

State Marketplace Stabilization Strategies



American Hospital
Association®

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Executive Summary

The Health Insurance Marketplaces established by the Affordable Care Act (ACA) have become an important source of coverage for more than 10 million Americans, many of whom receive federal subsidies to reduce the cost of coverage. However, many of the Marketplaces are exhibiting signs of instability, including volatility in plan participation and significant year-over-year premium rate increases. If instability is not addressed, insurers may choose not to sell in a Marketplace, leaving consumers without options for coverage and without the ability to access federal premium and cost-sharing subsidies.

While many of the factors contributing to Marketplace instability could be addressed through changes in federal policy, states also have levers to stabilize their Marketplaces and ensure health coverage is available. The American Hospital Association (AHA) worked with Manatt Health to identify a suite of state-level solutions to these issues. Given the unique characteristics of each state, there is no single option that would work for all states, and all of the options come with implementation hurdles. Among other considerations, we discuss which solutions may be more or less appropriate based on a state's characteristics.

In addition to this work, the AHA is simultaneously pursuing federal solutions that could improve the stability of the Marketplaces. Our recommendations for Congress and the Centers for Medicare & Medicaid Services can be accessed [here](#).

State-level Factors Contributing to Marketplace Instability

There are several state-level factors contributing to the lack of insurer participation in a market, including:

- **Demographic Characteristics:** Some Marketplace risk pools are not balanced because they have not attracted enough young or healthy people, or because a disproportionate number of high-need individuals have purchased coverage.
- **Lack of Payer Competition and Insurance Landscape:** Some areas have historically had a low level of competition among commercial payers, resulting in few affordable choices for individuals seeking Marketplace plans.
- **Failure to Expand Medicaid:** States that have not expanded Medicaid have more low-income and unhealthy individuals in their Marketplace pools, negatively impacting the Marketplace risk pool.
- **Continuation of Transitional Health Plans:** In markets where pre-ACA plans continue to be sold, more healthy individuals remain outside of the Marketplace risk pool.
- **Lack of State Priority on Improving Individual Market:** An adversarial political climate toward the ACA or health plans can decrease health plan and consumer participation and increase the likelihood of bare markets.
- **Poor Medicaid-Individual Market Coordination/Regulatory Alignment:** Limited coordination between Medicaid and the individual market decreases the success of the Marketplaces.

State Options for Providing Coverage in Instances of Bare Markets

While states cannot solve all of the conditions leading to market instability, they can address bare and at-risk markets. The solutions identified in this paper are divided into *four* categories:

1. Solutions that address high-risk enrollees, including through reinsurance programs and high risk pools.
2. Solutions that create or leverage existing state-sponsored insurance products, such as the state-employee health benefit program.
3. Solutions that leverage Medicaid, such as by incorporating requirements to sell marketplace products into Medicaid managed care contracts.
4. Solutions that expand the use of premium tax-credits on a county or state level.

Each option is assessed for its effect on access, affordability and health plan participation, as well as whether the solution provides a short-term or long-term fix.

State-Based Solutions Overview



Addressing High-Risk Enrollees

- Reinsurance programs
- High-risk pools



State-Sponsored Products

- Buy-in to D.C. Marketplace (or other SBM)
- Basic health plan
- Buy-in to state employee plan



Leveraging Medicaid

- Leverage Medicaid to offer a new public product
- Buy-in to Medicaid
- Expanding Medicaid
- Tying Medicaid managed care and Marketplace contracts (e.g., Nevada)
- Medicaid premium assistance (e.g., Arkansas model)



Other Solutions

- Tax credits for non-compliant plans

Introduction

More than 10 million individuals purchase health coverage through the Health Insurance Marketplaces established by the Affordable Care Act (ACA). Since their inception in 2014, the Marketplaces in some areas of the country have struggled to stabilize, with lower than anticipated enrollment, volatility in plan participation and significant premium rate increases in some years. In this paper, we explore the factors contributing to Marketplace instability, state policy levers to address these issues, and options for providing coverage when no plans are available through a Marketplace.

ACA Marketplaces

The Marketplaces were designed to address a number of challenges in the individual health insurance market that prevented many individuals from being able to purchase coverage at affordable rates or in some cases, at all. While some features of the ACA Marketplaces offer important consumer protections, they have had unintended negative consequences when combined with lower than anticipated enrollment among younger, healthier individuals.

Prior to implementation of the ACA, the individual health insurance market did not adequately serve individuals without access to coverage through an employer or public program. Most states allowed medical underwriting, which resulted in health plans denying coverage or charging higher premiums to individuals with pre-existing conditions or other health risks. Insurance was unaffordable for many until the ACA banned this practice and required health plans to cover a core set of essential health benefits (EHBs) at a standard rate for everyone. The ACA also created standardized plan options and required the development of online Marketplaces that would make

Bare and At-risk Markets: Role of Federal and State Governments

Federal solutions to market instability would likely be simpler to implement than state-by-state solutions. Federal policymakers could pursue options such as a national reinsurance program with robust funding to shore up the Marketplaces or provide default coverage options in instances of bare markets, such as by allowing consumers to buy into Medicare or use their tax credits for non-ACA compliant plans. Given the current political environment, these types of federal solutions may not be adopted in the near term, leaving states in the best position to address bare or at-risk markets, especially since bare markets will continue to emerge across the nation until market stability issues are addressed at the federal level. While states cannot remedy all of the underlying causes of market instability, they do have levers to ensure coverage remains available. For example, state insurance commissioners have been remarkably effective at persuading health plans to fill in the small number of bare markets that have cropped up this year.

it easier to shop for and enroll in these plans as well as apply for and enroll in Medicaid or the Children's Health Insurance Program (CHIP), if eligible.

While these changes have enabled more than 10 million individuals to gain insurance through the individual market¹, the new requirements resulted in higher premiums for the subset of young and healthy individuals who previously benefited from pre-ACA rating practices and were able to buy less comprehensive plans at cheaper rates. To help mitigate this change and ensure affordable coverage, the ACA included premium and cost-sharing subsidies for low- and middle-income individuals purchasing plans on the Marketplaces. The ACA also established the individual mandate to help encourage enrollment. These policies, however, combined with other factors described below, did not do enough to encourage young and healthy individuals to enroll. Compounded by inaccurate pricing of plans in the early years of ACA implementation, many health plans experienced losses on their Marketplace offerings, thus leading to stagnating or declining participation in many markets. Looking ahead, this trend is expected to continue – leading to fewer plan choices and higher Marketplace premiums on the plans that remain – unless policymakers at the state and federal levels make policy changes to stabilize the Marketplaces.

Uncertainties in the direction of federal policy emerged in 2017, creating a new wave of instability. Uncertainty around

federal enforcement of the individual mandate, continuation of cost-sharing reduction (CSR) payments and the potential repeal and replace of the ACA have exacerbated the challenges associated with achieving balanced risk pools. As a result, some health plans, particularly for-profit health plans, have exited Marketplaces in some or all of the counties where they previously sold plans. During the summer and into September of 2017, the number of counties with no health plans offering Marketplace plans² – so-called “bare counties” – reached a high of 40. As of Dec. 1, all counties have at least one health plan, but underlying concerns about the Marketplaces persist. The recent repeal of the individual mandate at the end of December 2017 may also impact Marketplace coverage.³ Ideally, counties would have more than one health plan; counties with just one health plan are one step away from becoming a bare market, and health plans that are the sole offer in a county hold significant leverage to raise premiums. We refer to markets likely to lose one or more health plans as “at-risk markets” for the remainder of this paper.

Why Does Marketplace Instability Matter?

The potential fall-out of market instability is serious for all stakeholders: without access to Marketplace plans, eligible individuals would not have access to premium tax credits or CSRs to help pay for care, which would have a downstream financial impact on hospitals, health systems and other providers of medical services in these areas. This paper will discuss a range of solutions that states can implement to address market instability and ensure people in bare or at-risk markets can access and afford insurance. **Not all solutions are optimal or even possible in every state; feasibility would depend on the state's demographics, current programs, infrastructure and political dynamics. The following analysis will describe the pros and cons of different options and discuss the optimal conditions for each solution.**

We note that when policymakers discuss instability in the market, they often refer to both the number of health plans as well as the premiums and costs consumers face in a market. In areas where premiums are high, consumers, particularly young and healthy consumers with fewer health care needs, may choose not to enroll. As discussed above, this can have a damaging effect on markets and perpetuates problems in the health care systems spurred by high uninsured rates (e.g., increased inappropriate emergency room usage). While our definitions of bare markets and at-risk markets do not touch on rising costs/premiums or affordability, we acknowledge where solutions improve or worsen these problems as well as issuer participation issues. States facing rapidly rising premiums may choose to explore some of these solutions, even if they are not grappling with bare or at risk counties.

Conditions Related to Bare Markets

There are several market conditions related to instances when no insurer will sell in a market. The following factors impact the risk pools, health care costs and health plan competition vital to the success of the Marketplaces.

Demographic Characteristics

Some Marketplace risk pools are not balanced because they have not attracted enough young or healthy people, or because a disproportionate number of high-need individuals have purchased coverage (“adverse selection”). Only 28 percent of Marketplace enrollees in 2014 were between the ages of 18-34, which is below the 40 percent many actuaries say is needed to stabilize premiums.⁴ This problem persists. Young, healthy individuals are more likely than older or sicker enrollees to forego coverage, making the calculation that it is less expensive to pay the individual mandate penalty and out-of-pocket health care costs than to pay premiums for insurance.⁵ As a result, the risk pools contain too few young, healthy individuals, and too many older, sicker individuals. This problem could continue to spiral as increased uncertainty leads health plans to raise premiums, which would cause more people to determine it is preferable to pay the penalty rather than purchase insurance.

Many insurance companies were also, at least initially, unable to adequately predict utilization; lack of experience with the Marketplace population resulted in health plans estimating that Marketplace consumers were healthier overall than was the case. In addition, some of the newly insured had pent up demand as they delayed care until they gained coverage. As a result of higher-than-expected costs, many plans incurred losses and either retreated from the Marketplaces or raised premiums. While health plans may create better mechanisms to predict costs over time, issues related to pent up demand and the health of the risk pool will remain unless more healthy individuals enroll.

Lack of Payer Competition and Insurance Landscape

Some areas have historically had a low level of competition among commercial payers, resulting in few affordable choices for individuals seeking Marketplace plans. Studies have shown that an increased number of health plans in a market is directly related to more competitive prices for commercial insurance. For example, adding one health plan reduces silver plan premiums by 1.2 percent for the average cost plan and 3.5 percent for the benchmark plan.⁶

Failure to Expand Medicaid

States that have failed to expand Medicaid have more low-income and unhealthy individuals in their Marketplace pools – individuals who would otherwise be covered under Medicaid. These individuals are less likely to have prior access to coverage and, therefore, more likely to have pent up demand for care.⁷ In fact, very low-income individuals, who are most at risk for cycling on and off of coverage due to changes in program eligibility, are also at risk for a vicious cycle of pent up demand as they lose and gain coverage. Together, these factors end up negatively impacting the Marketplace risk pool.⁸ As a result, health plans in non-expansion states often incur losses; some have subsequently left the market while others have stayed but raised premiums.

Continuation of Transitional Health Plans

“Grandfathering” and “grandmothering” policies also contributed to Marketplace instability.⁹ The federal government, in the early implementation period of the ACA, allowed individuals who preferred their current coverage to keep it, a policy that became known as “grandfathering.” State government also allowed individuals to stay on pre-ACA plans that did not comply with the post-2014 ACA regulations such as covering the 10 essential health benefits, known as “grandmothering.”¹⁰ As discussed above, people who purchased these plans prior to the ACA are likely healthier because they were subject to medical underwriting. As a result of maintaining their prior plan, these healthy individuals remain outside of the Marketplace risk pool. While this may seem insignificant, an example from Tennessee shows that it is not. A loophole in the ACA allowed the Farm Bureau to continue to offer non-compliant health plans. Because the plans are subject to underwriting and are not required to cover as many benefits, only relatively healthy individuals chose these plans. Approximately 55,000 Tennesseans chose to remain outside of the Marketplace and purchase coverage through the Farm Bureau. Excluding 55,000 relatively healthy Farm Bureau enrollees from the Tennessee Marketplace risk pool – which has current enrollment of approximately 230,000 – has had a significant effect on the overall health of the risk pool.¹¹

Lack of State Priority on Improving Individual Market

In addition to federal policy, state policies and priorities affect Marketplaces. An adversarial political climate toward the ACA or health plans can decrease health plan participation and increase the likelihood of bare markets. The importance of engagement was seen this year when several state insurance commissioners actively engaged with their insurers to find solutions for bare markets in states as varied as Ohio, Tennessee, Missouri, Nevada and Washington.

Another key area of state influence is marketing and outreach, particularly the amount of effort put into enrolling the young and healthy in the Marketplaces. During the first open enrollment period in Connecticut, the state raised awareness of the Marketplace and made it easier for individuals to enroll by holding enrollment fairs to bring potential customers and insurance brokers together on Saturday mornings. As a result, the Connecticut Marketplace doubled the enrollment goal for the state, more than 200,000 customers, during this time period.¹² In contrast, states that do not focus on enrolling individuals are likely to face adverse selection – only those expecting to be in need of health care services would seek out health insurance – damaging the Marketplace’s risk pool.

While state policies and attitudes toward the Marketplaces affect consumer behavior and health plan participation, non-governmental organizations also can have significant positive impact. For example, Florida had huge success enrolling individuals for the Marketplace despite legislation that did not support enrollment efforts, because the University of South Florida led an effort to enroll individuals.¹³

Poor Medicaid-Individual Market Coordination/Regulatory Alignment

Limited coordination between Medicaid and the individual market decreases the success of the Marketplaces. State Medicaid and insurance agencies often have different cultures, missions and priorities. Medicaid directors want to ensure that Medicaid delivers high-value care for vulnerable populations and they are concerned about state costs more than balanced risk pools. In contrast, insurance commissioners regulate health plans to ensure solvency and fair treatment of customers. They tend to focus on balanced risk pools and commercial pricing. Thus, these agencies are not naturally aligned absent a concerted effort by agency leadership to partner on areas of common ground, like network adequacy and payment reform.

Solutions

While states cannot solve all of the conditions leading to market instability, they can address bare and at-risk markets. The solutions identified in this paper can be divided into the following four categories:

- Solutions that address high-risk enrollees;
- Solutions that create state-sponsored insurance products;
- Solutions that leverage Medicaid; and
- Solutions that expand the use of premium tax-credits on a county or state level.

This paper evaluates eleven state policy options that span these categories, recognizing that each state will have a different combination of state resources and market issues. States have different populations, insurance infrastructures and Medicaid and Marketplace programs and, therefore, proposals that might be relatively easy to execute in one state might be impossible in another. By providing analyses of each solution, this paper can serve as a guide for states looking to ensure that all individuals can access and afford insurance.

We evaluate these policy options on a number of factors, discussed below. Some of our conclusions could change depending on the more detailed decisions a state might make in implementing a particular policy.

- **Effects on access and affordability (both premiums and cost-sharing).** Many, but not all, of the policies would encourage lower premiums and cost-sharing for at least some of the plans offered on the Marketplace.
- **Effects on health plan participation.** Some of the policies would make the Marketplaces more attractive to health plans, increasing participation and therefore competition.
- **Other notable policy effects.** Many of the policies would have other helpful policy effects in addition to those above, such as enhancing continuity of coverage, comprehensiveness of benefits and/or network adequacy.
- **Whether the solution provides a short-term or long-term fix.** Policies that are easier to establish (from both a state and federal perspective) and easier to unwind can be used to stabilize markets in the short-term. In fact, some of these policies are most likely to be palatable only when presented as short-term, rather than permanent, fixes. Other policies would be harder to establish, but could provide long-term stability.
- **The market conditions, policy vehicles and levels of difficulty needed for implementation.** Individual insurance market dynamics determine which policies are more or less viable for addressing the issues a state or county is facing. Implementation also requires various levels of difficulty and different state and federal policy vehicles.

Key for Policy Evaluation

Affordability

- ⊕ Policy would lower premiums/cost sharing
- ⊖ Policy would raise premiums/cost sharing
- ⊕/⊖ Policy could lower or raise premiums, depending on market dynamics in the state, how the policy is implemented and/or have effects that vary for different groups
- Policy does not affect premiums/cost-sharing

Health Plan Participation

- ⊕ Policy would incentivize issuers to participate in the Marketplace
- ⊖ Policy would disincentivize issuers from participating in the Marketplace
- ⊕/⊖ Policy could incentivize issuers to participate in the Marketplace, depending on market dynamics in the state and/or how the policy is implemented
- Policy does not directly affect issuer participation

Short Term

- ✓ Policy can be implemented quickly
- Policy cannot be implemented quickly

Long Term

- ✓ Policy can provide long-term stability
- Policy cannot provide long-term stability

Can Target Bare or At-risk Counties

- ✓ Policy can be targeted to bare or at-risk counties, as opposed to needing to be implemented statewide
- Policy cannot be targeted to bare or at-risk counties

After describing the state policy options, we conclude with a discussion of the effects of these solutions on hospitals and health systems.

Addressing High-risk Enrollees: Reinsurance

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Moderate	+		+	✓	✓	
Necessary Conditions/Notes						
Easier if state already has some structure in place to administer the program						

Overview

Reinsurance is a mechanism for spreading the costs of expensive claims by pooling them together and paying for them through a separate financing system, allowing health plans to exclude those costs from their standard premiums. To reduce premiums, the separate financing system must include funding from outside the individual market. Without an external subsidy, reinsurance simply redistributes costs among the insurers in the individual market but does not reduce premiums overall. States are able to develop reinsurance programs using state financing, which can be supplemented with federal support through 1332 waivers. A statewide reinsurance program is one of the more effective policies for preventing bare markets and stabilizing at-risk markets. However, reinsurance programs can take time to implement, particularly to identify sufficient funding.

States that have experienced high premium rate increases or have bare or at-risk markets could benefit from implementing a reinsurance program. Assuming the financing for the reinsurance came from an external source (e.g., state financing through a tax increase), a reinsurance program would alleviate health plan risk, encouraging health plan participation and decreasing Marketplace premiums.

A reinsurance program would not solve all Marketplace stability issues, however. Reinsurance could reduce health plan incentives to manage high-cost cases depending on the structure of the program. Reinsurance programs typically try to control for this by keeping health plans partially responsible for claims costs, such as putting a limit on the amount that is subject to reinsurance, or providing incentives to keep overall costs down.

Implementation

Reinsurance programs require moderate effort including state legislative authority and broad-based funding. Establishing the proper infrastructure to manage the program is challenging and likely time-intensive. States best equipped to implement this policy are those that have an existing financing mechanism that could be used to administer the program. States able to fund a reinsurance program independently can do so without federal action or approval. However, a state may apply for a 1332 waiver to leverage savings to the federal government as the federal government would have to pay less for tax credits as premiums decrease.

Federal and State Reinsurance Programs

The ACA established a transitional and temporary (January 2014-December 2016) reinsurance program to stabilize individual market premiums in the initial years. The program was financed by broad assessments on most forms of health coverage, including insured and self-insured group coverage to generate a subsidy to the individual market. Those contributions were used by the federal government to pay health plans a percentage of the claims incurred by high-cost enrollees in the individual market. Total contributions over the life of the program were \$25 billion.¹⁴

Since the sunset of the federal transitional reinsurance program, four states have established state-financed reinsurance programs and have filed Section 1332 waivers that make their programs contingent on receiving federal pass-through funding to recoup the federal savings on tax credits attributable to their reinsurance programs. Alaska's¹⁵ program prevented a market collapse in 2017 and the state recently received approval for its waiver, which is projected to save the federal government more than \$300 over the next five years. Minnesota,¹⁶ and Oregon¹⁷ also had similar waivers approved, all of which include actuarial projections showing significant premium reductions attributable to their reinsurance programs.

Addressing High-risk Enrollees: High-risk Pools

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Difficult	+/-		+	✓	✓	✓
Necessary Conditions/Notes						
Requires a change in federal law to expand to additional populations						

Overview

A high-risk pool is a mechanism for segregating unhealthy enrollees into a separate program to remove the cost of caring for these individuals from “standard” premiums, in this case, Marketplace premiums. High-risk pools typically have separate rules concerning allowable policies and enrollee benefits, primarily to manage the high costs associated with this population. For example, high-risk pools often charge enrollees higher premiums and may impose policies such as enrollment waiting periods and caps on certain benefits, both of which inhibit the ability of people with high health needs to gain access to care.

High risk pools accomplish the same goal as reinsurance – financing the costs of high risk enrollees – but unlike reinsurance, high-risk enrollees would be kept outside of the Marketplace risk pool. This would cause Marketplace premiums to decrease but would require a solution to cover the higher costs for high-risk individuals. In previous state high-risk pools, the higher costs were typically covered by a combination of higher premiums on enrollees, insurer assessments and state subsidies.

States with experience running successful high-risk pools are best equipped to reestablish these programs as they already have the necessary infrastructure to manage them. States that wish to establish a high-risk pool could choose to do so either as a long-term solution or as a short-term fix in bare or at-risk markets while other longer-term solutions are developed. Some form of a high-risk pool targeted at bare counties may provide a politically feasible solution, but would require a change in federal law to be a workable solution.

Implementation

States choosing to establish or reestablish a high-risk pool would be required to waive guaranteed issue, the ACA provision requiring health plans to offer coverage to all eligible applicants at standard rates (i.e., no rating for health conditions). This provision cannot currently be waived under Section 1332, meaning that states can only maintain high-risk pools for enrollees who remain in pre-ACA high risk pools by choice and enrollees who are not eligible for Marketplace coverage.

States would find implementing the policy difficult as it would require new legislation and financing. Financing is generally the biggest challenge and typically leads to rationing of benefits since high-risk enrollees are very expensive. In addition, to keep costs down, a state could decide to set provider rates lower than the commercial rates for the high-risk pool.

State High-risk Pools: Wisconsin

Prior to the ACA, 35 states operated high-risk pools that covered 226,615 individuals. The Wisconsin Health Insurance Risk-Sharing Plan (HIRSP), Wisconsin’s high-risk pool, provided medical and prescription drug coverage for individuals who were shut out of the commercial health insurance market because of high costs or because they had certain medical conditions. Leading up to implementation of the ACA, the program covered approximately 22,000 individuals.

The HIRSP was funded by a combination of enrollee premiums, a health insurer fee, reduced reimbursement to providers and a small amount of federal grant funds. The program cost nearly \$180 million annually to operate, and for several years, the program operated at a loss.¹⁸ Enrollees could choose between plans with different premium and cost-sharing structures, with deductibles ranging from \$1,000 to \$7,500. Individuals in households earning less than \$34,000 were eligible for subsidies to help offset these costs; in 2012, 27 percent of enrollees were eligible. In order to meet rising costs, the state increased the premiums by 15 percent in July 2011 and by another 9 percent six months later in January 2012.

The state closed the HIRSP after full implementation of the ACA coverage programs in 2014.

State-sponsored Products: Buy-in to D.C. Marketplace

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Variable	+/-	+/-		✓		✓
Necessary Conditions/Notes						
Requires close collaboration among states; may be easier to implement as a short term fix to reduce concerns about policy implications but would bring logistical challenges						

Overview

A state with bare or at-risk counties could choose to leverage the District of Columbia (D.C.) Marketplace or some other state-based Marketplace (as opposed to one run through the federal infrastructure of www.HealthCare.gov) to offer its individual products under terms agreed to by the two parties. The D.C. Marketplace is particularly well-equipped for this as it already offers plans nationally in response to the requirement that it serve all Congressional staff, although that coverage is group coverage and it would take some work to make individual products available in a bare or at-risk county. Ultimately, this strategy is workable as long as the health plan has a provider network in the target counties, meaning that a state could leverage any willing Marketplace with national or regional carriers that have provider networks in the target counties.

Leveraging another state's Marketplace is truly a bare or at-risk county fix – it does not directly impact any of the underlying issues with market instability, such as rising premiums or health plan participation, it just provides access to a plan when there is not another option. States in which Marketplace carriers have strong networks and alignment between Marketplace and state regulatory and business issues requiring interstate coordination (e.g., product pricing) are best equipped to implement this policy.

Implementation

A state interested in leveraging another state's Marketplace would need to negotiate with that Marketplace to determine the parameters of the arrangement. Federal government approval would not be needed as long as the coverage offered meets federal standards.¹⁹

The level of difficulty required to establish this relationship would vary, depending on how easily state-to-state coordination issues could be agreed upon. For example, states would need to decide whether coverage offered would be required to meet the specific state's benefit requirements and network adequacy rules. Such an arrangement could also raise challenging issues related to state control if regulatory disputes arose. For example, decisions would need to be made about which state would handle enrollee complaints or health plan misconduct issues.

State-sponsored Products: Basic Health Plan

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Moderate	+	+	-		✓	
Necessary Conditions/Notes						
May take time to implement; requires federal approval but not a waiver so faster relative to other options						

Overview

The ACA created an option for states to establish a Basic Health Program (BHP) to provide coverage for individuals with incomes between 133 percent and 200 percent of poverty, who do not qualify for Medicaid.²⁰ A BHP program is similar to Medicaid managed care in that it is a coverage program designed by the state, but administered through a private health plan. States choosing to implement this option are able to leverage their purchasing power to create less expensive plans than the Marketplace plans, while still covering at least the 10 essential health benefits. While these plans are state-run, the federal government contributes 95 percent of the tax credit and CSR payments that it would have paid had the BHP enrollees purchased Marketplace coverage. To date, two states, New York and Minnesota, have implemented this program. In these states, individuals who qualify for the BHP are required to enroll to access their ACA subsidies and do not have the option of enrolling in a QHP with federal subsidies. New York estimates that approximately 90 percent of BHP spending is paid for by the federal government, with state and local funds supporting the remainder.²¹ (Note: The Trump Administration's recent decision to eliminate CSR payments will affect BHP payments as well.)

States could choose to implement a BHP for lower-income individuals (133 percent to 200 percent of poverty) themselves, or, alternatively, they could work with another state to open enrollment into that state's BHP. The latter may be an option for states that cannot operate their own BHP for political or administrative reasons. Either option would make the most sense to implement as a statewide solution, as opposed to in one or several bare counties. Therefore, these options are best suited to states where the bare or at-risk markets are widespread. In addition, this would only provide coverage for a portion of the population who would be otherwise eligible for marketplace subsidies. Therefore, this solution is best-suited in conjunction with another coverage option that would be available to individuals who do not qualify for the BHP program unless the state seeks a waiver to change the BHP eligibility rules.

Implementation

While states must apply for and receive federal approval to implement a BHP, the type of approval (sec. 1331) is less complicated than applying for a federal waiver. The challenge to implement this option is more likely to reside at the state political level, as implementation would require significant state investment to fund the BHP and to invest in the infrastructure needed to administer it. Implementation would also require coordination between the state's Medicaid agency and Marketplace or insurance agency.

New York's Basic Health Plan

New York's Basic Health Plan, known as the "Essential Plan," was approved in 2015²² for Jan. 1, 2016 enrollment. The Essential Plan is available for individuals with incomes between 138-200 percent of poverty and lawfully present non-citizens with incomes lower than 138 percent of poverty who may not enroll in Medicaid due to their immigration status.²³ Plans are offered by 14 private health plans via New York's Marketplace. All Essential Plans have no deductible and save individuals on average \$1,100 compared to a qualified health plan sold on the marketplaces.²⁴

Despite enrollment growth of 75 percent since January 2016, the Essential Plan saved New York's Medicaid program over \$1 billion in its first year and was projected to save an additional \$635 million in state fiscal year 2016-2017.²⁵ The majority of savings are attributable to new federal contributions covering lawful non-citizens, a population previously covered wholly by state-funded Medicaid.

State-sponsored Products: Buy-in To State Employee Plan

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Moderate	+/-	+/-	-	✓		✓
Necessary Conditions/Notes						
May be easier to implement as a short term fix and/or only for bare or at-risk counties in order to reduce concerns from state employees that the cost of their coverage would increase						

Overview

A state could allow individual market consumers in bare/at-risk counties or statewide to enroll in the state employee health benefit program.²⁶ With federal approval, individuals who qualify could apply their premium tax credit and the anticipated value of any CSRs towards the cost of coverage. States also may need to modify the benefit plan in order to meet Marketplace regulations or gain additional federal approval to permit consumers to use tax credits and CSRs to purchase plans with benefit packages that do not comply with ACA requirements.

States with employee health benefits that are stable and not experiencing funding or other challenges are most likely to succeed in implementing this option. This is especially important as the cost of the state employee health plan could rise if the Marketplace population brings less healthy lives into the risk pool. As a result, states may encounter political resistance implementing these plans. Health plans participating in the state employee benefit plan may also choose to leave if the risk pool becomes unmanageable.

The effect of this policy on consumer affordability and comprehensiveness of benefits depends on implementation. In states where the employee plans are more comprehensive than Marketplace plans, state plan enrollees may have lower cost-sharing options and more benefits. Alternatively, if the state employer plan offers Marketplace coverage, the cost-sharing structure would stay the same.

Implementation

Implementing this option would require both state and federal action, and is therefore moderately difficult. If the Marketplace enrollees were added to the state employee plan risk pool, states would need to pass legislation allowing non-state employees to buy into state coverage and overcome state employee concerns about the stability of the state risk pool.²⁷ States also may need to increase administrative capabilities if they decide to modify the benefit package, cost sharing or other benefit features for the buy-in option to accommodate Marketplace-eligible enrollees. States may need 1332 waiver approval to offer employee plans that do not comply with ACA requirements.

Kentucky's State Employer Buy-in

In 1994, Kentucky passed a statute²⁸ that would allow individuals to buy-in to the self-insured health plan for state employees and retirees. This program, called "CommonHealth of Kentucky," lasted for several years. In 1997 and 1998, 697 and 605 people purchased this insurance, respectively. However, due to adverse selection, the 2 percent of individuals enrolled via the buy-in option represented 4 percent of the claims. The state lost approximately \$1.4 million annually on this population. As a result, the CommonHealth program, along with much of the rest of Kentucky's reform plan, was abandoned after several years.²⁹

Leveraging Medicaid: Leveraging Medicaid to Offer a New Public Product

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Difficult	+	+	+/-		✓	
Necessary Conditions/Notes						
Would require significant investment to develop the new product, so better if a permanent solution rather than a short term fix						

Overview

States could design a new public coverage product, which would be offered on the individual Marketplaces, by leveraging their Medicaid managed care organizations (MCOs) and infrastructure. This option is best suited to states with mature Medicaid managed care programs and robust participation of MCOs. States could choose to sell such a product statewide or solely in bare or at-risk markets. While selling only in bare or at-risk counties may be more politically viable, this option would require significant work for a short-term, county-level fix.

Offering a new public product on the Marketplace would drive health plan competition, as the public product would likely be more affordable than other plans being sold as a result of MCOs leveraging their Medicaid provider networks and reimbursement levels (which are generally lower than commercial level reimbursement in most states). This would lead to lower premiums and consumer out-of-pocket costs on the Marketplace. However, offering such a plan also could dampen new health plans' interest in entering the market, since competition would be stiffer.

Implementation

Though this policy does not necessarily require federal approval, state dynamics may make this policy difficult to implement. Many states would face internal political opposition related to creating a product that resembles a “public option” with Medicaid provider reimbursement levels. Without political will and strong leadership, passing the necessary state legislation may be difficult. If a state were able to pass legislation authorizing a public product, state agencies would be required to work collaboratively to design and implement such a product consistent with state law and Marketplace standards. If the state chose to offer a product that did not meet Marketplace standards, the state would need to apply for a federal 1332 waiver.

Minnesota's Experience: Leveraging Medicaid to Offer a New Public Product

In early 2017, Minnesota's legislature introduced a bill³⁰ requiring the state to seek a federal 1332 waiver permitting an expansion of the state's Basic Health Program, MinnesotaCare, to higher income individuals. The bill aimed to increase access to doctors across the state, improve coverage options for rural Minnesotans and introduce a low-cost option on the state's Marketplace to compete with other Marketplace plans. Under the proposal, Minnesotans with income above 200 percent of poverty (i.e., ineligible for Medicaid or MinnesotaCare, the State's Basic Health Program) would be able to purchase a MinnesotaCare plan offered on the state's Marketplace.³¹ Enrollees would pay the full premium cost (approximately \$469 per person in 2018, 12 percent less than the average statewide premium) and would be still eligible for federal premium tax credits.

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Difficult	+	+	-	✓	✓	✓
Necessary Conditions/Notes						
Significant level of state coordination and federal approval needed						

Overview

With federal approval, states could permit individuals with incomes above Medicaid eligibility levels to buy-in to a Medicaid benefit package using ACA tax credits. Medicaid buy-in proposals have emerged in Nevada and recently have been proposed by Senator Schatz of Hawaii, and these proposals are similar in their detail and specificity. Crafting a Medicaid buy-in would require that states make a series of complex policy decisions, including:

- **Covered Benefits.** The Medicaid benefit package for the buy-in program would likely require narrower benefits than “standard” Medicaid, perhaps eliminating some typical Medicaid benefits such as non-emergency medical transportation and long-term care services and supports. These changes would better align the benefit with commercial benefits and drive more affordable premiums.
- **Cost-sharing.** The buy-in would likely require higher cost-sharing (deductibles, co-payments) than “standard” Medicaid benefits to more closely align with commercial coverage and to make premiums affordable for consumers.
- **Provider Reimbursement.** States would be required to determine the level of provider reimbursement for providers serving buy-in enrollees – whether reimbursement would be set at or higher than current Medicaid levels, and whether these higher reimbursement levels would apply to all Medicaid enrollees, or just the buy-in population.
- **Statewideness.** States could implement this statewide or at the county-level as a solution for bare or at-risk counties.
- **Federal Approval.** The Medicaid buy-in would likely require an 1115 waiver for the state to craft a tailored benefit package, as described above, and to implement in a less than statewide geography. This would require states to seek and receive CMS flexibility to waive key Medicaid requirements.

This strategy would work best in states that expanded Medicaid and have Medicaid managed care plans to administer the buy-in. Individuals eligible for subsidized insurance in the Marketplace are more similar to the Medicaid expansion population, and states that expanded Medicaid would be more familiar with serving this population. Additionally, if a state has not expanded Medicaid, it could lead to the politically controversial and confusing situation in which some individuals with higher incomes (100-400 percent FPL) would be in the Medicaid program, but lower income individuals (<100 percent FPL) would not. Medicaid managed care programs allow states to better predict costs, and these organizations already have contracts with provider networks and experience administering Medicaid programs.

This policy would address both consumer access and affordability issues. Additionally for individuals whose incomes shift between Medicaid and Marketplace eligibility, this option could facilitate continuity of coverage by enabling an individual to stay in the same or similar plan, including the provider network.

Implementation

Implementing a Medicaid buy-in would require federal approval, close collaboration of state agencies and political will to implement. At the federal level, states would need an 1115 waiver to make modifications to the Medicaid benefit and a 1332 waiver to permit the use of tax credits toward the buy-in. At the state level, there may be internal political opposition related to a buy-in, especially if provider reimbursement levels are lower than Marketplace plans or the policy increases state Medicaid costs.

Leveraging Medicaid: Using Medicaid Waivers to Expand Coverage

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Difficult	+	+	-	✓		✓
Necessary Conditions/Notes						
Significant level of state coordination and federal approval needed						

Overview

States could leverage flexibility through 1115 waivers to expand Medicaid eligibility levels on a temporary or permanent basis in certain counties, or use Medicaid dollars to “wrap around” premium tax credits to make Marketplace coverage more affordable in all or a subset of markets, thus increasing Marketplace enrollment and potentially attracting more plan participation. These strategies would require state legislation and federal approval and may face political opposition.

This plan is most suited to states that have already expanded Medicaid, and it would increase state Medicaid costs. Therefore, this may be a better solution for bare or at-risk markets. However, a temporary expansion would not address the fundamental issues destabilizing the Marketplace, nor would it attract new issuers to the bare or at-risk county or counties.

Using Medicaid dollars to wrap Marketplace subsidies is a broader based strategy that could be implemented statewide or in counties with no health plan or just one health plan, as a mechanism to encourage enrollment and therefore, health plan participation.

Both of these waiver options would result in consumers having access to plans with lower premiums and out-of-pocket costs.

Implementation

These Medicaid waiver options come with a significant degree of difficulty to implement. They require authorizing state legislation, appropriated state funds for the new Medicaid expenditures and federal approval through an 1115 waiver. Implementing this plan also would require significant political buy-in to overcome opposition related to expanding Medicaid.

Leveraging Medicaid: Tying Medicaid Managed Care and Marketplace Contracts

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Moderate	+		+		✓	✓
Necessary Conditions/Notes						
<ul style="list-style-type: none"> • State must have Medicaid managed care • Timing is important to ensure contract terms can be updated before open enrollment/new MCO cycle • Significant level of state coordination needed 						

Overview

States could require health plans participating in Medicaid managed care contracts to participate in the Marketplace, or alternatively give favorable treatment to those issuers that do so to incentivize Marketplace participation. This policy could be applied uniformly to all carriers, or could only apply to health plans that meet certain size thresholds (e.g. percent of market share, number of Medicaid beneficiaries) in order not to discourage smaller health plans from offering Medicaid plans.

This strategy would only work in states with robust Medicaid managed care participation where the Medicaid business is profitable enough for health plans that they would not want to lose these contracts despite the risk of participating in the Marketplaces. States that implement this policy would need to be confident in this calculus as health plans could decide to pull out of the Medicaid market in response to such a mandate.

Tying Medicaid managed care contracts to participation in the Marketplaces has the potential to lower premiums and increase Marketplace participation. If MCOs price lower than private plans, consumers could benefit from lower premiums. Additionally, tying could not only incentivize health plans to remain in the Marketplaces, but also could increase competition by bringing additional health plans into the Marketplaces if the MCOs did not already participate.

Implementation

Because this policy does not require federal approval, it is easier to implement than many of the other options that have been described here.³² However, tying would still require significant coordination and, potentially, legislation at the state level. This policy would also require political buy-in from the legislature and/or governor to promote the policy in the face of potential opposition from health plans and to enable coordination and agreement among state agencies.

Nevada's Experience: Tying Medicaid Managed Care and Marketplace Contracts

Until recently, Nevada required all Medicaid managed care plans to provide at least one silver-rated and one gold-rated qualified health plan on the state's Marketplace, the Nevada Health Link. The policy was instituted "to minimize adverse impacts and improve continuity of care"³³ for Nevadans who moved between Medicaid, CHIP and coverage on Nevada Health Link, and increase Nevada Health Link coverage options. The requirement was executed via Nevada's Medicaid managed care plan procurement process, and failure to comply resulted in bid disqualification.

In Nevada's 2016 Request for Proposals for Medicaid managed care organizations, the state took another approach. They eliminated the Nevada Health Link coverage requirement; however, plans that indicated they would offer coverage on the Nevada Health Link were awarded additional points in the contract evaluation process.³⁴ All selected plans, except one, stated in their application that they anticipated offering plans on Nevada Health Link, protecting Nevadans who might be affected by carrier exits and lack of health plan choice in their counties.

Leveraging Medicaid: Medicaid Premium Assistance

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Difficult	+	+	+		✓	
Necessary Conditions/Notes						
Requires federal approval which could take time and if implemented might unravel the market						

Overview

State Medicaid agencies could implement a premium assistance model through which they purchase Marketplace coverage for Medicaid beneficiaries. The state would pay all or most of the consumer cost-sharing obligation and ensure access to Medicaid benefits not covered by the Marketplace plan. Implementing this policy would expand the size of the Marketplace risk pool, likely making the Marketplaces more stable – encouraging greater health plan participation and consumer affordability. This policy could be tailored to narrow beneficiary participation (e.g., limited to a subset of Medicaid enrollees, like new adults) and plan participation (e.g., limited to a subset of Marketplace plans like the two lowest cost silver plans).

This policy would work best in states that expanded Medicaid and have a critical mass of non-aged, non-disabled Medicaid beneficiaries because it would be best for the policy to be limited to a healthier adult population. This policy is also best suited for states that are primarily fee-for-service because transitioning away from a managed care model may prove politically and administratively complex. This policy requires significant coordination between the state's Medicaid and insurance agencies as well as having an active/progressive insurance regulator willing to promote the model and encourage new market entrants. Notably, some state experience suggests that Medicaid beneficiaries may be less healthy than Marketplace enrollees, and as such, higher cost. States would have to balance the benefits and risks of a bigger risk pool against bringing in somewhat less healthy enrollees.

Implementation

Implementing a Medicaid premium assistance program would be difficult as it would require both a change in state legislation and federal approval. At the state level, political will may be hard to build as this would likely increase the state's Medicaid costs because of the higher cost of commercial coverage relative to Medicaid in most states, which would generate higher Marketplace premium costs as compared to fee-for-service Medicaid. Implementing a Medicaid premium assistance program would also be operationally difficult. The state Medicaid and insurance agencies would need to work together and with Marketplace health plans to design Marketplace products that comply with Medicaid rules. States relying on the www.HealthCare.gov platform would need to work with Department of Health and Human Services to alter shopping/enrollment functionality to enroll Medicaid beneficiaries in the Marketplace or build a state-based shopping/enrollment portal.

Arkansas Medicaid Premium Assistance Policy

Arkansas expanded Medicaid to adults at or below 138 percent of poverty via a Section 1115 demonstration in 2013.³⁵ The demonstration, known as the “Arkansas Health Care Independence Program,” allowed the state's newly eligible adults to enroll in coverage on the state's Marketplace with the state paying for that coverage through Medicaid premium assistance. The premium assistance policy moved approximately 225,000 individuals onto the state's individual market, which increased the size of Arkansas' Marketplace risk pool, ultimately lowering enrollee premiums and stabilizing the Marketplace. Arkansas renewed³⁶ the demonstration (now known as ‘Arkansas Works’) in January 2017, adding a mandatory employer-sponsored insurance program and instituting premiums for enrollees with income over 100 percent FPL.

Other Solutions: Tax Credits for Non-Compliant Plans

Level of Difficulty	Affordability		Health Plan Participation	Short Term	Long Term	Can Target Bare or At-risk Counties
	Premiums	Cost Sharing				
Moderate	+	-	+	✓		✓
Necessary Conditions/Notes						
<ul style="list-style-type: none"> Requires federal approval which could take time If implemented, could unravel the market 						

Overview

With federal approval, states could allow eligible individuals to use their premium tax credits on non-ACA compliant plans. States could require plans that are purchased with tax credits to comply with ACA standards, even if they are sold off-Marketplace. Alternatively, states could choose new standards for tax credit-eligible plans. These could be minor changes, such as allowing plans that do not meet the state's network adequacy standards to provide coverage in a bare county, or more major changes, such as no longer requiring coverage of some of the essential health benefits.

This policy would be best-implemented as a short-term fix in instances where there are no other options for Marketplace coverage, as it would not address the underlying issues with the market. In fact, it could be counterproductive in the long-term. By loosening regulations on plans and/or reducing the comprehensiveness of benefits, health plans would be able to offer less expensive plans off-Marketplace, which would be attractive to young and healthy consumers. This would further deteriorate the Marketplace risk pool, continuing to disincentivize issuer participation and raise premiums. In addition, unless the state is able to coordinate an advanced payment of the tax credits to the health plans offering non-compliant plans, consumers would only be able to access their tax credit at tax filing, not at the time of premium payment, making coverage unaffordable under this option for many lower income individuals.

Implementation

While this policy would require federal approval through a 1332 waiver or non-enforcement of tax credit requirements, it may not be as difficult as some of the other options requiring federal approval as this policy is consistent with the Trump Administration and Congressional leadership's policy position. The biggest challenge in implementation would be if the state sought to make the tax credits available in advance in order to immediately lower a consumer's premium payment. Providing tax credits to non-Marketplace plans in advance would require coordination between the federal government, state government and plans to determine the appropriate tax credit amount and establish a mechanism for paying the plans the advance payments each month.

Health care coverage is critical to patient access to care and supports hospitals' and health systems' abilities to manage the care of members of their communities. How that coverage is structured and financed, however, can have implications for providers. Most of the options identified in this paper will require that the state pursue an 1115 or 1332 waiver or both. States must engage with stakeholders, such as hospitals and health systems, as part of the waiver development process. In evaluating coverage proposals, hospitals and health systems will want to consider:

- **The provider rates that would be used and how those rates support or challenge hospitals' and health systems' ability to sustain health care services in their communities.** Historically, Medicaid pays providers below costs,³⁷ and it is possible that states would leverage Medicaid reimbursement rates in any coverage plan that either directly leverages Medicaid or is managed by the state.
- **How coverage will be financed, including whether an additional fee or tax will be levied on providers or if the program relies on reductions in provider reimbursement.** States will need to look at a variety of financing mechanisms to support options to stabilize insurance markets and provide alternative coverage options. States could consider a tax on providers as one source of financing or reductions to provider payment rates.
- **Whether the coverage will be comprehensive and the impact any changes in benefit package may have on patients' ability to access care.** If solutions turn toward approaches that allow for reduced benefits, including those that do not meet the ACA's essential health benefit standards, hospitals and health plans are likely to encounter more patients without adequate coverage for the care needed. Patients may be unable to afford necessary care and, therefore, avoid seeing a provider until the situation exacerbates. Hospitals and health systems may need to review their charity care policies or other mechanisms to help patients pay for care that is no longer covered by their health plan.
- **How patient cost-sharing will be structured and the potential impact on utilization, uncompensated care and bad debt.** All these solutions are likely to have an impact on patient cost-sharing and, therefore, hospital utilization, uncompensated care and bad debt. Hospitals and health systems will need to understand their current markets and determine if these solutions would improve coverage and provide an adequate level of insurance. For example, hospitals and health systems report decreased utilization and increases in bad debt for patients who are covered through high-deductible health plans.

Affordability Related Terms

- **Affordability:** Total cost of health care for patient is within the financial means of the patient.
- **Co-Insurance:** A percentage of the total cost of service paid by an insured patient for a covered service. The health plan pays the rest of the cost to the provider. For example, if a covered service is \$100 and the co-insurance is 15 percent, the patient would pay \$15.
- **Co-Pays:** Fixed amount paid by an insured patient for a covered service after the patient pays the deductible. The health plan pays the rest of the cost to the provider.
- **Cost-Sharing:** The amount or percentage a consumer is expected to pay for a covered health care service (i.e., co-pay, co-insurance, deductibles).
- **Deductibles:** The amount a consumer must pay before the insurance plan starts to pay for most benefits.
- **Out-of-Pocket Costs:** The health care costs paid by a consumer. Includes co-insurance, co-pays, and deductibles. Maximum out-of-pocket caps (limits on out-of-pocket costs) do not include premiums.
- **Premium:** Monthly amount a person pays for health insurance.

General Insurance Terms

- **Adverse Selection:** Tendency for high-risk or high-cost individuals to obtain insurance over healthier or lower risk individuals. This makes the insurance pool unhealthier and, therefore, more costly.
- **Benefit Package:** Services covered by an insurance plan.
- **Fee-For-Service (FFS):** A payment model in which providers receive payment for each service provided.
- **High-risk Enrollees:** Enrollees that are unhealthy and therefore increase the risk and expected cost for a group of insured individuals. For example, enrollees with pre-existing conditions such as diabetes or cancer.
- **Health Plan Participation:** Number of health plans participating in a particular rating area, usually a county.
- **Health Plan:** The entity that provides coverage to consumers through the Marketplaces.
- **Network Adequacy:** Ability of a health plan (e.g. insurance) to provide enough in-network providers for individuals to receive timely and sufficient access to care. Governed by state and federal requirements for Medicaid and Marketplace coverage.
- **Risk Pool:** Individuals collectively covered by a health plan allowing risk to be distributed across the group.
- **State Mandate:** State laws that require health plans to cover specific health benefits and services.

Hospital Consideration Terms

- **Continuity of Care:** Access to the same health care benefits and providers over time. In this context, refers to the continuity of benefits and providers as people cross the income threshold between Medicaid and the individual market.

- **Provider Network:** Doctors and hospitals an insured person is able to access through their insurance plan. If a person accesses services “out-of-network,” those services may have higher cost-sharing, or may not be covered.
- **Provider Tax:** A tax or fee imposed by the state on providers or certain classes of providers (e.g., on inpatient hospital services).
- **Reimbursement Levels:** Amount of money providers are reimbursed for healthcare services. In many states, Medicaid reimburses below cost while private health plans reimburse above cost.
- **Scope of Coverage:** Range of services covered by an insurance plan.

Marketplace Terms

- **Advanced Premium Tax Credit (APTC):** A tax credit that lowers premiums for qualifying individuals that purchase health insurance plans on the Marketplace.
- **Cost Sharing Reductions (CSR):** Subsidies that the federal government pays to health plans for them to provide lower deductibles, co-pays and co-insurance for qualifying individuals purchasing silver plans on the Marketplaces.
- **Federal Poverty Level (FPL):** A measurement of income. Federal poverty level is used to determine eligibility for Medicaid and for tax credits on the Marketplaces.
- **Grandfathered Health Plan:** An individual health insurance policy purchased on or before March 23, 2010. These plans weren’t sold through the Marketplace but by insurance companies, agents or brokers. They may not include some rights and protections provided under the ACA.
- **Grandmothered:** An individual health insurance policy purchased on or before January 2014. These policies include ACA reforms that took effect before 2014 but not after.
- **Marketplace:** Shorthand for the “Health Insurance Marketplace,” an online shopping and enrollment service created by the ACA. Each state has its own Marketplace; some are managed by the federal government and some are state-run.
- **Federally-Facilitated Marketplace (FFM):** A state Marketplace operated by the federal government.
- **State-Based Marketplace (SBM):** A state Marketplace operated by a state, rather than the federal government.
- **Rating Area:** Geographic area for which a health plan participating in the individual market must provide the same plan at the same price. Often defined at the county-level.
- **Stability Fund:** Funding for market stabilization that has been discussed during repeal and replace negotiations.

Types of Insurance Plans

- **Basic Health Plan (BHP):** Health plans for low income individuals offered by the state. Plans must be at least as affordable as those offered on the Marketplace and cover the ten Essential Health Benefits.
- **Co-Operative (CO-OP):** Local, non-profit health insurance companies.

- **High-deductible Health Plan (HDHP):** An insurance plan that has a low premium but high deductible that a consumer must pay before the insurance covers most services.
- **Medicaid Managed Care (MMC):** Private insurance companies that contract with the state to provide coverage for Medicaid enrollees.
- **Medicaid State Plan:** Each state implements Medicaid differently and is therefore required to file a plan listing eligibility standards and services provided. CMS reviews state plans and provides guidance.
- **Qualifying Health Plan (QHP):** Plans that are ACA-compliant (e.g., provide essential health benefits, meet affordability requirements) and are sold on the Marketplaces (i.e., FFM or SBM).

Waivers/Legal Regulations

- **1115 Waiver:** Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) authority to waive provisions of Medicaid requirements and allow a state to use federal Medicaid funds in ways that are not otherwise allowed under federal rules. The authority is provided at the Secretary's discretion for demonstration projects that the Secretary determines promote Medicaid program objectives. There are comprehensive 1115 waivers that allow broad changes in eligibility, benefits, cost sharing and provider payments. There are more narrow 1115 waivers that focus on specific services and populations.
- **1332 Waiver:** Section 1332 of the ACA permits a state to apply for a State Innovation Waiver to pursue innovative strategies for providing access to high quality, affordable health insurance while retaining the basic protections of the ACA.
- **Sec. 1331/Basic Health Plan:** Section of the ACA that allows for the creation of basic health plans. BHP can be approved without a waiver if the plan meets the requirements in statute and regulation.

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