

Introduction

During the open enrollment period for the 2018 plan year, approximately 11.8 million people enrolled in marketplace coverage and 74 million people enrolled in Medicaid, bringing the United States' uninsured rate to 12.2¹. States continue to identify and pursue strategies to further reduce the numbers of uninsured, to make coverage more affordable for consumers and to improve access to care. In the absence of federal legislation to stabilize the individual market, states are seeking options to strengthen their marketplaces and maintain coverage gains.

In recent months, several proposals have been introduced at both the federal and state levels that would permit people above Medicaid eligibility levels to “buy in” to Medicaid or would leverage the Medicaid program to strengthen coverage across the individual market and Medicaid. These state initiatives include the following (see Appendix for more detail):

- › Massachusetts' proposal, which passed the state Senate in November 2017 and may be introduced in the House, would give the state the option to offer a tailored Medicaid product, including to participating employers of Medicaid-eligible individuals, and to expand affordable coverage options for consumers.² Additionally, the state's fiscal year (FY) 2018 budget includes a provision that requires the Health Connector to undertake a study on the feasibility of establishing a small employer premium sharing plan for the coverage of nondisabled, non-elderly adults with incomes below 138 percent of the federal poverty level (FPL) and their dependents eligible for participation in the Medicaid program.³
- › Minnesota legislators have reintroduced legislation to allow individuals with incomes above 201 percent of the FPL—that is, above the eligibility level for MinnesotaCare, the state's Basic Health Plan (BHP)—to purchase a MinnesotaCare-like product on the marketplace, to expand affordable options for consumers.⁴
- › New Mexico's legislature authorized a study on the implications of a Medicaid buy-in proposal intended to lower health care costs and expand affordable coverage to residents, including those earning less than 200 percent of the FPL following the passage of legislation in February 2018.⁵

In addition to these states' efforts, other states are in the early stages of debating such initiatives. States may consider leveraging other state health coverage programs, like public employee benefit plans, as vehicles for a buy-in program that advances state goals. This paper focuses on Medicaid buy-in proposals.

For purposes of this paper, we define Medicaid buy-in as a state proposal to provide health care coverage to individuals with incomes above the current Medicaid eligibility level by leveraging Medicaid in some way—such as using the Medicaid provider network, reimbursement, the Medicaid infrastructure and/or Medicaid-like benefits—to offer a more affordable or accessible coverage option in the state. A state has flexibility in designing a Medicaid buy-in proposal, making policy decisions across a range of key program features—like provider network, reimbursement rates and the role of private plans—to create a program that resembles a Medicaid benefit, a marketplace product or a hybrid of the two. State decisions related to Medicaid buy-in program design will depend on the policy goals for the program and market considerations.

This issue brief describes the central considerations that a state must take into account when developing a Medicaid buy-in proposal, including its primary policy goals. These considerations will influence the product design a state will want to pursue. We also discuss the primary models for state-administered Medicaid buy-in proposals, and the administrative considerations and authorities needed for each model. Finally, for those models that will require approval of a state innovation waiver under Section 1332 of the Affordable Care Act (ACA), we examine Section 1332 deficit neutrality and pass-through funding implications that states will want to consider as they craft their buy-in proposals.

State Goals for Medicaid Buy-In and Impact on Product Design

States considering a Medicaid buy-in may have a range of goals, some of which might be in conflict with others.

- › **Access and Competition.** A state may be focused on improving marketplace coverage within its current structure, for example, ensuring that there are no bare counties, or those without an offering issuer. In the past few years, several states have been at risk for having no qualified health plan (QHP) available within certain counties, which would mean consumers in that county would not have access to premium tax credits to help cover the costs of purchasing a plan.⁶ During the 2018 plan year, there were 40 counties that were at risk for having no QHP, although by open enrollment, all counties had at least one QHP available to consumers.⁷ Another related goal might be to ensure consumers have a choice of multiple QHPs in counties throughout a state, in which case a state might consider a buy-in to increase competition in the marketplace.
- › **Affordability.** States might be focused on improving premium affordability in the marketplace, particularly for those consumers with incomes above 400 percent of the FPL or those without access to premium tax credits. As average premiums rise, the premium tax credit level adjusts and mitigates the impact on those with subsidized coverage. Thus, rising premiums disproportionately affect those with incomes above 400 percent of the FPL who pay the entire premium themselves.⁸ Some states are focused on the buy-in as a tool to make premiums more affordable for unsubsidized individuals and families in the individual or small group market, who bear the full brunt of rising premiums. Other states may view the buy-in as a way to lower deductibles and other cost-sharing for services for those enrolled in QHPs—many states are grappling with this affordability issue. In 2018, the average silver plan deductible is \$3,937.⁹ Finally, some states may consider using a buy-in to offer additional benefits beyond essential health benefits on a more affordable basis, such as adult dental.
- › **Market Alignment.** States may view a buy-in as a method to strengthen alignment between Medicaid and marketplace coverage by ensuring that the same (or partnering) issuers, plans and provider networks are offered in Medicaid and the marketplace as individuals transition between coverage programs. Aligning marketplace and Medicaid products enhances the consumer's experience by enabling access to and continuity of coverage, and can advance state priorities in population health, coverage and care management for high-cost populations, as well as payment reforms that pay providers for value rather than volume of services. Continuity of coverage over time, particularly within the same plan, is essential to advancing state goals related to population health and value-based payment reform.
- › **Single-Payer Glide Path.** Finally, as the single-payer discussion is revived at the federal and state levels, some state policymakers may see the buy-in as an alternative to single payer or as an incremental step to achieving a single-payer system.

As noted above, some of these goals may conflict. For example, states might want a buy-in product to increase competition in the short term and provide a glide path to a single-payer system in the longer term. Additionally, it may be challenging for states to design a Medicaid buy-in product that meets multiple goals even when goals do not directly conflict with one another, such as providing increased competition and increased affordability without increasing cost to the state. For example, a state may want both increased competition and better affordability, but a more affordable option might lead to less competition, depending on insurer behavior. As a result, states that are motivated to address multiple problems will need to prioritize their goals to ensure that their design decisions for their buy-in program proposals support and advance their highest priority goals. State policymakers seeking to advance a Medicaid buy-in also will need to understand and account for divergent perspectives of stakeholders (e.g., advocates, insurers, providers) who may have different motivations and goals for Medicaid buy-in, or may oppose it altogether.

Models for Buy-In Proposals

States may choose one of two primary models for their Medicaid buy-in design depending on a variety of factors, including but not limited to their program goals, expediency and appetite for obtaining a 1332 waiver.

Model 1: State-Sponsored Product on the Marketplace

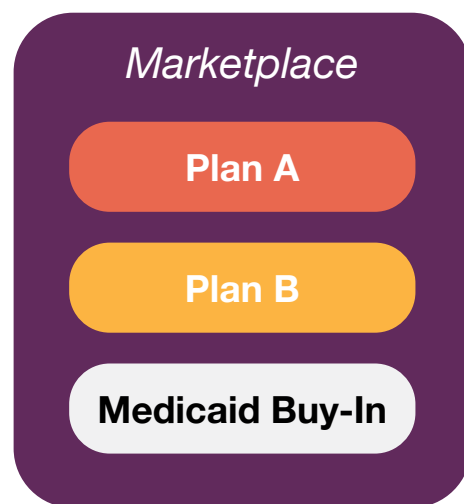
Under this model, the state would leverage its Medicaid program infrastructure and purchasing power to create a state-sponsored public coverage alternative that meets QHP standards and is offered through the marketplace alongside other QHPs. Under this option, the state would contract with its Medicaid managed care organizations (MCOs) to provide the product. Notably, states that contract directly with accountable care organizations (ACOs) to serve the Medicaid population (like Massachusetts and Minnesota)

could allow consumers to purchase ACO-based products through a buy-in, but such an arrangement would likely require 1332 waiver authority as ACOs are not typically licensed insurers/plans. The state may set provider rates, although the rates would need to be at a level that permitted the plan to meet network adequacy requirements. For example, the state could determine that the rates for the buy-in product should be consistent with Medicaid rates, set at a rate between Medicaid and QHP provider rates, or consistent with Medicare rates, depending on what is feasible to ensure adequate provider participation.

Model 1: State-Sponsored Product on the Marketplace



Individuals who qualify for tax credits can use them toward the purchase of the Medicaid buy-in



The state-sponsored buy-in product would generally be designed to meet marketplace standards and qualify for advance premium tax credits (APTCs). Eligibility for this product would be the same as eligibility for marketplace coverage—everyone could purchase coverage on their own, and individuals between 100 percent and 400 percent of the FPL would use tax credits for premiums if they meet other eligibility criteria, such as no “affordable” (as defined by the ACA) employer-sponsored coverage offered. (Though as we discuss later, the state could make design decisions in this model that would necessitate a 1332 waiver.) Premiums would be established by the value of the coverage, consistent with ACA rating rules and state regulations. This coverage would participate in the individual market single-risk pool and risk adjustment, so that individual market enrollees not in the buy-in will benefit from the stabilizing effect of having more participants in the individual market. States that are pursuing a Medicaid buy-in to address bare counties could limit this offering to certain counties. If there were no MCOs able to offer statewide coverage, the state could contract with multiple MCOs to ensure that a buy-in offering would be available statewide. Minnesota’s MinnesotaCare buy-in proposal is an example of the state-sponsored product model.

Operational Considerations and Implementation Authority

It is possible to structure the state-sponsored product buy-in option without the need for 1332 waiver authority, which states might want to seriously consider given the administrative burden of applying for a 1332 waiver and the uncertainty of approval. Meeting requirements under waivers necessitates a longer implementation process than if a state implements policies under its own authority, and is conditioned on federal approval. Importantly, 1332

Section 1332 Waivers

- › Section 1332 of the ACA permits states to apply for a State Innovation Waiver to pursue strategies for providing residents with access to high-quality, affordable health insurance as an alternative (in whole or in part) to standard marketplace coverage.
- › States can apply for waivers of selected marketplace requirements, including those governing essential health benefits and tax credits (but not rating requirements or guaranteed issue), if they stay within **four guardrails** to retain the basic protections of the ACA. Coverage provided under a 1332 waiver must:
 1. Be at least as comprehensive as coverage provided absent the waiver;
 2. Provide coverage and cost-sharing protections so that coverage is at least as affordable as coverage absent a waiver;
 3. Provide coverage to a number of residents of the state comparable to the number of residents that would be provided coverage absent a waiver; and
 4. Not increase the federal deficit.
- › If a state's 1332 waiver proposal reduced federal spending on marketplace subsidies, the state could receive "pass-through" funding in the amount of the net savings to the federal government. For example, in the three states with approved reinsurance waivers (Alaska, Minnesota and Oregon), the states reap the federal savings for their policies that reduce premiums, which in turn lowers tax credits and thus federal expenditures. In addition to working within the confines of existing marketplace coverage (e.g., through reinsurance), states can also use 1332 waiver pass-through funding to provide coverage that differs from the ACA structure.

waiver approval is not guaranteed, as an administration retains discretion to deny a 1332 waiver even if all statutory requirements are met.¹⁰ Because premium tax credits can be paid only to QHPs, the state's plan would need to meet all the requirements necessary to be certified as a QHP in order to avoid the need for a 1332 waiver. Notably, the state could impose stricter standards in its state-sponsored buy-in product, provided those standards do not conflict with the federal QHP requirements (e.g., require the plans to offer all metal tier options rather than just the gold and silver options required of all QHP issuers).

States that do not want to contract with an issuer to offer the buy-in product (i.e. the state seeks to "stand in the shoes of the issuer" to offer the product), or that want to receive the tax credits directly to fund the buy-in (similar to how the BHP is administered) likely need to obtain a waiver to do so. However, since the ACA requirement is for a QHP to be offered by a state-licensed issuer, it may be possible to structure the buy-in in such a way that the state insurance commissioner is content to deem the state-offered plan as a QHP.¹¹

A state that seeks to offer a product that is not individual health insurance coverage offered by a state-licensed health insurance issuer (such as an arrangement where federal premium tax credits are paid directly to the state, which uses them for a state-administered health coverage program) may confront additional complexities. For example, the federal risk adjustment program transfers funds from health insurance issuers in the individual market with lower-risk enrollees to those with higher-risk enrollees. But as such programs are administered by the U.S. Department of Health and Human Services (HHS) in all states today, risk adjustment is available only to state-licensed health insurance issuers in the individual market. Under the ACA, states may choose to run their own risk adjustment program for the individual market without a waiver, and a state doing so might have the flexibility to expand the scope of the program to include

coverage that is not offered by a state-licensed health insurance issuer. However, establishing a risk adjustment program is a significant undertaking, and it might be more feasible for a state to offer the buy-in program through state-licensed health insurance issuers only, rather than creating a program that would operate outside of risk adjustment or taking on administering risk adjustment. States that want to vary some of the requirements for QHPs, changing cost-sharing requirements (i.e., changing metal levels), would also need a 1332 waiver to do so.

A final operational consideration is that this strategy requires close collaboration of the state Medicaid and insurance agencies, with the Medicaid agency likely in the role of designing and procuring a state-sponsored buy-in that will be a QHP, and the insurance agency in the role of licensing, certifying and regulating the plan, as a QHP must be a state-licensed issuer.¹²

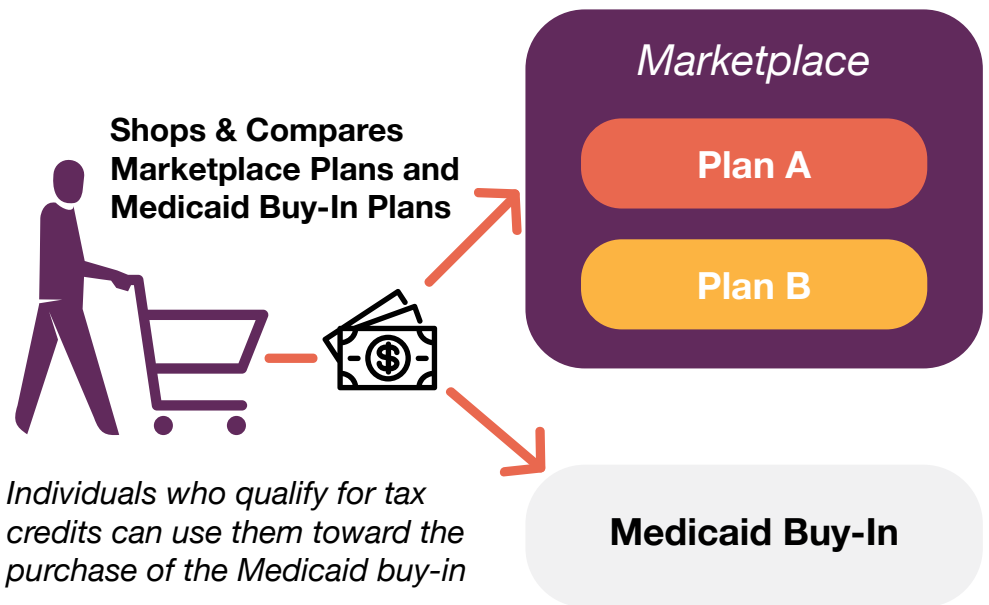
Some states may wish to consider variations on the program rules and cost structures that apply to the Medicaid buy-in to be more generous than QHP rules and closer to Medicaid rules. This might include a “wrap” on benefits or cost-sharing to make the Medicaid buy-in slightly richer. This scenario would require a Section 1115 waiver if the state seeks to use Medicaid funding with federal financial participation (FFP). Notably, the availability of this type of product could cause risk segmentation in the marketplace.

Model 2: Medicaid Buy-In Outside of the Marketplace

Under this model, the state would make a Medicaid-like benefit available to consumers whose incomes are higher than the Medicaid eligibility level, *separate* from, and outside of, the single risk pool that includes all ACA-compliant individual market plans both on and off the marketplace. Benefits in this buy-in model would be similar to Medicaid, but with premiums and cost-sharing set by the state. The program would presumably be structured in a way to allow consumers to use their APTCs to purchase the buy-in product. A state

could design this product as an extension of an existing Medicaid buy-in program, or craft a new buy-in product designed to meet state goals. Because this product is outside of the individual market risk pool, it would not be considered individual health insurance coverage, thus it would not be subject to private insurance rating requirements. The eligibility level for the buy-in would be above current Medicaid eligibility levels, and could mirror marketplace eligibility, as under Model 1; states could also restrict eligibility for this buy-in product, for reasons described below.

Model 2: Medicaid Buy-In Outside of the Marketplace



Operational Considerations and Implementation Authority

A major consideration related to this option is its effect on marketplace coverage. If the Medicaid buy-in is an alternative to marketplace coverage that consumers can choose in lieu of enrolling in a subsidized QHP, states will need to consider its impact on risk selection and whether to implement tools to address that impact. For example, if

this product is open to everyone eligible for marketplace coverage and a significant number of individuals leave the marketplace to purchase it because the coverage is less expensive or more generous, such a result could destabilize the marketplace. Lower enrollment in the marketplace might lead to lower participation by insurers and/or increased marketplace premiums for remaining individuals who do not opt for the Medicaid buy-in. This might be the desired result if the state's goal is to move toward a single-payer approach. However, if a state seeks to avoid this result, it might decide to limit the buy-in option to certain populations (e.g., by income, geography or specific health conditions) to address risk selection and/or to limit costs. If the state restricts enrollment on these or other bases, it is possible that the buy-in could help the marketplace by serving as a type of high-risk pool, lowering individual market premiums overall and making the marketplace more attractive to issuers.

This option most certainly requires a 1332 waiver if the state seeks to allow individuals to use premium tax credits to purchase the buy-in product, because this product would not be a QHP. Because this coverage is not individual market insurance,¹³ states could restrict enrollment (e.g., establish an enrollment ceiling, limit eligibility). Since the state would be pursuing a 1332 waiver, it also would need to make sure that consumers staying in the marketplace were not worse off as a result of the waiver, consistent with the four guardrails for 1332 waivers.

1332 Waiver Deficit Neutrality and Pass-Through Funding

As discussed above, a state can create a Medicaid buy-in product without obtaining a 1332 waiver if the product meets all the standards under the ACA. However, a state must seek a 1332 waiver if aspects of its Medicaid buy-in design do not comply with certain marketplace requirements (e.g., essential health benefits, QHP requirements or restrictions on enrollment that differ from marketplace coverage). Additionally, a state would need to seek a waiver to use federal pass-through funds (i.e., federal savings that result from a reduction in marketplace subsidy payments, adjusted downward as needed to maintain deficit neutrality) for coverage outside of the marketplace as in Model 2.¹⁴

Regardless of the goals of a state's 1332 waiver, federal savings and associated pass-through funds may be generated from policy and/or coverage changes made under the waiver, and a state may consider repurposing these savings as part of a more comprehensive reform package. There are several ways in which a buy-in might achieve savings for the federal government:

- › A Medicaid buy-in on the marketplace with a lower-premium plan could reduce the benchmark for tax credit subsidies and therefore reduce federal costs (Model 1), which the state could receive as pass-through funding under a 1332 waiver and use for other purposes.
- › A Medicaid buy-in outside the marketplace (Model 2) would generate federal savings and therefore pass-through funds by reducing the number of individuals receiving tax credit subsidies in the marketplace. The ultimate amount of pass-through funding would depend on the risk profile of those who enroll in the buy-in, due to the impact on average premiums for those who remain in the marketplace.¹⁵ For any given population of buy-in enrollees, if the state is able to provide buy-in coverage at a lower cost (e.g., through lower provider payment rates) than the amount of pass-through funding provided, it could use the savings for other purposes.

In order to obtain a 1332 waiver, a state must demonstrate deficit neutrality, which means that the waiver will not increase the federal deficit.¹⁶ As part of its deficit neutrality evaluation, the Department of Treasury will weigh the federal savings from any reductions in tax credits against any increase in federal spending (e.g., due to higher marketplace utilization and/or enrollment) or any decrease in federal revenues (e.g., lower user fees paid to the federally facilitated marketplace) that would result from a Medicaid buy-in compared with the status quo.

The level of pass-through funding that a state might receive to support a buy-in will vary considerably depending on the structure of whether the plan is inside or outside of the marketplace, as will the risks to the state.

Pass-Through Calculation in Model 1

Under the first model, where the state is offering a product on the marketplace and tax credits are used within the marketplace, APTC funding flows directly to the buy-in plan. Assuming that a state-sponsored product under an approved waiver would lower the benchmark premium, the state would separately receive pass-through funding in the amount of APTC savings to the federal government due to the waiver, with a reduction in the pass-through amount as needed to maintain deficit neutrality. For example, if the state had additional affordability provisions (e.g., lower deductibles) in its waiver proposal, the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury would consider whether these provisions would increase enrollment or utilization compared with current law. These assumptions would impact the value of the pass-through funding. Under this model, the state is at risk for claims costs exceeding revenues from APTC and enrollee premium payments (as with any other carrier on the marketplace), but could use its pass-through funding to address any shortfalls.

Pass-Through Calculation in Model 2

Under the second model, where the state is offering a product outside of the marketplace, tax credit dollars would be used outside of the marketplace to purchase Medicaid-like coverage. By establishing a program outside of the construct of the ACA, the state is repurposing a portion of tax credits rather than making a policy change that influences tax credit spending but leaves the ACA structure largely intact. Thus, the state would receive a pass-through amount that includes a global payment for the tax credits that would otherwise have been paid for by buy-in enrollees, as well as any APTC savings to the marketplace due to the state's waiver. As with Model 1, the pass-through amount would be reduced for deficit neutrality as needed. Because the state's pass-through funding would be akin to a block grant, it would be at-risk if enrollment were higher than expected or if buy-in enrollees were a higher-cost pool than expected.

Conclusion

States have substantial flexibility in designing a Medicaid buy-in product to achieve their goals with respect to marketplace access and competition, insurance premium and cost-sharing affordability, and alignment across Medicaid and individual insurance market coverage. State decisions with respect to whether Medicaid buy-in is the optimal vehicle to pursue these goals, and the "best fit" among buy-in models, will be driven by a prioritization of policy goals, a state's appetite for pursuing a 1332 waiver, and consideration of the buy-in's implications for the marketplace overall. States' decisions to pursue Medicaid buy-in, and the specific design of the program, also will be influenced by opportunity for pass-through savings under a 1332 waiver, and whether a state needs to repurpose those savings as part of the buy-in approach or for a broader health reform initiative that may be the subject of a 1332 waiver. As states grapple with an ever-evolving federal regulatory landscape impacting marketplace stabilization, Medicaid buy-in may emerge, in some states, as a viable solution in their efforts to achieve sustainable and stable insurance options for their residents.

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ABOUT MANATT HEALTH

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Appendix: Additional Detail on State Initiatives

Jurisdiction	Legislation
Federal/Hawaii	<p>S. 2001/H.R. 4129¹⁷</p> <p>State Public Option Act (“Schatz/Lujan Bill”)</p> <ul style="list-style-type: none"> » Introduced in the Senate and House on October 25, 2017; no further action since » Creates an optional eligibility group for residents who are not concurrently enrolled in other coverage » Medicaid buy-in is designated as a QHP and treated as the second-lowest-cost silver plan; premiums for buy-in coverage are eligible for APTCs
Massachusetts	<p>S. 2211, Section 157¹⁸</p> <ul style="list-style-type: none"> » Passed Senate on November 9, 2017; House may take up the bill for debate in 2018 » Goal to improve affordability, including for individuals with access to employer sponsored insurance » Available to all individuals, including people who are Medicaid eligible whose employers participate » Financed with APTCs, CSRs, existing state subsidies, employer contributions for those employers that buy in, consumer cost-sharing » Any optional expanded plan offered to an employer shall require the employer to pay no less than 50% of the projected cost of coverage » Requires Office of Medicaid to report on October 1, 2018 as to whether or not an expanded plan will be implemented
Minnesota	<ul style="list-style-type: none"> » Legislation reintroduced in April 2018.¹⁹ » Goal to address the lack of affordable options available in the individual market in Minnesota » Available to individuals with income above 201% of the FPL (i.e., above BHP eligibility) who are determined eligible for enrollment in a QHP with or without APTCs/CSRs » Permits individuals who are eligible for APTCs and CSRs to use those subsidies to purchase the MinnesotaCare buy-in option » No state subsidy for buy-in
Nevada	<p>A.B. 374²⁰</p> <ul style="list-style-type: none"> » Vetoed by governor in June 2017; workgroup formed to review option » Available to people who are otherwise ineligible for Medicaid » Permits individuals who are eligible for APTCs and CSRs to use those subsidies to purchase coverage from the Nevada Care Plan

Endnotes

1. Centers for Medicare & Medicaid Services. *Health Insurance Exchanges 2018 Open Enrollment Period Final Report*. <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-03.html>. Published April 3, 2018. Accessed April 24, 2018; Kaiser Family Foundation. *Total Monthly Medicaid and CHIP Enrollment*. <https://www.kff.org/health-reform/state-indicator/total-monthly-medicare-and-chip-enrollment/?currentTimeframe=0&sortModel=%7B%22colld%22:%22Location%22,%22sort%22:%22asc%22%7D>. Published December 2017. Accessed April 24, 2018; Auter Z. U.S. Uninsured rate steady at 12.2% in fourth quarter of 2017. *Gallup*. January 16, 2018. <http://news.gallup.com/poll/225383/uninsured-rate-steady-fourth-quarter-2017.aspx>. Accessed April 24, 2018.
2. S. 2211, <https://malegislature.gov/Bills/190/S2211>.
3. Massachusetts FY2018 Budget. Retrieved from <https://malegislature.gov/Budget/FY2018/FinalBudget>.
4. SF58, https://www.revisor.mn.gov/bills/text.php?number=SF58&version=latest&session=ls90&session_year=2017&session_number=0.
5. SM3, https://legiscan.com/NM/text/SM3/id/1664961/New_Mexico-2018-SM3-Introduced.pdf.
6. A QHP is an insurance product that has marketplace certification, provides essential health benefits, follows established limits on cost-sharing (e.g., deductibles, copayments and out-of-pocket maximum amounts) and meets other requirements under the ACA. 42 U.S. Code § 18021.
7. American Hospital Association. *State Marketplace Stabilization Strategies*. <https://www.aha.org/white-papers/2018-01-17-aha-white-paper-state-marketplace-stabilization-strategies>. Published January 2018. Accessed April 23, 2018.
8. When the administration stopped making cost-sharing reduction payments to plans in 2017, plans still had to provide reduced cost-sharing to those consumers eligible for them, and premiums increased as a result. Most states let QHPs “load” those costs into silver-level plans, which meant that some tax-credit-eligible people actually experienced premium decreases, while the unsubsidized populations in the marketplace were impacted by rising premiums.
9. Pearson, CF, Sloan, C., Carpenter, E. *Most Counties Will Have Free 2018 Exchange Plans for Low-Income Enrollees*. Avalere Health; November 2, 2017. <http://avalere.com/expertise/managed-care/insights/most-counties-will-have-free-2018-exchange-plans-for-low-income-enrollees>. Accessed April 24, 2018.
10. Section 1332 indicates that the Secretary “may” approve waivers, and the CMS guidance notes the “Secretaries retain their discretionary authority under Section 1332 to deny waivers when appropriate given consideration of the application as whole, including the four requirements.” U.S. Department of Health and Human Services. (December 16, 2015). Department of the Treasury; Waivers for State Innovation. 80 Fed. Reg. 78,131 (codified at 31 CFR 33 and 45 CFR 155). <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>.
11. ACA Section 1412 (c)(2)(A) states, “The Secretary of the Treasury shall make the advance payment under this section of any premium tax credit allowed under section 36B of the Internal Revenue Code of 1986 to the issuer of a qualified health plan on a monthly basis (or such other periodic basis as the Secretary may provide).” <https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm>.
12. ACA Section 1301, <https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/html/PLAW-111publ148.htm>.
13. Guaranteed issue prevents a plan or a state from capping or restricting enrollment except for specific circumstances.
14. While Section 1332 refers to pass-through calculations as inclusive of both tax credits and cost-sharing reductions (CSRs), we refer to tax credits through the remainder of this issue brief given that CSRs are no longer being paid.
15. For example, if high utilizers are attracted to a Medicaid buy-in outside of the marketplace, it effectively creates a high-risk pool that could reduce premiums and the benchmark for tax credit subsidies for those who remain in the marketplace, thereby increasing pass-through funding. Conversely, if low-risk individuals enroll in the buy-in, it could increase premiums and subsidies for those who remain in the marketplace, reducing pass-through funding.
16. Federal guidance states that “[u]nder the deficit neutrality requirement, the projected Federal spending net of Federal revenues under the State Innovation Waiver must be equal to or lower than projected Federal spending net of Federal revenues in the absence of the waiver. The estimated effect on Federal revenue includes all changes in income, payroll, or excise tax revenue, as well as any other forms of revenue (including user fees), that would result from the proposed waiver. Estimated effects would include, for example, changes in: The premium tax credit and health coverage tax credit, individual shared responsibility payments, employer shared responsibility payments, the excise tax on high-cost employer-sponsored plans, the credit for small businesses offering health insurance, and changes in income and payroll taxes resulting from changes in tax exclusions for employer-sponsored insurance and in deductions for medical expenses.” U.S. Department of Health and Human Services. (December 16, 2015). Department of the Treasury; Waivers for State Innovation. 80 Fed. Reg. 78,131 (codified at 31 CFR 33 and 45 CFR 155). <https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation>.
17. H.R. 4129, <https://www.congress.gov/bill/115th-congress/house-bill/4129/text>.
18. S. 2211, Section 157, <https://malegislature.gov/Bills/190/S2211>.
19. SF58, https://www.revisor.mn.gov/bills/text.php?number=SF58&version=latest&session=ls90&session_year=2017&session_number=0.
20. A.B.374, <https://www.leg.state.nv.us/App/NELIS/REL/79th2017/Bill/5393/Overview>.