Revisiting the Public Option – Medicaid Buy-Ins

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At the same time that health policy changes – large and small – continue at the Federal level, State efforts to strengthen health insurance markets and reduce premium cost increases for consumers while ensuring access to high quality, affordable health care persist. One recent development in a number of states, as well at the Federal level, is the renewed exploration of a public health insurance option. Public options have been proposed since prior to the passage of the Patient Protection and Affordable Care Act (ACA) and can be designed in various ways. However, the version most commonly under consideration recently is in the form of offering an option to purchase Medicaid coverage. This past legislative cycle, a number of state legislatures either considered Medicaid buy-in enabling legislation or authorized impact studies to determine the costs associated with a Medicaid buy-in and the best way by which to deliver such an option for coverage.

Many states considering a Medicaid buy-in public option have expressed the hope that it will provide an affordable coverage option for individuals, noting that insurance remains highly costly even for those individuals receiving Federal premium subsidies or employer contributions. Many of the details of how a public option would work in a particular state are under study or were not fully outlined in legislation. However, recent legislation provides some insight into possible designs. State proposals include offering the buy-in with benefits based on existing plans - either mirroring public program benefits, as proposed in Minnesota for example, or a Silver level commercial products, as proposed in Federal legislation. Buy-in plans have been proposed to be offered on the existing Medicaid or Marketplace eligibility portals. Generally, enrollees would be charged premiums for the full cost of the plan, though states are exploring utilizing State and / or Federal funds to provide subsidies to low-income enrollees.

In the coming months, many of the impact studies will be made public and more fleshed out proposals may take shape. This may attract more attention to the topic, especially if the study results indicate offering Medicaid buy-in coverage would, in fact, result in cost savings to consumers and possibly also states.

This report provides a brief history of the concept and origin of public health insurance options, design options, implications and considerations for states, as well as an overview of recent State and Federal legislation. This topic is likely to continue to be on the forefront of health policy debate, and this report seeks to provide a foundation as states start setting legislative priorities over the coming months. We will continue to follow this topic and share the results of any impact studies produced by or for states exploring establishing a Medicaid buy-in public option.

Introduction to Public Options

The concept of a public health insurance option as a tool for expanding access and affordability is not new. The proposal to make available, for purchase, a government-sponsored insurance plan side-by-side with private insurance options first emerged as part of a health reform proposal developed in California in the early 2000s, and resurfaces from time to time as a method of reducing health cost burdens and expanding access to care. Consideration of a Federal public option was a prominent part of the debate over the ACA. It was included in several versions of bills debated as part of passage of the ACA, including the bills passed out of the various committees of jurisdiction in the House of Representatives as well as the legislation passed by the House.[1]

As included in the House-passed legislation, the public option would have been a “Qualified Health Benefit Plan” (QHBP) created by the Federal Department of Health and Human Services that would have been offered on the Marketplace along with private QHBPs.[2] The public buy-in plans would have abided by the same coverage rules applying to private insurance plans, including those relative to plan design and premiums. Those purchasing the coverage would have paid premiums unless eligible for subsidies not directly tied to the public option. The public option was also included in the health reform bill passed by the Senate Health, Education, Labor, and Pensions

[1] Halpin, Helen and Harbage, Peter, “The Origins and Demise of the Public Option” *Health Affairs* June 2010 (1117-1124), *available at* https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2010.0363.
[2] http://housedocs.house.gov/rules/health/111_ahcaa.pdf

Committee. However, it was not included in the legislation passed by the Senate that ultimately became the foundation of the ACA, nor was it included in the reconciliation package ultimately adopted.

Supporters pointed to the public option as a tool to drive choice, competition, and lower rates; a vehicle to promote delivery system reforms; and a way to provide an alternative to profit-driven insurance. Ultimately, however, concerns about the expanding role of government in health care and that the public option would be a stepping stone to a single-payer health care system led to its demise.

The concept of a public option in the form of a public program buy-in, specifically, emerged briefly as an alternative to the standalone public option plan proposal during the debate over the ACA, with proposals to allow those under the age of 65 to buy-into the Medicare program. More recently, Presidential candidate and Senator Bernie Sanders has pushed the discussion further, advocating for a single-payer system building off of the Medicare program,[3] but proposals to make buying into Medicare *an option* also continue, with legislation filed as recently as this year.[4]

As attention now turns to the possibility of State public options in the form of Medicaid buy-in options, it is useful to also examine similar programs that are or were in place. One example is the Medicaid / Children's Health Insurance Program (CHIP) buy-in programs for children whose family income exceeds Medicaid or CHIP eligibility limits.[5] These programs, only a handful of which have continued to exist since implementation of the ACA, have generally functioned as true buy-in programs where the families pay the full cost for coverage and, sometimes, must also pay an additional amount to cover the state's administrative costs. In most of the states, these programs typically do not have income limits or other eligibility standards other than being available only for children.

Some states have what might be considered similar programs, in the form of charging premiums to certain Medicaid beneficiaries. While these individuals do not meet traditional Medicaid eligibility standards, these programs are different from most of the buy-ins being considered today in that the individuals must meet some eligibility standards. For example, some states have more limited buy-in programs for children with disabilities whose families have incomes that exceed Medicaid or CHIP eligibility limits. In most states, the family income must be less than 300 percent of the Federal Poverty Limit (FPL) for the child to qualify.[6] Similarly, nearly all states have a Medicaid buy-in option for adults with disabilities who are employed and have income in excess of traditional Medicaid eligibility.[7] In most states, eligibility for the adult buy-in coverage is limited based on income and assets. Most recently, several of the states who have expanded coverage to the Medicaid expansion group charge some premiums to those individuals.[8] However, again, they must be income eligible for the expansion. For most of these programs, the premiums that individuals / families pay are typically on a sliding scale based on family income.

[3] See https://www.sanders.senate.gov/download/medicare-for-all-act?id=6CA2351C-6EAE-4A11-BBE4-CE07984813C8&download=1&inline=file
[4] See https://www.congress.gov/bill/115th-congress/senate-bill/2708
[5] https://ccf.georgetown.edu/wp-content/uploads/2012/03/Strategy%20center_buy-in%20snapshot.pdf
[6] http://cahpp.org/project/the-catalyst-center/financing-strategy/medicaid-buy-ins/
[7] https://www.kff.org/other/state-indicator/medicaid-eligibility-through-buy-in-programs-for-working-people-with-disabilities/?activeTab=map&currentTimeframe=0&selectedDistributions=monthly-income-limit&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[8] Musumeci, Marybeth; Hinton, Elizabeth and Rudowitz, Robin, "Section 1115 Medicaid Expansion Waivers: A Look at Key Themes and State Specific Waiver Provisions: *Kaiser Family Foundation* August 2017, *available at* http://files.kff.org/attachment/Issue-Brief-Section-1115-Medicaid-Expansion-Waivers-A-Look-at-Key-Themes-and-State-Specific-Waiver-Provisions.

Benefit Design Considerations

Full Medicaid buy-ins that do not utilize Federal Medicaid funding may be designed without complying with Medicaid rules.[9] While some states presently contemplating a public option assume some reliance on Federal Medicaid funds, not relying on such funds provides states with the flexibility to further limit benefits – particularly those that are not typically offered by private insurance, such as non-emergency medical transport (NEMT) and long term care – and increase cost sharing. However, historically states have often chosen to offer the Medicaid benefit package as the buy-in plan design. Likewise, Minnesota, for example, proposed to align buy-in public option coverage closely with the current MinnesotaCare program - with legislation that sought to maintain the current benefits, though tied to its Basic Health Program and not the state's Medicaid benefits.

As states determine how to approach benefits for a Medicaid buy-in, they will need to balance competing factors. On the one hand, aligning with an existing Medicaid package of benefits will minimize the burden on the state of administering the buy-in and ease the impact of churn and potential confusion as people may move back and forth between Medicaid eligibility and the buy-in. However, including benefits that are not traditionally included in private insurance will increase the cost of the coverage (mitigating the impact on affordability and coverage) and may cause adverse selection as people compare benefit packages and consider whether they need the broader scope of benefits provided by the buy-in compared to other options, as discussed further below.

On the other hand, if the coverage will be offered as a Qualified Health Plan (QHP) on the state's Marketplace - which would ensure that individuals would also be eligible for Advance Premium Tax Credits (APTCs) and Cost-Sharing Reductions (CSRs) - the state must ensure that the buy-in coverage aligns with the Essential Health Benefits (EHBs). Connecticut and Maryland are both currently studying how to best offer the product on the state Marketplace, and Massachusetts legislation proposed the same.

While most Medicaid coverage is overall more generous than commercial coverage, certain EHBs (for example, substance use disorder services and rehabilitative and habilitative care) are not mandatory benefits for traditional Medicaid benefit packages.[10] It is also possible that the coverage will not fully align with the state's EHB benchmark plan design. With the elimination of the individual mandate penalty, this is not an issue for those purposes. However, under the ACA, coverage cannot be sold on the Marketplace if it does not comply with the EHB. It is possible, however, that a State could get a Section 1332 State Innovation Waiver[11] to allow the buy-in package to vary from the state's EHB benchmark to some degree as long as it meets the Section 1332 guardrails, including that the coverage must be at least as comprehensive as outlined under the EHBs.[12] This could be achieved by demonstrating that, while not aligning completely, the Medicaid package is more comprehensive as far as other benefits. In fact, many states studying the public option have included in their authorizing legislation language that directs the state to apply for waivers to support the buy-in.

Similar to benefits, cost sharing for full buy-ins can exceed the Medicaid limits. To better align with comparable commercial coverage, improve affordability of premiums, and avoid potential adverse selection, the state should consider increasing cost sharing for the buy-in population above the Medicaid levels. However, in creating buy-in specific cost sharing, the state will need to ensure it complies with ACA cost-sharing limits for private insurance. In fact, if the buy-in will be offered through the Marketplace, the state will need to ensure that the cost sharing fits within the actuarial value levels outlined in the ACA, at least the Silver and Gold levels in which QHP issuers are required to participate – as well as the Silver cost-sharing reduction plans[13] - or waive that requirement via a Section 1332 Waiver. Both the State and Federal Medicaid buy-in public option legislation recently or currently under consideration include an increase to cost sharing above Medicaid levels, as well as authorization to seek

[9] Buy-in programs that are an optional expansion of the Medicaid program with the support of Federal Medicaid funds are subject to Federal Medicaid rules regarding benefits and cost sharing. This includes the buy-in programs for disabled children and adults. However, states exploring a Medicaid buy-in public option may be able to leverage Federal Advance Premium Tax Credit funds via a Section 1332 Waiver (as explored below) without being subject to Federal Medicaid rules regarding benefits and cost sharing.
[10] See 42 U.S.C. 18022(b); 42 CFR 440.210
[11] 42 U.S.C. 18052
[12] Health Policy News has written extensively on Section 1332 Waivers. The most recent report can be found here.
[13] 45 CFR 156.200(c)(1); 45 CFR 156.420

any necessary waivers, as noted above. The proposed Minnesota legislation, specifically, included authorization for regulators adjust the public option plan to an actuarial value "no lower than 87 percent."

The state must also ensure that if the buy-in is offered through the Marketplace, it complies with other ACA rules for coverage and cost sharing, including, for example, that preventive care for all enrollees is provided without cost sharing.[14]

Implications and Considerations for States

Medicaid buy-in proposals hold the potential of expanding options available to uninsured individuals in State health insurance markets. The hope is that expanding the coverage options available will promote affordability and innovation by increasing competition, particularly, from a program with lower administrative spending. However, states must be mindful of a range of considerations and potential implications to both the Medicaid program and their commercial health insurance markets as they determine how to approach the buy-in.

Impact of Broadening the Medicaid Risk Pool

In each state, the impact of expanding the Medicaid risk pool to include individuals who purchase buy-in coverage will vary. In some states, the commercial population will be healthier on average than the Medicaid population. For states with Medicaid Managed Care, the per member per month (PMPM) cost for all enrollees (including those paid for by the Medicaid program), would be reduced as a result of a stronger risk pool, bringing financial benefit to the state. If, however, the commercial population is sicker relative to the Medicaid population, that will negatively impact the strength of the entire Medicaid risk pool, which would – again – particularly impact states with Managed Care delivery systems. In those states, the PMPM cost for all members could increase, causing financial burden to the state.

Impact of Plan Design

The impact of the buy-in on the Medicaid risk pool could be heightened by adverse selection; and such concerns could alternatively impact the commercial insurance market in the state. As outlined above, states will need to determine whether the buy-in will utilize the existing Medicaid benefits package or an alternative package that may align better with the commercial health insurance market.

Allowing individuals to buy-in to the existing Medicaid package – similar to Minnesota's proposal to align to its Basic Health Program coverage - would minimize the administrative burden on the state of having to design and administer an additional benefit package (and the potential resulting administrative cost that could be factored into premiums).

However, states must also consider how different benefit design and premiums have the potential to drive or forestall adverse selection and design the buy-in to avoid any detrimental consequences. Any coverage sold on the Marketplace must comply with QHP standards and, therefore, buy-in coverage sold on-Marketplace must be at least equivalent to the plans currently on the Marketplace – mitigating any likelihood of adverse selection. However, if the buy-in were to be designed to be sold outside of the Marketplace - as discussed further below - to the extent the Medicaid buy-in coverage is significantly skinnier than QHPs and comparably less expensive, it is likely that it would lead to adverse selection against the Marketplace, with healthier individuals leaving the Marketplace to purchase the buy-in and those with more health needs staying in the Marketplace. The result would be the more comprehensive QHPs becoming more expensive for those individuals needing more comprehensive coverage.

On the other hand, if the Medicaid buy-in aligns with the current Medicaid benefit package, including benefits such as NEMT and long term care that are not typically included in commercial benefit packages, there could be adverse selection against the Medicaid program, with those individuals with more significant health needs selecting to purchase buy-in coverage. If the coverage is offered through Medicaid Managed Care Organizations (MCOs), that could lead to premium increases for the entire Medicaid program, raising costs for the state.

[14] See 45 CFR 147.130(a); 42 CFR 447.56(a)(2)(ii)

Similarly, in State-administered Fee for Service (FFS) Medicaid, the state would run the financial risk of having to absorb losses if the premiums for the buy-in do not fully account for adverse selection.

Impact of Premium Rates

The state must also determine an appropriate premium for the buy-in. States will need to ensure premiums are adequate to cover the full cost of coverage, so that the state does not incur financial losses. Minnesota, for example, proposed establishing a public option premium rate similar to the average rate paid by the state to its MCOs. Additionally, states should consider including administrative costs (discussed below) in premiums. However, in doing so, the state must consider the applicability of Medical Loss Ratio (MLR) rules. If the buy-in is offered as a QHP on the Marketplace and premiums are set too high – above the limitations for administrative spending under Federal law – the state may trigger MLR limitations which would require the MCOs or the state (in FFS delivery systems) to account for and pay MLR rebates. Premiums that are set too high will also undermine the opportunity for the buy-in to promote greater competition and affordability on the Marketplace.

If the buy-in will be offered through the Marketplace, the state will also need to determine how to price the coverage in light of the fact that, currently, CSRs are required to be administered but the payments are not being made by the Federal government. This will require the state to price the Silver-level buy-in plans or all buy-ins to absorb the cost of those reductions.

As explored in more detail below, most states have explored allowing enrollees to access Federal or State premium subsidies.

Administrative Considerations

The introduction of a buy-in will come with new administrative tasks for the state. Implementing states will potentially need to undertake the design of a unique benefit package and cost-sharing designs, as explored above. If the buy-in will be offered through the Marketplace, it will need to have multiple cost-sharing designs for the required actuarial value levels of coverage unless the state will seek to waive that requirement through a Section 1332 Waiver. The state will also have to undertake the task of setting premium rates, balancing the considerations outlined above.

FFS states will need to manage an increased covered population as well as premium payments, which will be a new activity for some states. In Managed Care states, those tasks will be absorbed by the MCOs but may lead to new administrative fees for the state.

The state can offset these administrative costs and fees within the premium as long as the administrative portion meets MLR standards as noted above.

The state must also consider how the buy-in will be purchased, and the current impact studies underway in Maryland and Connecticut are reviewing the best avenue by which to do so. If it is offered through the Marketplace, the state would not need to alter its Medicaid portal or create a new one for buy-in enrollees. In addition, if the coverage is purchased through the Marketplace, eligible enrollees would be able to use APTCs to purchase the coverage and avail themselves of CSRs (though the cost of those reductions are now included in the premium as outlined above).

However, offering the buy-in through the Marketplace will mean that the design of the buy-in must align with rules for QHPs and QHP issuers. In states that have Medicaid Managed Care, the MCOs would need to become licensed if they are not already. The state would need to consider how that requirement would apply to FFS Medicaid.

Minnesota, on the other hand, proposed to have the buy-in purchased through the MinnesotaCare portal. If the state choses to have the coverage sold through its Medicaid portal, it could seek a Section 1332 Waiver to receive the Federal APTC funds as pass-through funds to use to subsidize the buy-in premiums for all or certain enrollees[15] and it could explore options via a Section 1115 Medicaid Waiver[16] or Medicaid State Plan

[15] See 42 U.S.C. 18052(a)(3)
[16] See 42 U.S.C. 1396n

Amendment[17] to leverage Federal Medicaid funds to subsidize premiums. In a few instances, state-based subsidies are also being proposed, in particular by those states that currently subsidize state Marketplace premiums (see *Massachusetts* below for more details).

States selling the buy-in through the Medicaid portal will also need to decide if they will offer the buy-in on an ongoing basis or adhere to the commercial market open enrollment period (OEP). Minnesota proposed utilizing the MinnesotaCare open enrollment periods. Offering coverage outside of the OEP may create adverse selection concerns and result in cost pressures to the Medicaid risk pool as people may wait until they are sick to purchase the coverage. It also may impact the strength of the commercial risk pool as currently healthy individuals may forgo that coverage, knowing they have an option for purchasing coverage throughout the year.

Carrier and Provider Issues

States with Medicaid Managed Care delivery systems will need to consider the impact on those carriers. As stated above, those who are not currently licensed commercial carriers will need to become one if the buy-in will be sold through the Marketplace. Regardless, the risk pool and complexity for those issuers will be growing. The state will need to understand whether the MCOs are open to such changes or whether they may choose to end their contracts with the state.

There is also potential complexity related to providers. Providers argue that Medicaid reimbursement rates are too low and may argue that they should receive different reimbursement rates for the buy-in population. Failing to do increase reimbursement rates may lead providers to leave the Medicaid network and lead to greater access issues, or increase cost-shifting to the commercial market. On the other hand, maintaining current reimbursement rates will further incentivize innovation and efficiencies in the health care system.

Regardless, the Medicaid program will need to ensure the network is large enough to absorb the greater enrollment without access issues that trigger Medicaid or private insurance rules. If Medicaid chooses to negotiate separate rates for buy-in members, it will be an additional administrative task to undertake but the state may benefit from its negotiating position with a large existing population.

Recent Developments on Medicaid Buy-In Public Options

As noted above, several states have recently or are currently considering implementing or studying a Medicaid buy-in public option. Legislation to allow states to explore the public option as a way to address rising health care costs was also filed at the Federal level this past session. Detailed below are the approaches of key states as well as the Federal legislation, including the projected state cost (when available) associated with implementing the buy-in. Also included is a legislative tracking chart (*see Figure 1)* that includes the status of and access to pending or recently failed legislative efforts for use by policymakers. Before the end of the year, we will be updating this chart to include key proposals and details from the impact studies currently underway in a number of states.

[17] 42 U.S.C. 1396a

State Efforts

Connecticut:

This past spring, Connecticut conducted public hearings on the public option plan outlined in House Bill 5463: An Act Concerning a Medicaid Public Option. The House bill proposed that the Commissioner of the Department of Social Services and the Office of Health Strategy and the Healthcare Cabinet, conduct a study on how a Medicaid public option (to be referred to as HUSKY E) could be offered as a choice on Connecticut's health insurance Marketplace, Access Health CT. The study is required to include an analysis related to: (1) the application for a Section 1332 Waiver to allow eligible individuals to use APTCs and CSRs; (2) whether to charge HUSKY enrollees copayments and deductibles and, if so, in what amounts; and (3) whether the HUSKY E plan should be sold on the Connecticut Marketplace as a QHP. The study included in the May 2018 version of the bill is due back to the House Committee on Human Services by January 1, 2019.

Maryland:

Maryland is currently undergoing a Medicaid Buy-In Study (Senate Bill 878) with the report due by December 31, 2018. The Maryland Health Insurance Coverage Protection Commission is tasked with generally evaluating the impact of a buy-in that would offer coverage under a QHP purchased through the Marketplace. More specifically, the study will evaluate and report on: "(1) the benefits and consequences of a Medicaid buy-in program; (2) the circumstances under which the State should consider such a program; (3) eligibility criteria; (4) general parameters for a coverage package; (5) a financial structure; (6) the structure of a risk pool and the consequences of combining the buy-in risk pool with Medicaid; (7) an administrative structure; (8) an evaluation of whether a Medicaid waiver would be required to implement any commission recommendations; and (9) any other buy-in options that should be considered."[18]

Massachusetts:

On January 23, 2017, the Massachusetts legislature introduced legislation entitled the "Public Health Insurance Option." The Massachusetts proposal would allow the state to offer a tailored Medicaid product to all individuals, including employers of Medicaid-eligible individuals in order to expand affordable coverage options for consumers. The buy-in would be financed with APTCs, CSRs, existing state subsidies, employer contributions for the employers that buy in, as well as consumer cost sharing. The Senate held a hearing on this matter in 2017, and there is a study order currently pending as part of the State budget bill that was not yet final as of the time of publication.

[18] See Maryland Senate Bill 878, *available at* http://mgaleg.maryland.gov/2018RS/fnotes/bil_0008/sb0878.pdf.

Minnesota:

Minnesota had a busy legislative cycle relative to the public option. Slightly different than the other proposals, the state proposed to allow the purchase of coverage through its Basic Health Program (BHP), MinnesotaCare, via SF 58. Accompanying legislation (HF 92) directed the state to seek a waiver from the Federal government if necessary for the establishment of a public option. The original bill would have permitted individuals shopping for health insurance on the individual market with income levels above 200 percent of the FPL to purchase the BHP. It is estimated the cost per enrollee would have been $5,628 a year, compared to $6,468 a year currently on the Marketplace. The legislation failed to pass as initially introduced but was revised to include a plan available to individuals with income above 201 percent of the FPL (above BHP eligibility) who are determined eligible for enrollment in a QHP with or without APTCs and CSRs. The plan permits individuals who are eligible for APTCs and CSRs to use those subsidies to purchase the MinnesotaCare buy-in option (subject to approval by the Federal government via a waiver). The last action on the bills was referral to the Health and Human Services Finance and Policy committee.

Nevada:

The Nevada legislature passed Assembly Bill 374 in Spring 2017, which would have allowed income eligible residents to enroll in a public Medicaid buy-in - but the bill was vetoed by the Governor. This public option would have been available to people who were otherwise ineligible for Medicaid, but met income eligibility criteria for APTCs and CSRs. Eligible individuals would have been able to use those subsidies to purchase coverage from the Nevada Care Plan. Although Assembly Bill 374 was unsuccessful, the concepts in that bill are now under study by the Legislative Committee on Health Care. The committee is examining the opportunities for the establishment of an option "similar to the Medicaid managed care program to be made available through the Silver State Health Insurance Exchange (the state's Marketplace) to a person who is otherwise ineligible for Medicaid."[19] Additionally, the committee must report by September 1, 2018 on the whether a person eligible for APTC or CSRs could use those subsidies to pay for a Medicaid buy-in type plan.

[19] See Nevada Assembly Bill 374, *available at* https://www.leg.state.nv.us/App/NELIS/REL/79th2017/Bill/5393/Overview.

New Mexico:

In February 2018, New Mexico authorized a study on the implications of a Medicaid buy-in proposal intended to lower health care costs and expand affordable coverage to residents, a particular concern for those earning less than 200 percent FPL. The study will examine, in part, the policy and fiscal implications of offering a Medicaid buy-in coverage, including the health plan costs of private insurance as compared to Medicaid managed care. The Legislative Health and Human Services committee is also tasked with gathering public feedback and determining the impact on key stakeholders.

New Mexico currently has 180,000 uninsured state residents that could qualify for this plan. Marketplace premiums in New Mexico have been relatively stable and lower than many other states across the country, yet many still go uninsured due to the cost, with the average bronze plan costing close to $7,000 per year. The legislation states that "fifty-three percent of low-income adults who have private health insurance through their employers, the marketplace or individual coverage and whose incomes are below two hundred percent of the federal poverty level have health care costs deemed to be 'unaffordable'." [20]

Wisconsin:

This past spring, legislative efforts to pass a Medicaid buy-in option in Wisconsin failed. The "BadgerCare Public Option," would have allowed Wisconsinites and small businesses to enroll in BadgerCare (the state's Medicaid program) at full price. It was estimated that allowing access via a buy-in would save consumers on average more than 15 percent compared with existing health insurance options in Dane County and more than 30 percent when compared with the lowest average Silver Plan statewide. On average, it was estimated that the BadgerCare buy-in would cost enrollees $7,224 a year, versus $8,350 for existing private market plans (based on an average Silver plan premium). The bill failed to pass in March of 2018, but there is still support for exploration of options that allow for buy-in to BadgerCare.

Federal Efforts

Federal legislation entitled the State Public Option Act was introduced in October 2017. The Act would allow all states to offer a Medicaid buy-in as a QHP and to treat the buy-in option as the second lowest- cost Silver plan. The Act would enable states to charge premiums up to 9.5 percent of a family's income, copayments, and deductibles for the plans based on existing standards in the ACA, and eligible individuals would be able to use APTCs to help cover the costs of premiums. Plans would be required to cover the ten EHBs required under the ACA. The bill is currently in the Senate Health Care Finance Committee.

[20] Per the Commonwealth Fund's Health Care Affordability Index

Figure 1: Legislative Tracking Chart

State	Program	Date Introduced	Bill Name	Legislation
Current Effort				
Connecticut	An Act Concerning The Study Of Health Insurance Options For Individuals Ineligible For Medicaid	5/3/2018	*File No. 202 & HB 5463*	https://www.cga.ct.gov/2018/FC/2018HB-05463-R000202-FC.htm
Connecticut	The HUSKY E plan	3/7/2018	*Raised Bill 5463*	https://www.cga.ct.gov/2018/TOB/h/pdf/2018HB-05463-R00-HB.pdf
Maryland	Maryland Health Insurance Coverage Protection Commission – Medicaid Buy–In Study	2/18/2018	*Senate Bill 878*	http://mgaleg.maryland.gov/2018RS/fnotes/bil_0008/sb0878.pdf
Massachusetts	Public Health Insurance Option	1/23/2017	*S.618*	https://malegislature.gov/Bills/190/S618
Massachusetts	Transformative Health Care	11/9/2017	*S. 2211, Section 157*	https://malegislature.gov/Bills/190/S2211
Minnesota	MinnesotaCare	1/9/2017	*SF 58*	https://www.revisor.mn.gov/bills/text.php?number=SF58&version=latest&session=ls90&session_year=2017&session_number=0
Nevada	Nevada Care Plan	3/20/2017	*Assembly Bill 374*	https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB374_EN.pdf
New Mexico	Medicaid Buy-In Study	2/8/2018	*SM003*	https://www.nmlegis.gov/Sessions/18%20Regular/memorials/senate/SM003.pdf
Wisconsin	BadgerCare Public Option	7/5/2017	*Assembly Bill 449*	https://docs.legis.wisconsin.gov/2017/related/proposals/ab449
Federal Effort				
	State Public Option Act (Schatz/Lujan Bill)	10/24/2017	S.2001/H.R 4129	https://www.congress.gov/bill/115th-congress/senate-bill/2001/text

Next Steps

Consideration of Medicaid buy-in public options is likely to continue in the upcoming State and Federal legislative cycles as policymakers debate the best way by which to deliver affordable health care to the most individuals. As noted above Maryland, Connecticut, New Mexico and likely Massachusetts[21] will release impact analyses of the public option over the coming months. The results of this work will be closely scrutinized, and could serve as the catalyst for even more widespread exploration if they show it to be a financially and operationally viable option. We will continue to monitor and report on developments both at the State and Federal level.

[21] The Massachusetts budget was not yet finalized at time of publication but a study order is included in proposed budget version.

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