Medicaid Buy-In: Program Options and Considerations

The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) made a number of reforms intended to promote health insurance coverage and affordability. These included giving states the option to expand Medicaid eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL) with an enhanced federal matching rate, an option taken up by more than half of states.[1,2]

The ACA also created health insurance exchanges offering access to individual market health insurance plans, which provided minimum essential coverage for individuals, and, for some eligible enrollees, premium and cost-sharing subsidies.[3] Since these policies took effect, the uninsured rate has declined, with 13.25 million fewer uninsured individuals in 2017 compared to 2013 (Berchick et al. 2018). Studies have also shown improvements in access to care and reductions in out-of-pocket spending among newly insured individuals (Glied et al. 2017, Selden et al. 2017, Garfield and Young 2015). Despite this progress, many low- and middle-income families still lack affordable health coverage choices, and concerns about rising out-of-pocket costs remain.[4]

State and federal policymakers have proposed various strategies to improve overall coverage and affordability, including allowing people to buy into their state Medicaid program or coverage comparable to that on the ACA exchanges. Although the details of various proposals differ substantially, they share a common element: using the flexibility allowed under the ACA to create new state-administered options as alternatives to existing exchange coverage. The term Medicaid buy-in is often used to describe such proposals because the programs would be administered by the state or rely on existing Medicaid infrastructure and would require individuals to pay a premium to purchase, or buy into, coverage. In general, these programs focus on:

- increasing the number of people with insurance coverage;
- leveraging existing state infrastructure to promote administrative efficiency and simplicity;
- improving access to and competition among exchange plans (e.g., providing more options to people living in geographic areas with few choices); and,
- increasing affordability of premiums and cost sharing.

Currently, states have the option to allow working individuals with disabilities to purchase Medicaid coverage with a monthly premium (MACPAC 2017a).[5] However, recent proposals have sought to extend this general approach to a broader population, specifically for individuals with income above current Medicaid eligibility levels and within or above the income range currently eligible for exchange subsidies.

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The argument for buy-in programs is that Medicaid's existing administrative structures and purchasing power could be used to negotiate rates with providers and health plans, allowing states to offer more affordable health insurance coverage options than are currently available (United States of Care 2019).

Federal policy may make it difficult for states to adopt and finance these programs. While some approaches could be implemented under Medicaid state plan authority, others would require states to seek federal waiver approval. Specifically, states taking approaches that focus on the individual commercial market would need approval under Section 1332 of the ACA, which allows states to apply for waivers of ACA requirements. States making changes to their Medicaid programs that are not otherwise permitted under federal Medicaid rules would need approval under Section 1115 of the Social Security Act (the Act). States would have to meet certain requirements, including budget neutrality requirements (in the case of Section 1115 authority) and deficit neutrality requirements (in the case of Section 1332 authority).

This brief provides background information on how current law affects state ability to set up buy-in programs, discusses various proposals at the state and federal **levels**, and raises key policy considerations. It is important to note that many proposals to date lack sufficient detail to predict their effects, and unknown factors could affect their outcomes.

Design Issues

Policymakers and researchers have discussed several approaches to designing Medicaid buy-in programs. Although states have the option under current law to expand Medicaid to individuals above 133 percent FPL, and could charge premiums for those individuals to buy into coverage, few states have expressed interest in doing so. Instead, most state-level proposals would establish new state-administered coverage options structured and financed separately from the existing Medicaid program. Proposed federal legislation would provide states with new authority and a prescribed approach for adopting Medicaid buy-in programs that combine elements of Medicaid and exchange coverage (Table 1).

Medicaid expansion above 133 percent FPL

States can use Medicaid state plan authority to extend Medicaid to individuals with higher incomes. Under Section 1902(a)(10)(A)(ii)(XX) of the Act, states can cover adults under age 65 with income over 133 percent FPL, up to the income threshold chosen by the state. A current non-expansion state choosing this option would also need to adopt the Medicaid expansion (i.e., expanding coverage to non-disabled adults with income up to 133 percent FPL under Section 1902(a)(10)(A)(ii)(VIII) of the Act).

States could, but are not required to, charge premiums based on income on a sliding scale or other structure. Any premiums and cost sharing would need to follow requirements outlined in Sections 1916 and 1916A of the Act and accompanying regulations, including those stipulating that premiums may not be charged to beneficiaries with income below 150 percent FPL, and that aggregate premiums and cost sharing may not exceed 5 percent of family income. States using this authority would be required to comply with all other federal Medicaid rules, including offering all mandatory Medicaid benefits and

providing all applicable beneficiary protections. States would need to apply for and receive a Section 1115 Medicaid demonstration waiver in order to deviate from any of these requirements.

Expanding Medicaid to higher-income individuals would result in individuals moving from exchange to Medicaid coverage, and would increase state spending relative to the status quo. Under current law, individuals with family income between 100 and 400 percent FPL (in non-expansion states) or between 133 and 400 percent FPL (in expansion states) who are enrolled in exchange plans receive subsidies financed entirely by the federal government; moving these individuals to Medicaid, for which spending is shared by the state and the federal government, would shift the spending burden substantially toward states.[6] Although states can set the eligibility levels of their choice, they may not cover individuals at a higher income level without also covering all individuals with lower incomes (§ 1902(hh)(1) of the Act). This means that states may not use this option to cover individuals over 400 percent FPL, who do not qualify for subsidies on the exchange, without also covering individuals below that level.

States seeking to expand coverage and promote affordability for populations whose coverage is currently unsubsidized may find using this approach attractive; providing coverage through Medicaid offers states more control to set premiums and cost sharing, define benefits and provider networks, and administer the program. However, it may not appeal to states seeking to address concerns about exchange coverage such as the availability of plans, competition between plans or issues related to the risk pool. In addition, it exposes states to greater spending by pulling individuals out of the exchange rather than providing an alternative plan option on the exchange. In fact, few states have expressed interested in this option. Currently, only the District of Columbia uses state plan authority to cover low-income adults with income up to 200 percent FPL, but does not require premiums.[7,8] Delaware studied an expansion approach in 2019, but ultimately chose not to pursue this policy, citing high financial and operational burden on the state.[9]

Alternative state-led approaches

Other state-led approaches sometimes described as Medicaid buy-in proposals would use the flexibility provided under the ACA to create new coverage options. The extent to which they share features with Medicaid is actually rather limited. For example, under most policy proposals, eligibility and benefit requirements would follow those of exchange plans rather than Medicaid; financing would come from enrollee premiums, federal subsidies, state funds or other sources, but not from federal Medicaid matching funds (Table 1).

TABLE 1. Comparing Proposed Approaches to Establishing a Medicaid Buy-In Program

Design element	Medicaid expansion to individuals with incomes over 133 percent FPL	Alternatives to Medicaid	
		Offered on the exchange	Other approaches
Structure	Medicaid state plan option	State-administered plan offered on the exchange	Multiple options (e.g., coverage through Medicaid FFS or MCO, state employee health plan, or BHP-like plan)
Eligibility	Individuals with incomes over 133 percent FPL; upper limit set by state	Anyone currently eligible to purchase exchange coverage	Criteria set by state but subject to Section 1332 requirement that it provides coverage to a comparable number of people as covered under the ACA
Benefits	State plan benefit package or alternative benefit plan (which must include the 10 EHBs)	At minimum must include the 10 EHBs	Criteria set by state but subject to Section 1332 requirement that coverage is at least as comprehensive as plans available under the ACA
Premiums and cost sharing	Set by state in accordance with federal Medicaid rules including that: • state may not charge premiums to individuals with incomes below 150 percent FPL; • total out-of-pocket expenses (including premiums and any other cost sharing) may not exceed 5 percent of income	Established using same methods as other exchange plans	Criteria set by state but subject to Section 1332 requirement that coverage is at least as affordable as plans available under the ACA
Financing	State and federal Medicaid funds at applicable FMAP	Enrollee premiums; eligible individuals keep and use APTCs and CSRs; possible federal pass-through funds	Multiple options, including enrollee premiums, state funds, federal pass-through funds, or combination
Type of waiver needed if deviating from requirements	Section 1115 waiver	Section 1332 waiver	Section 1332 waiver

Notes: ACA is the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended). APTC is advanced premium tax credit. BHP is basic health program. CSR is cost-sharing reduction. EHB is essential health benefit. FMAP is federal medical assistance percentage. FFS is fee for service. FPL is federal poverty level. MCO is managed care organization.

Sources: MACPAC 2018, 2016a.

Programs would be administered and overseen by the state Medicaid agency, share Medicaid data and IT systems, leverage the state's existing Medicaid managed care contracts or provider networks, or rely on the state Medicaid program in some other way. However, states might find it difficult to use Medicaid administrative structures for programs that follow exchange requirements. For example, under Colorado's proposal (see below), the state option would be jointly administered by the Colorado Department of Health Care Policy and Financing (HCPF), which administers Medicaid and CHIP, and by the Colorado Department of Insurance (DOI). The proposal indicates that HCPF and DOI would partner with the new state program to develop alternative payment methodologies, technology innovations, and other potential program improvements, but the new coverage program would not use any of Medicaid's infrastructure (DOI and HCPF 2019).

State proposals. One approach sometimes described as a Medicaid buy-in involves offering a state-sponsored insurance plan for purchase on the exchange. This approach allows states to exercise more control over provider payment rates, premiums and cost sharing, and other features of exchange coverage. States could minimize risk and administrative burden by contracting a health plan to deliver benefits. If the plan meets federal and state requirements to be certified as a qualified health plan, then states may not need a Section 1332 waiver to offer it on the exchange.

States that have enacted legislation to move forward on a state coverage option include Colorado and Washington:

- **Colorado State Coverage Option.** Through legislation passed in May 2019, the Colorado General Assembly required the Colorado DOI and HCPF to develop a plan to implement a state coverage option for sale on and off the exchange beginning in January 2022.

  Under the plan, submitted to the legislature in November 2019, the two departments will jointly oversee and set standards and requirements for a state option plan. All insurance carriers in the state over a certain size will be required to offer the option at the bronze, silver, and gold metal tiers.[10] Provider payments will be set to 155 to 218 percent of Medicare rates, which is expected to result in savings of approximately 7.1 to 19.8 percent on monthly premiums. Colorado will seek a Section 1332 waiver to receive premium tax credit pass through funding that will be used to provide enhanced benefits and additional premium and cost-sharing subsidies. Enrollment in the Colorado individual market will increase by an estimated 18,100 (Bly and Phillips 2020, DOI and HCPF 2019).

- **Cascade Care.** Following legislation passed in May 2019, the state of Washington will offer public option plans on the exchange beginning in 2021. The state will contract with private insurance companies to deliver benefits, pay claims, and perform other administrative actions; the state will set parameters and oversee the program. To help reduce premiums and out-of-pocket costs, the state will cap provider payments at 160 percent of federal Medicare rates. This action is expected to result in savings to enrollees of 5 to10 percent (James 2019).

Additional states have considered setting up a state coverage option through legislation. Examples include:

- **Connecticut Option.** This proposal, introduced by Governor Ned Lamont along with several state legislative leaders, would offer individuals and families the choice to purchase a public option plan on the exchange. It would provide financial assistance to enrollees who are not currently receiving federal subsidies and additional assistance to those who receive subsidies (State of Connecticut 2019).
- **Nevada A.B. 347** (also referred to as Sprinklecare). This bill, approved by the state legislature in 2017 but ultimately vetoed by Governor Brian Sandoval, would have made a state-sponsored option available for purchase on the exchange (Montero 2017).[11]
- **ONECare Minnesota Plan.** This plan, proposed by Governor Tim Waltz and introduced as H.F. 3, would allow Minnesotans to buy into a public option on the exchange and pay monthly premiums at levels established by the state commissioner of human services.[12] Beginning in 2023, platinum-level plans would be available for purchase on the exchange; silver- or gold-level plans would be made available if certain triggers occur (e.g., if any rating area lacks an option on the exchange). The plan would include the 10 EHBs plus dental and vision benefits (Bierschbach 2019).[13,14,15]

Several other approaches have been proposed by state legislators and policy experts. Examples include:

- giving individuals and families the option to directly purchase Medicaid coverage from the state Medicaid agency, which would provide coverage through fee-for-service Medicaid or a Medicaid managed care plan with financing from enrollee premiums rather than federal and state Medicaid funds;
- giving individuals and families or small business employers the option to directly purchase the state employee health plan; and
- adopting an expanded version of a Basic Health Program (BHP) to allow individuals and families with income over 200 percent FPL (the current BHP eligibility threshold) to purchase coverage United States of Care 2020, Boozang et al.2018).[16]

Federal requirements and state flexibility. Under current law, states may offer a state-sponsored coverage option and allow eligible individuals to use their exchange subsidies to purchase it as long as the plan is made available on the exchange along with other exchange plans and complies with state and federal requirements to be certified as a qualified health plan:

- Premiums and cost sharing must be established through the same mechanisms used for exchange plans and subject to actuarial soundness.
- Individuals eligible for advanced premium tax credits and cost-sharing reductions must be able to use those subsidies to offset their premium and cost-sharing responsibilities.
- Benefits include at least the 10 essential health benefits (EHBs).
- The plan is part of the single risk pool and participates in risk adjustments.
- Other state and federal requirements for exchange plans, including those related to network adequacy and beneficiary protection, apply.

Proposals that deviate from these requirements, would require states to seek Section 1332 waiver authority. Such authority would be needed for altering benefits, eligibility, or cost sharing in plans offered on the exchange; selling a plan outside of the exchange while still allowing individuals to use ACA exchange subsidies; or receiving part of any federal savings achieved by lowering the benchmark premium (Boozang et al. 2018). Any such plan would need to meet Section 1332 requirements, including that coverage provided is at least as comparable, affordable, and comprehensive as would be available under the ACA (MACPAC 2016). These requirements may be difficult for states to meet and even for programs that meet them, federal approval is not guaranteed.

Federal proposals

Legislation introduced in the 116th Congress, the State Public Option Act (S. 489), would allow states to more easily adopt Medicaid buy-in programs and authorize the use of federal Medicaid funds for this purpose.[17] Specifically, this legislation would allow states to offer Medicaid coverage for purchase on the exchange under Section 1902 of the Act, meaning that states could take up the option through a state plan amendment rather than seeking a Section 1115 or 1332 waiver.

The bill would allow states to offer Medicaid coverage on the exchanges to anyone otherwise ineligible for Medicaid and not concurrently enrolled in another health insurance plan.[18] The benefit package would be the alternative benefit plan, including the 10 EHBs.[19] The state could set actuarially sound premiums and cost sharing within the limitations set for exchange plans by the ACA. The Medicaid plan would be considered a silver-level exchange plan, so individuals eligible for cost-sharing reductions and premium tax credits could use both when purchasing coverage. For those with incomes over 400 percent FPL, premiums would be capped at 9.5 percent of family income.

Financing would be derived from several sources. States would first need to use revenues from enrollee premiums and premium tax credits. Any additional expenses would be shared by the state and federal government at the state's federal medical assistance percentage (FMAP). Any excess revenues would be shared equally with the federal government. Administrative expenditures would be matched at 90 percent.

Key Considerations

Policymakers interested in establishing a Medicaid buy-in or similar state-administered program must consider several issues, including financing mechanisms, effects of the buy-in option on the individual insurance market, the challenge of setting provider payment rates, and the administrative difficulties associated with setting up a new program and negotiating waiver authority.

Financing. Although states expanding Medicaid to individuals who would otherwise be eligible for exchange subsidies can receive federal matching funds, there is no federal financing source for other types of proposed Medicaid buy-in programs. Most of the state-led buy-in proposals would rely fully or in part on enrollee premiums. While premiums could be structured to allow eligible individuals to use their premium tax credits and cost-sharing reduction subsidies to purchase coverage, doing so may require Section 1332 waiver approval.

States could use general revenues or other state revenue sources to extend subsidies to individuals not currently eligible for premium tax credits (i.e., individuals with income below 100 percent FPL or above 400 percent FPL); enhance subsidies for those who are already eligible, as Colorado plans to do; provide additional benefits; or increase provider payment rates. They could also seek federal funding negotiated under a Section 1332 waiver to reflect the amount of premium tax credits that individuals in the state would otherwise receive. Specifically:

- A buy-in plan offered on the exchange at a lower premium than existing plans could reduce the benchmark for federal premium tax credits, generating federal savings. The state could potentially receive federal funds in an amount that reflects the value of the federal savings associated with lowering the benchmark, sometimes referred to as pass-through funding.
- For a buy-in option offered separately from the exchange, states could receive a global payment for the federal premium tax credits that eligible enrollees would have received had they enrolled in exchange coverage, as well as any federal savings associated with lowering the benchmark (CMS 2019, Boozang et al. 2018).

The amount of federal funding is subject to negotiation and approval is not guaranteed. The Centers for Medicare & Medicaid Services (CMS) estimates that 13 states will receive pass-through funding for Section 1332 waiver programs in 2020 (CMS 2020a). The amount of pass-through funding that states receive is calculated annually based on data that states submit to CMS on rates, premiums, premium tax credits, and other information, and can change substantially from year to year.

Effects on the individual insurance market. Any state considering a new program serving the same population currently served by the exchanges would need to consider how this would affect the individual market. A buy-in option set up outside the exchanges (e.g., an expansion of the Medicaid program, a BHP-like option, or the ability to buy into the state's employee benefit plan) could destabilize the exchanges if premiums and cost sharing are significantly lower or coverage is more generous, drawing individuals away from plans on the exchange. If many individuals leave the exchange for the buy-in option, premiums for those who remain in exchange plans could increase, plans could drop out of participation, or both (Brooks-LaSure et al. 2019, Brooks-LaSure et al. 2018). To mitigate such effects, states could limit enrollment to specific groups of enrollees, such as those living in specific geographic areas with no or few exchange plan options. Alternatively, states could limit enrollment in the buy-in option to people with chronic health conditions; doing so could shield the exchange risk pool and reduce coverage costs for those who remain (Boozang et al. 2018).

A buy-in option on the exchange could also affect the stability of the exchange. If the premiums were substantially lower than other exchange options could reduce premiums for enrollees not receiving subsidies and create additional competition but could also cause other plans to leave the market (Boozang et al. 2018). Moreover, a lower premium that brings down the benchmark plan price would reduce the value of premium tax credits. This would decrease costs to the federal government but could also reduce buying power for enrollees receiving subsidies, and in some cases, lead to higher premiums (Bly and Phillips 2020, Corlette et al. 2020, Ingold 2019).

Establishing provider payments and maintaining provider participation. The notion that a buy-in option would be more affordable for consumers than existing options is primarily premised on the assumption that provider payments would be similar to those paid by Medicaid. However, it is unclear if plans could establish adequate networks for a new or larger population than the population they are currently covering at current Medicaid rates. On average, Medicaid fee-for-service physician payment rates are two-thirds of the rates Medicare pays (although this varies greatly by state and service) creating longstanding concerns about their effect on physician participation and access to care in the current Medicaid program (MACPAC 2017b).

Some Medicaid buy-in and state public option proposals have acknowledged this challenge, and would raise provider payment rates to current Medicare rates or higher. For example, the State Public Option Act envisions that, in general, provider payment rates would be equal to current Medicaid rates in the states; but it would increase payments to primary care providers to Medicare levels and expand the primary care provider types eligible for these rates. A study examining the possible effects of a buy-in plan paying Medicare rates in Colorado estimated annual cost savings to consumers as high as $2,228 per person, or 28 percent (Brooks-LaSure et al. 2018).

Paying Medicare rates, however, may not be sufficient to ensure adequate access to care: analysis of the ACA's Medicaid primary care payment increase by MACPAC and others have shown that raising Medicaid primary care payments to Medicare levels had a limited or unclear effect on provider participation (Mulcahy et al. 2018, MACPAC 2015). In Washington, the only state that has enacted a state public option to date, policymakers ultimately set provider payment rates at 160 percent of the Medicare rates (James 2019).

States or the federal government could potentially require providers to participate in the buy-in option. For example, Colorado's state coverage option proposal notes that the state may pursue measures to require hospitals and health systems to participate if there are areas where networks are inadequate (DOI and HCPF 2019). However, state and federal policymakers might be reluctant to mandate participation and could experience difficulty enacting the necessary legislation.

Administrative burden. Adding or expanding a Medicaid buy-in program would increase state administrative burden. Depending on the structure of the program, the Medicaid state agency, or the state agency responsible for exchange administration and oversight, or both, would need to conduct eligibility and enrollment, rate setting, procurement, oversight, and other functions. States might be able to take certain steps to limit their administrative burden, such as contracting with an existing Medicaid managed care plan to deliver benefits.

Negotiating waiver authority. Implementing most forms of a Medicaid buy-in option would require states to obtain a Section 1332 waiver. Waiver negotiations can be administratively burdensome, time and resource-intensive, and as noted above, approval is not guaranteed even if all requirements are met. To date, approved Section 1332 waivers are for reinsurance programs or other programs that are relatively limited in scope. In addition, neither CMS nor the U.S. Department of the Treasury has issued guidance outlining how states could use Section 1332 waivers to deviate from ACA requirements in order to offer a Medicaid buy-in or other state-administered health plan. The current administration has signaled its

preference for states to use Section 1332 to promote private, rather than public, coverage (DOT and HHS 2018). Negotiations over deficit neutrality, an important process for determining whether the state can receive federal pass-through funding, may be especially difficult. While CMS and Treasury have released guidance outlining how pass-through funding is calculated, it has not addressed this issue in the context of Medicaid buy-in or similar programs (CMS 2019).

Endnotes

[1] The ACA set a single income eligibility disregard equal to 5 percentage points of the FPL. For this reason, Medicaid eligibility is often referred to at its effective level of 138 percent FPL, even though the federal statute specifies 133 percent FPL.

[2] Although the ACA originally made the Medicaid expansion a requirement, the June 2012 Supreme Court ruling in *National Federation of Independent Business v. Sebelius* effectively made the Medicaid expansion an option.

[3] Individuals with income between 100 and 400 percent FPL in non-expansion states and income between 133 and 400 percent FPL in expansion states and no other offer of affordable health insurance coverage are eligible to receive premium tax credits based on their expected income for the plan year, household size, and cost of the benchmark plan, which is the second-lowest cost silver plan available to them on the exchange. Effectively, this means that premiums are capped, and cannot exceed a certain percent of family income. In 2020, the premium cap ranges from 2.06 percent of income for individuals with income 100–133 percent FPL to 9.78 percent of income for individuals with income 300–400 percent FPL (KFF 2020). The amount of the subsidy remains the same for individuals purchasing less expensive bronze plans or more expensive gold plans, meaning that individuals purchasing bronze plans could pay premiums lower than their premium cap and those purchasing gold plans could pay premiums higher than their premium cap.

Individuals who qualify for premium tax credits, and whose income is below 250 percent FPL, also qualify for cost-sharing reductions if they enroll in a silver plan. Cost-sharing reductions reduce deductibles, copayments, and other out-of-pocket costs for eligible individuals by effectively increasing the actuarial value of the plan. Individuals in the lowest income group (income below 150 percent FPL) receive the most assistance (KFF 2020).

[4] Over the last two years, insurance carriers have broadened their participation in the exchanges, offering more plans, and average benchmark premiums decreased slightly for 2020 (Fehr et al. 2019a). However, insurance markets in some states and counties with few plans participating have experienced instability. Moreover, although benchmark premiums decreased slightly on average for 2020, there was wide variation in premium changes across geographic area and plan level (Fehr et al. 2019b).

[5] These buy-in programs typically extend eligibility only to individuals who meet the Supplemental Security Income (SSI) definition of disability but have countable income or assets above SSI levels. They have historically been narrow in their goal of allowing individuals with high or complex health care needs to maintain their Medicaid coverage even as their income rises, and have enrolled only a small number of people (MACPAC 2018)

[6] Exchange plan enrollees must have no other offer of affordable coverage in order to be eligible for ACA exchange subsidies. This means that those who become eligible for Medicaid for any reason, including a coverage expansion, would automatically lose eligibility for ACA exchange subsidies.

[7] Many states have eligibility thresholds above 133 percent FPL for certain populations, including for children and pregnant women.

[8] Two states, New York and Minnesota, cover individuals 133–200 percent FPL under the Basic Health Program (BHP) option provided by Section 1331 of the ACA. The BHP option allows states to offer lower-cost health insurance coverage for individuals and families with income below 200 percent FPL who would otherwise be eligible to purchase exchange coverage, are citizens or legally present immigrants, and are not otherwise eligible for Medicaid, CHIP, or other minimum

essential coverage. The BHP is not a Medicaid state plan option, and states that operate a BHP do not receive federal Medicaid matching funds for this population. However, they receive federal funds equal to 95 percent of the amount of the premium tax credits and cost-sharing reductions that eligible enrollees would have received if they enrolled in exchange plans (CMS 2020b). The payment methodology, which determines the exact amount of federal funding, is published annually (84 FR 59529).

[9] Senate Concurrent Resolution 70 Study Group, *Final report.* (Del. 2017). https://news.choosehealthde.com/wp-content/uploads/2019/01/SCR-70-Medicaid-Buy-In-Study-Group-Final-Report-01.15.19.pdf.

[10] Metal tiers reflect the actuarial value of the plan. The actuarial values are 60 percent for bronze plans, 70 percent for silver plans, 80 percent for gold plans, and 90 percent for platinum plans.

[11] A.B. 374, 2017 Assemb., 79th Sess. (Nev. 2017). https://www.leg.state.nv.us/App/NELIS/REL/79th2017/Bill/5393/Overview.

[12] The previous governor of Minnesota, Mark Dayton, also proposed a buy-in plan, which would have made the state's BHP, MinnesotaCare, available to purchase on the exchange (State of Minnesota 2018). There are several active bills in the Minnesota legislature that would incorporate variations of this plan (United States of Care 2020).

[13] H.F. 3, 91st Leg. (Minn. 2019). https://www.revisor.mn.gov/bills/text.php?number=HF3&type=bill&version=1&session=ls91&session_year=2019&session_number=0.

[14] This list of examples in not intended to be exhaustive of all such activity occurring, or that has occurred, in states.

[15] The ACA specified 10 categories of services that health insurance plans must cover. The 10 EHBs are defined as: ambulatory services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care.

[16] Under Section 1331 of the ACA, states also have the option to create a Basic Health Program (BHP) to offer lower-cost health insurance coverage for individuals and families with income below 200 percent FPL who would otherwise be eligible to purchase exchange coverage, are citizens or legally present immigrants, and are not otherwise eligible for Medicaid, CHIP, or other minimum essential coverage. States that operate a BHP receive federal funds equal to 95 percent of the amount of the premium tax credits and cost-sharing reductions that eligible enrollees would have received if they enrolled in exchange plans (CMS 2019b). The payment methodology, which determines the exact amount of federal funding, is published annually.

[17] The State Public Option Act was originally introduced in the 115th Congress and reintroduced in the 116th Congress.

[18] Any person residing in the United States who is a U.S. citizen or lawfully present, not incarcerated, and not enrolled in Medicare, may enroll in exchange coverage.

[19] As an alternative to traditional Medicaid benefits, states were given authority under the Deficit Reduction Act of 2005 (P.L. 109-171) to enroll state-specified groups (excluding individuals with special medical needs and certain others) in benchmark and benchmark-equivalent benefit packages, also referred to as alternative benefit plans (APBs). The ACA required that benchmark and benchmark-equivalent packages include the 10 EHBs so that they align with plans offered through the individual and small group insurance markets. Adults who become eligible for Medicaid under the new adult group must be offered an ABP.

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