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Evolving Public Option/Medicaid Buy-In Models and Considerations

Maine Committee on Health Coverage, Insurance and Financial Services

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Manatt Health

December 16, 2019

Agenda

- Policy Context and State Goals
- Evolving State Option Models
- 1332 Waiver Considerations
- Creating a State-based Health Care Reform Package
- Overview of Health Care Cost Growth Target Models

Characteristics of the Remaining Uninsured

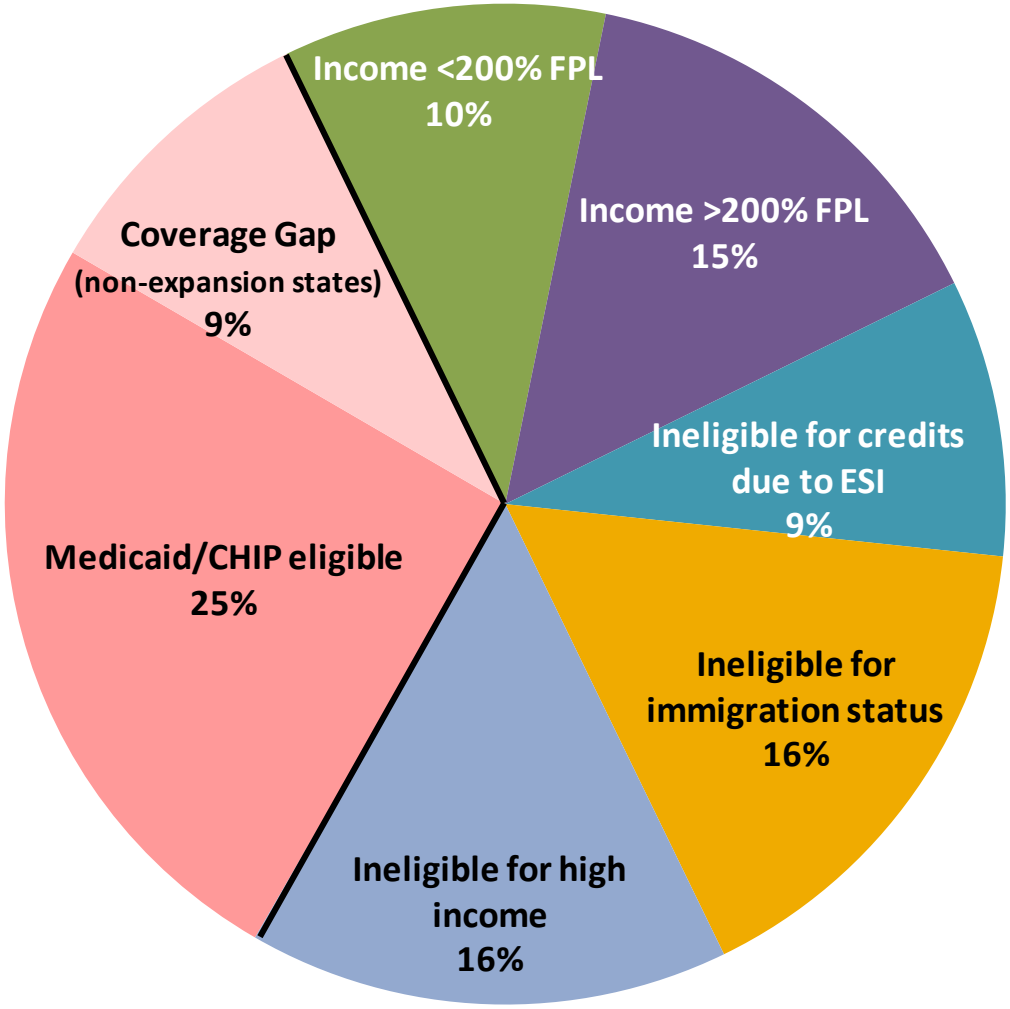
In 2017, 30 million non-elderly Americans remained uninsured

To continue expanding coverage, federal and state policymakers should consider the characteristics of the remaining uninsured when designing interventions

Program Eligibility for the Remaining Uninsured, Nationally

Medicaid Eligible

34% (10.3 M) of the currently uninsured are eligible for Medicaid/CHIP, in states that have and have not expanded Medicaid



Marketplace Eligible

25% are eligible for tax credits, but do not participate on the Marketplace

An additional 41% are ineligible for tax credits

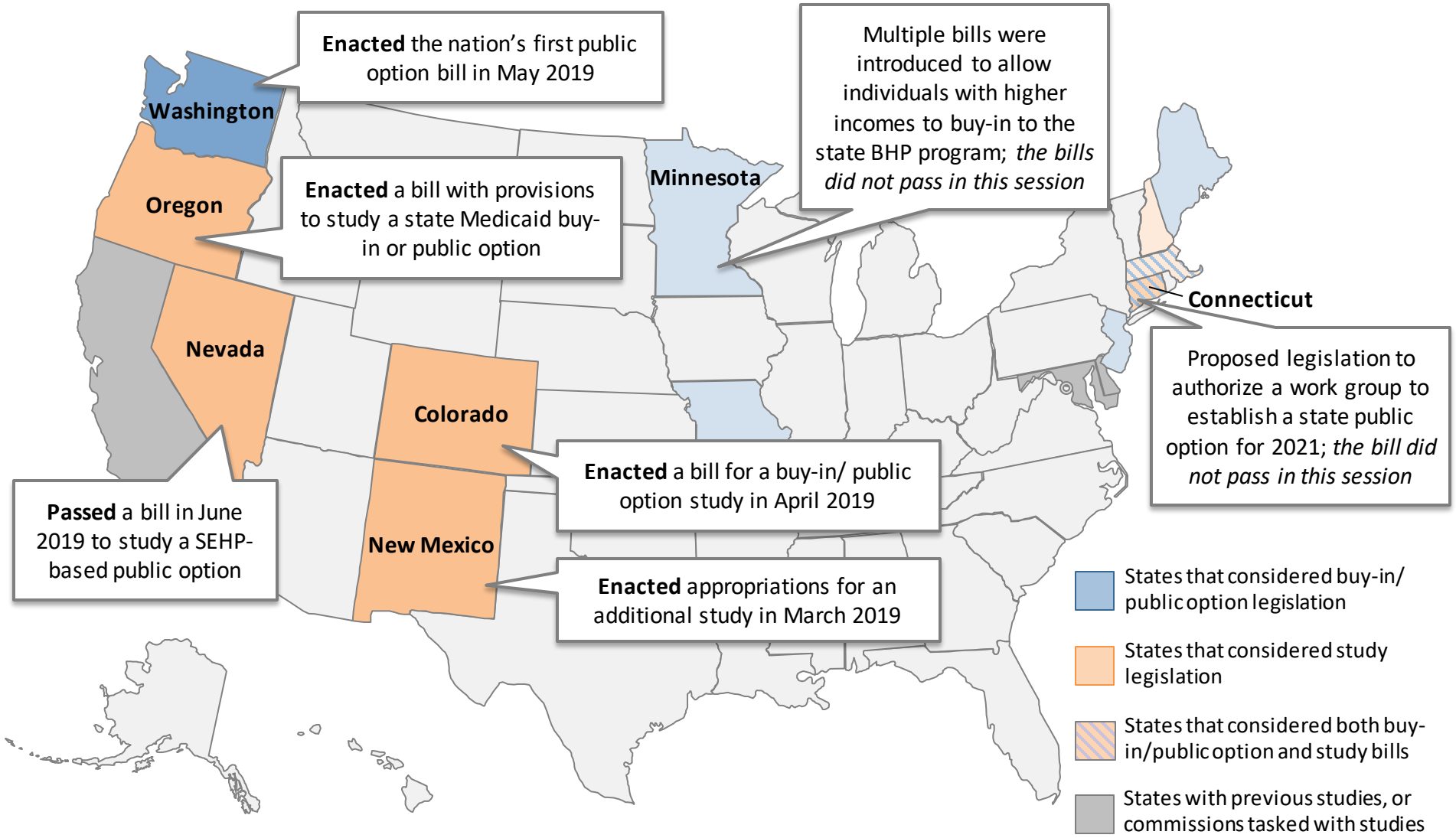
Adapted from the Urban Institute, Characteristics of the Remaining Uninsured: An Update, July 2018

State Affordability Goals

Each state has specific market dynamics and health policy goals to consider when choosing affordability and cost-containment policies

- Reduced premiums to make purchasing coverage more affordable
- Reduced cost-sharing (deductibles, co-insurance, etc.) to make coverage more attractive and care more affordable
- Access for the uninsured and unsubsidized
- Strengthening the Marketplace by attracting customers and maintaining a balanced risk pool
- Increasing state purchasing power across programs
- Promoting healthcare initiatives that improve health outcomes and result in long-term savings
- Curtailing overall healthcare costs

The State of Play for Buy-in/Public Option Proposals



Definition of "Medicaid Buy-in"

The concept of Medicaid buy-in is evolving, encompassing the original Medicaid-based proposals and extending to other programs through which **states can leverage government bargaining power to offer a more affordable coverage option**, like state employee health plans or a Basic Health Program

States are also increasingly interested in state-sponsored plans, or "public options," offered on the Marketplace in partnership with an existing insurer(s)

"State Options": Evolving Models

Off-Market Buy-in	On Marketplace Public Option	Basic Health Program Buy-In
The State makes Medicaid-*like* coverage available to consumers who are not eligible for Medicaid; coverage offered as an off-market, state-administered buy-in plan	The State offers a state-sponsored qualified health plan (QHP) on the Marketplace and may also offer a plan in the individual market to those who do not qualify for the Marketplace (e.g., for immigration status); potentially in partnership with an existing managed care plan	The State offers a Basic Health Program (BHP) to individuals with incomes below 200% of the federal poverty line (FPL) who are not Medicaid-eligible, and could redesign and expand plans to individuals with higher income eligibility, allowing them a choice to buy-in to the program

Potential Sources of State Option Savings

Model selection and design should play to the state's strengths and potential for buy-in savings, balanced against potential stakeholder impact

Savings sources may include:

- Provider payment rates
- Administrative efficiencies
- State purchasing power
- Long-term savings through investments in population health and delivery systems

Financing can be:

- Self-sustaining (financed only through enrollee premium contributions)
- Subsidized with state dollars
- Funded through federal savings obtained under a 1332 waiver
- Some combination of these three funding sources

Case Study: Washington State's First-in-the-Nation Public Option

The goal of Washington's public option is to increase affordability and choice for unsubsidized customers priced out of the market

- Under the law, Washington Health Care Authority will **contract with one or more insurers to provide state-sponsored plans**, known as "Cascade Care," on the state Marketplace for plan year 2021; the law also institutes standardized plans for all insurers on the Marketplace
- Cascade Care plans will be subject to an **aggregate reimbursement cap of 160% of Medicare rates**, with reimbursement floors for:
  - Primary care physician at <135% of Medicare
  - Rural hospitals at <101% of Medicare allowable costs
  - *Exceptions:* If the cap will raise premiums; if plans can achieve 10% premium reductions through other means; and/or plans are unable to form adequate networks given the reimbursement restrictions
- The study also commissioned studies on the potential impact of future **provider tying and state subsidies** for those <500% FPL

State Dynamics

- This year, 14 of 39 counties have only one insurer offering plans on the Marketplace
- 2019 average benchmark premiums are $381/month; below the national average
- Only 65% of Marketplace participants receive subsidies; one of the lowest rates in the nation

- The three state agencies— Washington Health Benefit Exchange (HBE), Health Care Authority (HCA), and Office of the Insurance Commissioner (OIC)—are working closely on all aspects of implementation
- The plans are projected to **reduce premiums by 5-10%**

Case Study: New Mexico: Studying Multiple Options

In 2018, New Mexico led the nation in the study of buy-in models, and performed a quantitative analysis of a Targeted Buy-in model

- Under previous legislation, New Mexico commissioned a study "to ensure health care coverage is expanded to low-income, uninsured residents." The study outlined four basic buy-in options:
  1. **Targeted Medicaid Buy-In**
  2. Qualified Health Plan (QHP) Public Option
  3. Basic Health Program (BHP)
  4. Medicaid Buy-In for All

State Dynamics

- New Mexico has a small Marketplace population, and benchmark premiums lower than the national average ($365 vs. $477) in 2019
- 82% of Marketplace enrollees receive subsidies and 34% of New Mexicans were on Medicaid in 2017, the highest proportion in the country

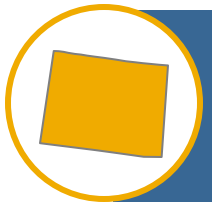
What's Next?

- New Mexico is engaged in re-strategizing after Targeted Buy-in legislation did not pass; the Governor, advocates, and key legislators remain supportive of buy-in as a 2020 legislative priority
- Funding for additional study was appropriated in 2019

Targeted Buy-In Study Results

- Specially targeted people ineligible for federal subsidies (e.g., immigration status or family glitch)
- Premiums reduction of 15-28% relative to the average and lowest-cost premiums in the Marketplace (est. $377-$403/monthly)
- Projected total enrollment from 7,000-16,000
- State costs ranging from $12 million to $48 million for state subsidies for low-income enrollees

Case Study: Colorado's State Option Study



In May, Colorado enacted HB 19-1004 to study a "state option for health care coverage" before November 2019

- **Coverage.** All state residents will be eligible; the plan will be available in all counties on- and off- the Marketplace
- **Benefits.** As a QHP, the State Option will cover all Essential Health Benefits and mandate "many" preventive care, primary care, and behavioral health care services be provided pre-deductible
- **Administration.** Offered through existing insurers; and carriers of a certain (unspecified) size will be required to offer the option
- **Savings.** Carriers will be requiring to achieve a 85% medical loss ratio (up from the current 80% obligation), use all prescription drug rebates and other compensation paid by drug manufacturers to reduce premiums, and cap facility reimbursements at 175%-225% of Medicare
- **Financing.** The State Option will be self-funded, but the report recommends applying for a 1332 waiver for federal pass-through funding
- **Premiums.** State analysis estimated a 9% to 18% premium decrease, compared to expected 2022 rates

State Dynamics

- In 2018, 16 of 64 (25%) of counties only had one insurer offering plans on the Marketplace
- 2019 average benchmark premiums are $488/month; above the national average ($477/month); in rural parts of the state premiums are over 40% higher
- 74% of Marketplace enrollees receive subsidies
- A recently-passed reinsurance program is expected to decrease premiums by 18% across the state

Public comment will be accepted until October 25; and the final due to the legislature on November 15

Emerging Lessons and Themes Across States

- Specific state dynamics will influence the option design choice
- Provider responses will depend on reimbursement rates and the option's enrollee population
- Stakeholders must balance priorities—target population (by income, uninsured, immigration status, etc.), premium vs. cost-sharing affordability, eligibility, etc.—and some concessions may be required
- Designs often impact subsidized and unsubsidized populations differently
- Concerns about the state risk and effects on the remaining population; particularly without federal waiver funding
- Combining reforms can help meet multiple goals, but a legislative package may make it harder to achieve consensus from multiple stakeholders

Meeting the 1332 Requirements

The 2015 guidance established strict standards for applying the guardrails; In 2018, the Departments of Health and Human Service and Treasury relaxed some of these standards, Administration has discretion not to approve waiver that meet all of the guardrails

Guardrails

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 Marketplace

3 *Affordability*

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

Other Requirements

CMS and the Treasury Department will require contingency language indicating that state will not implement policy in absence of a waiver

The state must indicate a waivable policy provision of the ACA to receive pass-through funding

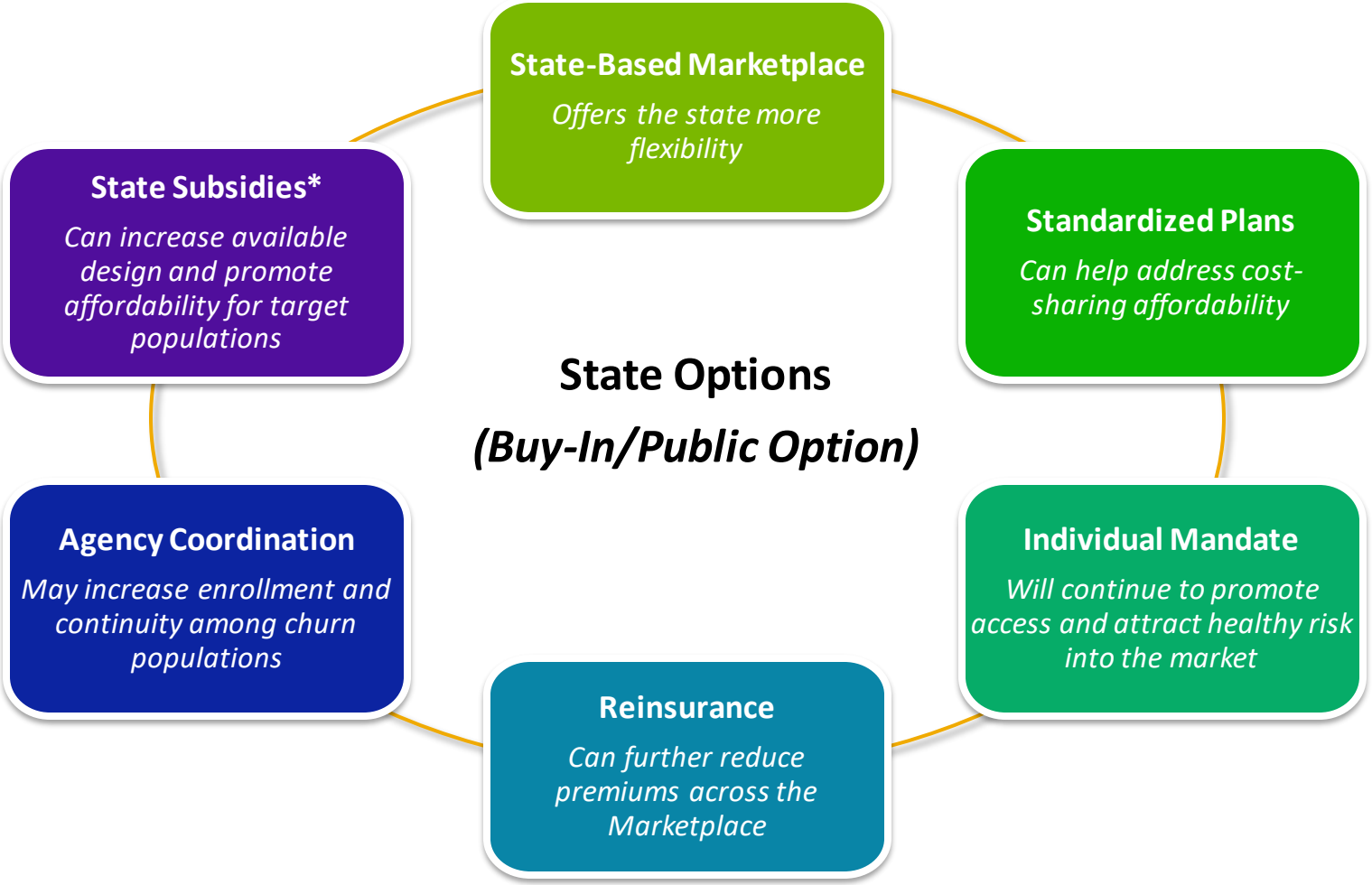
The State Option Cannot Solve Everything

- It is important to understand that a state option is **not a panacea**
- It is **not a one-size-fits-all model** for providing universal coverage and increasing affordability
- It may **not be the simplest way to address high out-of-pocket costs** or high premiums in the existing insurance market
- It **may not change behavior** among people who are currently eligible for other programs but do not seek coverage

- 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)

Combining Policies for A Health Reform Package

States can consider combining policies to meet a diverse set of health policy goals and states may design a legislative package that mitigates risks to other populations



*Savings from other policies could be used to fund subsidies

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Overview of Healthcare Growth Target Models

Massachusetts Cost Growth Target

In 2012, Massachusetts implemented the first statewide healthcare cost growth cap ("benchmarking") program to better monitor and respond to cost drivers across the state's healthcare ecosystem in order to decrease cost growth and improve transparency

- Established as part of sweeping health system reform in Chapter 224 of the Acts of 2012
  - Developed through stakeholder engagement process with buy-in from the state's largest payers and providers
- Final bill was signed by Governor Deval Patrick, and passed on a bipartisan basis with support of the attorney general and state auditor
- Program established new data collection infrastructure and reporting requirements for public and private payers
- Highlights when spending for attributed members exceeds state benchmark
- Since program was established, commercial spending growth has fallen below national rates

State Dynamics

- Landmark legislation to expand healthcare coverage
- Lowest uninsured rate in America, at 2.8%

State Goals

- Cost containment
- Increasing transparency

Massachusetts Governing Agencies

The program created two new state entities and gave additional administrative powers to the Attorney General to contain rising healthcare costs in the state

Health Policy Commission (HPC): Funded through the state's General Fund and Healthcare Payment Reform Fund and responsible for the following:

- Establishing and monitoring statewide and entity-specific spending against a cost growth benchmark
- Conducting market impact reviews
- Registering and certifying all provider organizations that operate in the state

Center for Health Information and Analysis (CHIA): An independent agency that serves as the state's primary hub for healthcare data and is responsible for conducting data analysis for the HP

State Attorney General (AG): Given new authorities to:

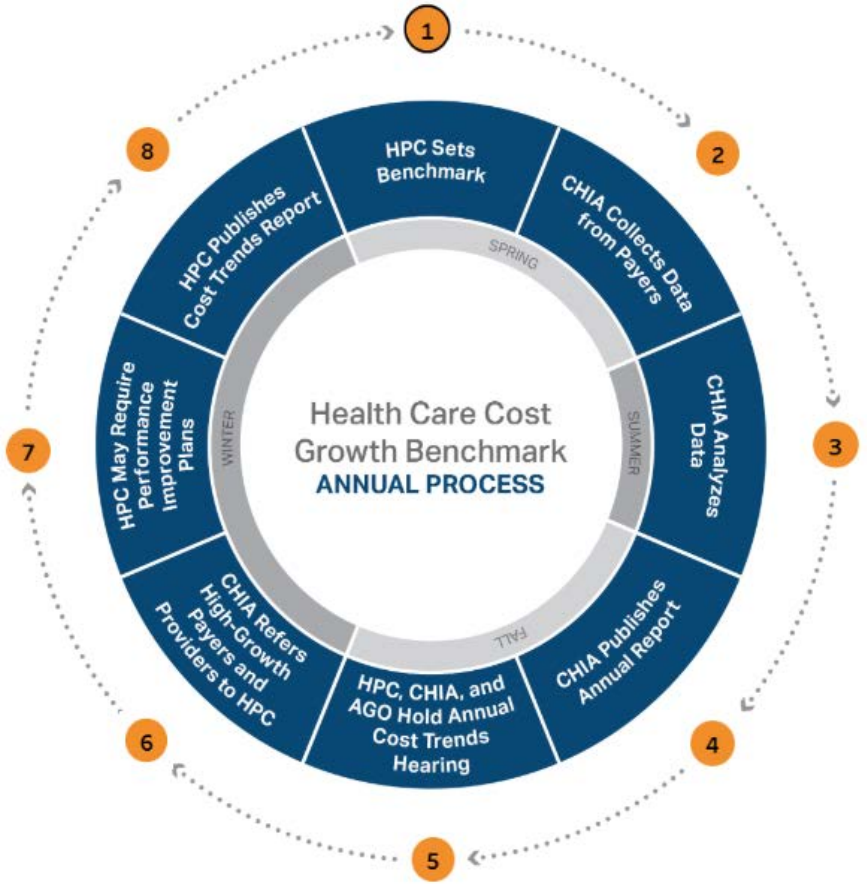
- Request information and question provider organizations on healthcare costs and cost trends
- Investigate provider organizations' responses, as referred by HPC
- Enforce the cost growth benchmarks set by HPC

Annual Cost Growth Process

The state uses a healthcare cost growth benchmark to determine how individual entities and the state overall are meeting healthcare cost targets

- The cost growth benchmark is set annually by the HPC, based on:
  - Potential gross state product
  - Annual Cost Trends Report from CHIA
  - Public hearings
  - Experienced healthcare spending trends, locally and nationally
- Provider/Payer cost growth monitored annually based on health status adjusted per member per month
- Healthcare entities with spending in excess of the benchmark are referred to:
  - Submit a performance improvement plan (PIP)
  - Potentially pay fines, up to $500K, for non-compliance with the PIP

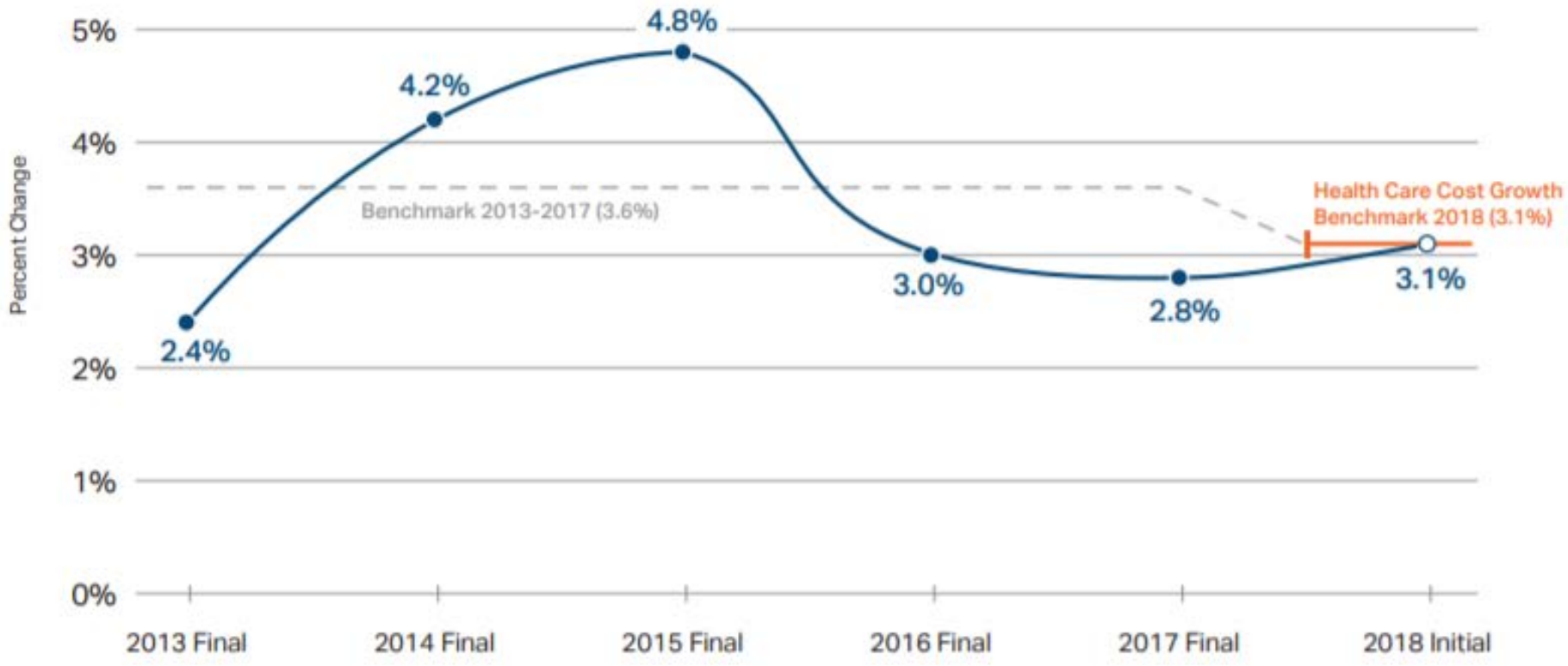
Annual Health Care Cost Growth Benchmark Setting Process



Massachusetts Growth Benchmark: Results to Date

Healthcare spending growth has varied—falling above and below the benchmark in three of the past five years—however, cost growth in the state has slowed compared with the national average

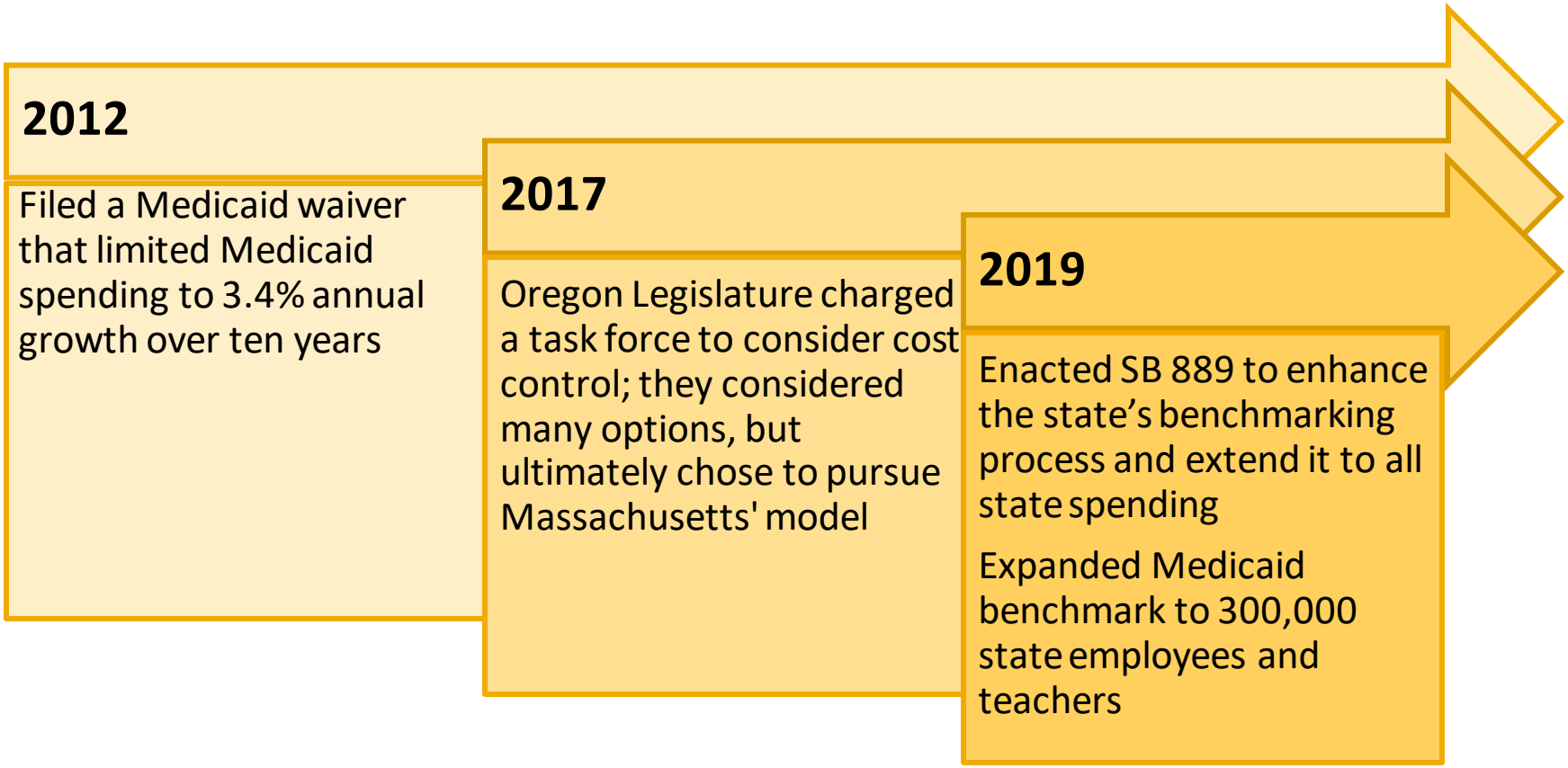
Per Capita Total Healthcare Expenditure Trends, 2013-2018



Massachusetts Health Policy Commission. 2019 Health Care Cost Trends Hearing. October 2019.

Oregon Benchmarking Program

Oregon has been a national leader in managing healthcare spending, including a landmark 2012 Medicaid waiver limiting Medicaid spending to a 3.4% annual cost growth benchmark over ten years



Analysis of Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group. National Health Expenditure Data: Health Expenditures by State of Provider, June 2017.

Model Parameters: Oregon vs. Massachusetts

Program Design	Massachusetts	Oregon
Governance	• Overseen by two new agencies—HPC and CHIA • Additional authority given to the AG	• No new agencies; overseen by Oregon Health Authority (OHA) • Created an implementation committee with broad authority
Setting the benchmark	Based on economic indicators and periodically reviewed	
Data reporting	• Requires payer and provider data submission	• Culture of benchmarking and reporting • Entity reporting mirrors MA

Annual reports	• Requires public report that identifies cost drivers and makes recommendations to address them
	  • CHIA: Data and benchmark results
	  • HPC: Policy recommendations
		• Requires public report that identifies cost drivers and makes recommendations to address them

Public hearings	Program holds public hearings on total expenditures and growth	
Enforcement	• Payers and providers who exceed the benchmark must submit PIPs, though no such plans have been publicly ordered yet	• The use of PIPs is still under legislative consideration
Delivery system reform	• Monitor quality, alternative payment model adoption and relative prices for health systems	• Statute emphasizes quality of care and innovative payment models

Resources Needed for a Successful Program

States should establish benchmarking programs commensurate with available resources, since programs can take on various forms and a range of scales to fit needs of the state and budget constraints

Staffing and expertise will be needed to support data collection, report writing, and stakeholder engagement

Setting and monitoring progress against the benchmark requires significant **data collection and analytical capacity** (e.g., all-payer claims database, auxiliary data reporting) that can be performed with existing or new resources depending on state infrastructure

Strong relationships with plans is required for a successful program

The ability to lead a **robust stakeholder engagement** throughout the process is required

Is your state interested in pursuing a cost growth cap/ benchmarking program?

Do you have the available resources? If not, what would you need to implement a successful program?

Key Questions for Maine

- What problem(s) is Maine trying to solve? Is the buy-in an effective strategy to address that problem(s)?
- Who remains uninsured in Maine and how will that influence policy design?
- What are the potential sources of cost-savings in the state?
- What existing infrastructure is the most natural fit for a state option?
- What are the potential impacts of a state option on other insurance markets in Maine?
- Does the state require, or would it be beneficial to pursue, a 1332 waiver?
- Is the State well positioned to implement a state option?

Questions?

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Thank you!

About Manatt Health

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For more information, visit https://www.manatt.com/Health.

Biography

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Education

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About

Skilled at managing complex projects involving a mix of public agencies and private stakeholders, Patricia Boozang advises clients on the implementation of coverage, delivery system and payment reforms across government and private health insurance programs. Her clients include federal agencies, foundations, states, healthcare delivery systems and health plans.

Patricia advises states on Medicaid expansion design, implementation and sustainability, and has deep experience in Section 1115 waiver design, development and implementation, including with Arkansas, New Hampshire, Montana and Virginia.

Patricia guides states and marketplaces on policy matters, including eligibility and enrollment, benefit design, delivery system improvements, and technology development. For Minnesota, she led Manatt Health's work to facilitate and provide subject matter knowledge to the Minnesota Health Care Financing Task Force, established in statute to make recommendations regarding the future of the state's Affordable Care Act marketplace and coverage programs including Medicaid.

As a technical assistance advisor in the Robert Wood Johnson Foundation's State Health and Value Strategies program, Patricia counsels states on a wide range of healthcare coverage policy matters, including those related to the ACA, 1115 and 1332 waivers, and federal regulatory changes related to healthcare coverage and delivery.

Drawing on her wealth of experience in Medicaid, Patricia regularly advises health plans and health systems on Medicaid managed care strategy and regulation, accountable care organization development, behavioral health access and integration, and other delivery system transformations.

Patricia is a frequent author and speaker on federal and state healthcare laws, regulation and policy. She leads Manatt Health's business policy, strategy and analytics practice.

Prior to joining Manatt in 2000, Patricia was part of the senior leadership team of Physician Weblink, a startup healthcare technology and physician management company. Earlier, she was a consultant at Sterling Health Capital Management Inc., providing strategic advice to healthcare delivery system clients on a range of issues including primary care development and Medicaid managed care. She began her career in strategic planning and managed care at the Brigham and Women's Hospital in Boston.