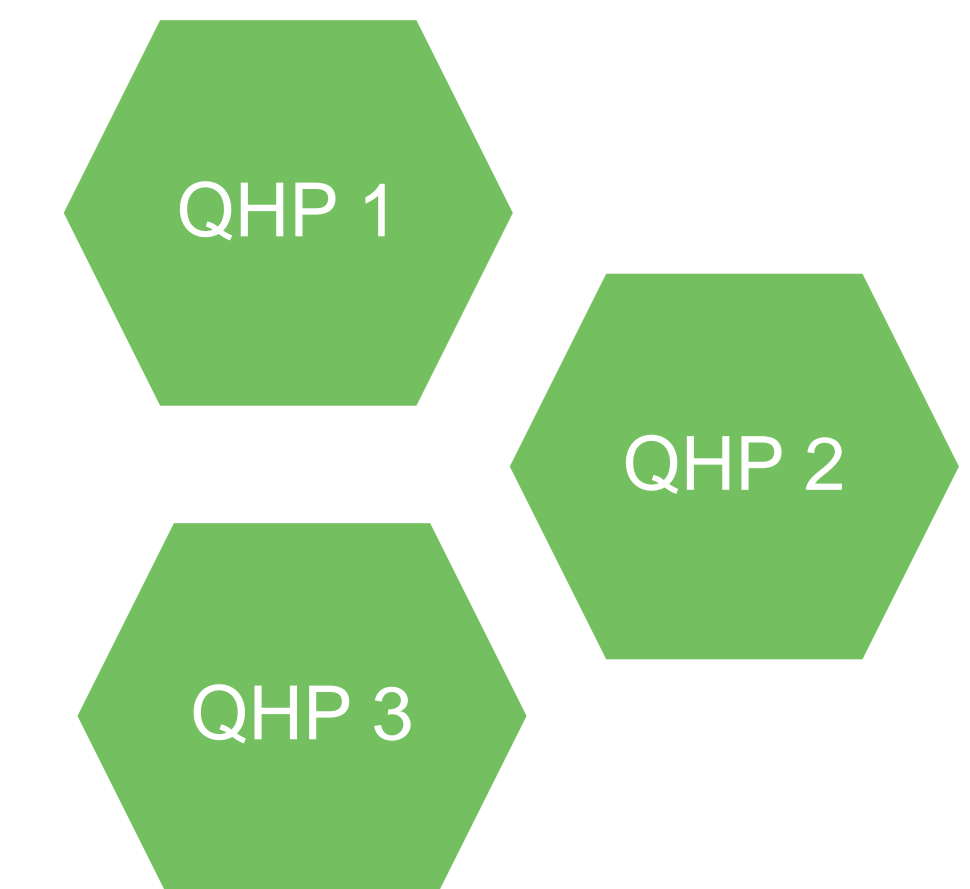
Same Risk Pool Scenario

- State allows insurers to develop and sell a Medicaid-like product with intermediate level of benefits, cost sharing and reimbursement
- State offers the product on the Marketplace along side other QHPs in the marketplace
- Benefits: Choice, affordability, coverage
- Risks: provider cost shifting, crowd out, level playing field, reduced APTCs

Relationship to Medicaid buy-in to the marketplace

Separate risk pool





Separate Risk Pool Scenario

- State segments the individual marketplace
- Potential segmentation: health status, by county, by income, other
- Benefits: Affordability, coverage
- Coordination with 1332 funding

Design option: Targeted Population

States can target the buy-in option to the disabled or medically-needy

Disabled or medically needy population

- Condition criteria
- Income limits
- Otherwise eligible for APTC in marketplace

Transition eligible individuals to Medicaid

- Commercial to Medicaid reimbursement

Premium rate reduction

- Significant reduction in individual market risk pool claims
- APTC savings generate potential federal pass-through

Relationship to Medicaid buy-in to the marketplace

Separate risk pool

Medicaid buy-in 1

Medicaid buy-in 2

Medicaid buy-in 3

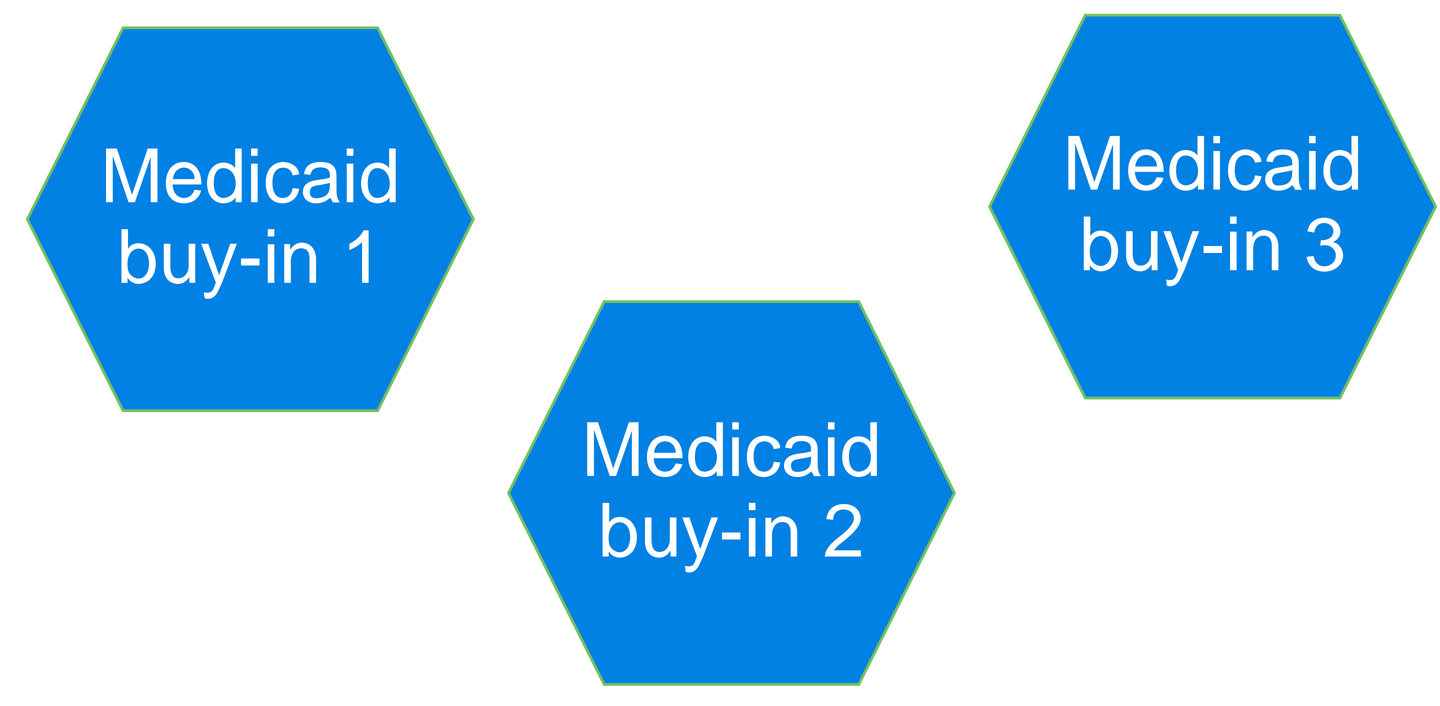
QHP 1

QHP 2

QHP 3

Relationship to Medicaid buy-in to the marketplace

Replace QHP coverage



Design option: Targeted Population

States can choose to offer buy-in to broader populations

- Potential eligibility conditions (mix and match)
  - By health status
  - By geography/county
  - By income
    - Gap only
    - Higher income, such as 200% FPL, 250% FPL, or even 400% FPL
- Limit to individuals without affordable employer coverage
- Coordination with CHIP

Removing higher cost populations improves ACA marketplace affordability

Broader eligibility that leads to crowd out may face opposition from insurers

Design options: benefits, premiums, and cost sharing

- Benefits
  - 1332 : At least as comprehensive as ACA marketplace
  - Add anything? Expanded SUD, dental, non-emergency transportation, community LTSS, other
- Monthly premium and cost sharing
  - 1332: At least as affordable as ACA marketplace
  - 1332 waiver concept A: State-specific premium assistance
  - Premium structure can be simplified, or vary by age, income, etc.
  - Cost sharing can be made more appropriate to target population
- Open enrollment period or flexible
- Payment models and provider reimbursement

Plan design generosity may be limited by available funding

Consider impact on various groups: young, old, healthy, smokers, those with or without subsidies, providers, insurers

1332 Waiver feasibility analysis: How much can we afford?

1. Assessment of current ACA marketplace – gaps, goals
2. Uninsured population – income levels, and barriers to purchasing insurance
3. Pass-through funding available
   - Exchange enrollment
   - Second lowest cost silver plan premiums
   - APTC
   - Other changes in federal revenue /expenses
4. Provider reimbursement
5. Networks: commercial vs Medicaid
6. Enrollment rates

Individual market enrollment and subsidy information

Profiles of the individual health insurance market for the 50 states and the District of Columbia

PREMIUM SUBSIDIES WILL BENEFIT QUALIFYING INDIVIDUALS IN THE STATE OF INDIANA BY $394 MILLION IN 2018.

FIGURE 2: INDIANA HEALTH INSURANCE MARKETPLACE ENROLLMENT

	2016	2017	2018
Individual Marketplace Enrollment	153,000	139,000	137,000
Individuals Receiving a Premium Subsidy	124,000	102,000	96,000
Individuals Receiving CSR Plan	69,000	65,000	59,000

Note: Values reflect estimated average monthly effectuated enrollment. Please see the methodology paper for more information on the estimate methodology.

FIGURE 3: SUMMARY OF AFFORDABLE CARE ACT SUBSIDIES

ANNUAL AVERAGE VALUES	2016	2017	2018
Individual Marketplace Premium	$5,000	$5,200	$6,000
Combined Premium/CSR Subsidy	$3,700	$3,900	$4,100

Note: Individual marketplace premium reflects gross premium for premium subsidy-eligible individuals prior to federal financial assistance. Premium and CSR subsidy values reflect twelve month effectuated enrollment period per APTC enrollee.

http://www.milliman.com/insight/2018/2018-summary-of-individual-market-enrollment-and-Affordable-Care-Act-subsidies/

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