DECIPHERING THE DIFFERENT OPTIONS TO EXPAND PUBLIC COVERAGE

American Academy of Actuaries
Objective. Independent. Effective.™

Panel
Barb Klever, Chair, Academy Individual and Small Group Markets Committee
Mike Nordstrom, Chair, Academy Medicaid Subcommittee
Catherine Murphy-Barron, Member, Academy Medicare Subcommittee

SOA 2019 Health Meeting Session 69 Panel Discussion, Phoenix, Ariz.—June 25, 2019

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Background

- Numerous federal and state-level proposals would expand the role of public health insurance programs
- Viability of the expansion and whether it would meet policy goals will depend on how key design features are specified

Background (cont.)

- Session will examine four general approaches and the details that matter
  - Government-facilitated marketplace option
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more/all

Background (cont.)

- Terms used in this session may differ from terms used in particular proposals
- There are not clear lines demarcating different options
- Particular proposals could have elements of more than one approach

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

How the design elements are specified will affect program outcomes

- Access to coverage and access to care
- Premiums and out-of-pocket costs
- Viability of public plan expansion
- Viability of existing individual and group markets

What are the goals of the public plan expansion?

- Increase access to affordable coverage?
- Increase plan availability?
- Reduce the number of uninsured?
- Exert downward pressure on provider prices?
- Reduce health care spending?

Who is the eligible population?

- All?
- Individuals of certain ages?
- Individuals without access to other coverage?
- Individuals in particular geographic areas?
- Can employers enroll workers in the public plan?
- Are any individuals/groups automatically enrolled?

Would enrollment in public plan be mandatory or optional?

- If public plan is one among other coverage choices, how will rules of the public plan compare to those of other coverage options (e.g., issue and rating rules, benefit coverage requirements, health insurer rules)?
  - If the rules differ, there could be selection effects between public plan and other existing markets.
  - Would the public plan be part of the Affordable Care Act (ACA) single risk pool? (Difficult to accomplish if it doesn't follow the ACA rules.)

What benefits would be covered and what patient cost-sharing would be required?

- Would benefits/cost-sharing follow ACA essential health benefit and actuarial value requirements? Medicaid benefits? Medicare benefits?
- Would supplemental coverage (e.g., Medigap) be available?
- Would ACA cost-sharing subsidies be available?

How would premiums be set?

- Would premiums be self-supporting or would they be subsidized by state or federal government?
  - Would there be any cross-subsidies between buy-in populations and current Medicare/Medicaid populations?
- Could individuals use ACA premium subsidies toward the public plan premium?
- How would premiums vary by age, geographic area, or other factors?

Would private plans be available?

- Would Medicare Advantage or Medicaid managed care plans be available?
- If so, would there be separate plans and bids for newly eligible and currently eligible populations?
  - Would private insurers have to cover both populations?

How would provider payment rates be set?

- Trade-offs between constraining plan costs (premiums) and the willingness of providers to participate (access)
- Would the plan have a provider network?

Other important design elements

- Who would administer the program?
  - Federal government
  - State governments
  - Private entities contracted to perform insurance and administrative tasks
- How would the program be financed?
- How would the transition be handled?

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Government-facilitated marketplace plans (aka public option)

- Public option would compete with other plans in the ACA marketplaces
- In general, public option would follow all of the ACA rules
- Difference is that the public option would base provider payment rates on Medicare, Medicaid, or some rate between those levels and commercial payment levels

Where would the public option operate?

- In all states and areas
- Or, limited to particular states depending on program goals
  - States/areas with no or few participating insurers
  - States/areas with high provider prices
  - Public option would compete with other plans in the ACA marketplaces
- Decision could be made at state or federal level
- How would option affect private plan participation?

What would provider payment rates be?

- Cost/access trade-offs
- Would lower provider payment rates give private insurers more leverage to negotiate with providers or would private plans find it more difficult to compete?

Would public option be part of the single risk pool?

- Public option would be be part of the single risk pool and follow all ACA rules (including issue, rating, and benefit coverage rules)
- If the public option were to deviate from ACA rules (e.g., offering different benefits):
  - Selection could result between the public option and the ACA plans
  - Risk adjustment program would be less able to mitigate selection differences

How would premiums be set?

- Would premiums be self supporting (aside from premium subsidies) or would additional state/federal funding be provided?
- Would the public option premiums be included in the calculation of the benchmark premium?
- Would public option premiums be subject to medical loss ratio (MLR) requirements (could be difficult to track admin expenses)?
- Would the public option be subject to other insurer requirements, such as health insurer taxes and fees and the need to hold adequate reserves?

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Medicaid buy-in

- Individuals not currently eligible for Medicaid would be able to enroll into Medicaid and pay any applicable premiums.
- Could be available on a state-by-state basis, at state discretion
- Federal approval needed if federal funds are required

What benefits would be covered?

- Current Medicaid benefit rules:
  - Federal rules require Medicaid to cover broad range of benefits; states can provide more
  - Benefits vary among states and within states by eligibility category
  - Medicaid mandated benefits include some services not part of ACA essential health benefits (EHB) and exclude some that are
- Would Medicaid buy-in benefits reflect state's current benefit package or be altered, e.g., to align with ACA EHB?

What cost sharing would be required?

- Current Medicaid benefits require little or no cost sharing.
- Would cost-sharing requirements increase if eligibility broadened beyond the low-income population?
- Could ACA cost-sharing subsidies be used for the buy-in?
  - How would that work if benefits differ?

Would buy-in include traditional Medicaid and/or coverage through an MCO?

- Many states allow/require segments of their Medicaid population to obtain coverage through a a Medicaid managed care organization (MCO).
- Would newly eligible enrollees have the same options/requirements?
- Would MCOs be required to cover both newly and currently eligible Medicaid enrollees?

How would premiums be set?

- Would premiums be self-supporting or would additional state/federal funding be provided?
- How would premiums vary by enrollee (e.g., by age, geographic factor, or income)
- Could ACA premium subsidies be used toward the buy-in?
  - If so, how would the ACA benchmark plan be determined?

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Medicare buy-in

- Individuals not currently eligible for Medicare would be able to enroll into Medicare and pay any applicable premiums
- Would be available on a nationwide basis
- Administered by federal government, potentially through contracts with private entities to perform insurance and administrative tasks

Who would be eligible to enroll?

- Could be made available to all or limited to certain groups, e.g., age 55-64
- Would employers be allowed to purchase coverage for their workers/early retirees?
  - At employer option?
  - At worker/retiree option?
- The impact on other markets could be larger the more expansively buy-in eligibility is defined

What benefits would be covered?

- Traditional Part A/B Medicare benefits don't cover all of the ACA EHB and there is no out-of-pocket cap. Would benefits be supplemented to better align with ACA?
  - Answer may depend on whether buy-in is limited to older adults or made available to all ages
  - Providing additional benefits to buy-in population would create inequities between newly and currently eligible
- Would Part D prescription drug coverage be optional?
- Cost-sharing subsidies
  - Would Medicare savings programs be available?
  - Could ACA cost-sharing subsidies be applied?

How would premiums be set?

- Would the buy-in program be distinct from current trust fund operations or would there be cross-subsidies?
- Would premiums be self-supporting?
- How would premiums vary by age, income, geographic region, or other factors?
- Premium subsidies:
  - Would Medicare savings programs be available?
  - Could buy-in enrollees use ACA premium subsidies?

What is the role of private coverage?

- Would supplemental coverage be available?
  - Would Medigap and employer retiree coverage be available to buy-in enrollees?
  - How would Medigap issue and rating rules work?
- Would Medicare Advantage (MA) plans be available?
  - Would there be separate MA bids for newly and currently eligible?
  - Would private insurers have to cover both populations?

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Medicare for more or for all

- Would more directly expand Medicare on a nationwide basis.
- Options include:
  - Incrementally lowering the age of eligibility (e.g., to age 55)
  - Extending eligibility to all
  - Extending eligibility to all and restructuring the program
- Administered by federal government, potentially through contracts with private entities to perform insurance and administrative tasks

Incrementally lowering the eligibility age

- Medicare would replace most other sources of coverage for newly eligible (Medicare could be secondary payer for active workers)
- Aside from age, program structure could remain
- Would shift health care spending to Medicare from other sources
  - Without increase in payroll taxes, Hospital Insurance (HI) Trust Fund would face additional financing challenges
  - Although younger average age could reduce per capita Part B/D costs (and premiums), additional general revenues would be needed in the aggregate

Extending Medicare to all

- Medicare would replace most other sources of coverage
- Would benefits be supplemented to reflect the needs of the younger enrollee population?
- How would financing be restructured?

Extending an enhanced version of Medicare to all

- It would really be a new program that would affect not just newly eligible enrollees, but current beneficiaries as well.
- What benefits would be covered and what would cost sharing be?
  - Would additional benefits be available for low-income enrollees?
- What would be the role of private plans?
  - Would Medicare Advantage plans be available?
  - Would private supplemental coverage be available?
- How would provider payment system be structured?
- How would the program be financed?

Agenda

- Background
- Key design issues for proposals to extend public insurance eligibility
- General approaches to expanding eligibility
  - Government-facilitated marketplace plan
  - Medicaid buy-in
  - Medicare buy-in
  - Medicare for more or for all
- Current federal proposals and state activity

Congressional Proposals --Public Plan Option--

- S. 3 Keeping Health Insurance Affordable Act (Cardin)
- S. 489/H.R. 1277 State Public Option Act (Schatz/Lujan)
- S. 981/H.R. 2000 Medicare-X Choice Act (Bennet&Kaine/Delgado)
- S. 1033/H.R. 2085 The CHOICE Act (Whitehouse/Schakowsky)
- S. 1261/H.R. 2463 Choose Medicare Act (Merkley/Richmond)

Proposals would create federal public plan option to be offered in individual market exchanges. Some would extend option to employers, enhance premium and cost-sharing subsidies, and/or impose prescription drug or other cost containment measures. Proposals would use Medicare or Medicaid providers and base provider payment rates on Medicare rates.

Congressional Proposals --Medicare Buy-in--

- S. 470 Medicare at 50 Act (Stabenow)
- H.R. 1346 Medicare Buy-In and Health Care Stabilization Act (Higgins)

Proposals would allow adults age 50+ to buy into Medicare (including Medicare Advantage).

Congressional Proposals
--Public Program with Employee Option--

- H.R. 2452 Medicare for America (DeLauro Schakowsky)

Would automatically enroll individuals in the individual market, Medicaid, and Medicare into public program. Employers can continue to offer qualified coverage; workers can opt for employer coverage or public program.

Congressional Proposals --(Enhanced) Medicare for All--

- S. 1129 Medicare for All (Sanders)
- H.R. 1384 Medicare for All (Jayapal)

Proposals would replace most health insurance with single federal program. Comprehensive benefits with no premiums and no or limited cost sharing.

State activity

- Buy-in/Public Option Proposals
  - Passed (1)
    - Washington State
  - Passed Study Legislation (3)
    - New Mexico; Colorado; Delaware
  - Considering Legislation (11)
    - Maine; New Jersey, Connecticut, Wisconsin, Iowa, Minnesota, Wyoming, Nevada, California, Oregon, Massachusetts
  - Considering Study Legislation (3)
    - Missouri, New Hampshire, Massachusetts

Questions?

For more information

American Academy of Actuaries

Expanding Access to Public Insurance Plans
https://www.actuary.org/files/publications/PublicInsurancePlans.pdf

Other resources

Comparison of Medicare-for-All and Public Plan Proposals, Kaiser Family Foundation

https://www.kff.org/interactive/compare-medicare-for-all-public-plan-proposals/

The "Medicare for All" Continuum, The Commonwealth Fund
https://www.commonwealthfund.org/blog/2019/medicare-all-continuum

For more information

David Linn

Senior Health Policy Analyst

American Academy of Actuaries

Linn@actuary.org

202-785-6931

American Academy of Actuaries
Objective. Independent. Effective.™