State Medicaid Buy-Ins: Implications for Low-Income Enrollees

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I. INTRODUCTION

Medicaid buy-ins recently gained attention and popularity after the Nevada Legislature, concerned that federal Medicaid expansion could be repealed and seeking an alternative, passed a bill allowing individuals over-income for Medicaid to purchase a plan similar to Nevada's traditional fee-for-service Medicaid in the state's health care Marketplace.[1] The bill was vetoed, but similar state-level "Medicaid buy-ins" have been publicly introduced in at least three other states, and are under discussion in at least half a dozen others.[2] There is no one model of a Medicaid buy-in. The contours of these proposals vary widely as to the income level eligible for participation, whether the model utilizes Medicaid federal financial participation, and the benefit package offered. While the proposals differ in important ways, they all seek to enable states to offer Medicaid or Medicaid-like plans as one of the options individuals have when shopping for insurance, and to allow premium tax credits (PTCs) to be used to purchase this insurance.

Proponents of buy-ins hope these programs will achieve a variety of goals: provide a new coverage option that may be more affordable or comprehensive than Marketplace coverage; create additional coverage options in counties with limited Marketplace choices or in states without Medicaid expansion; and lower the costs of private insurance offered in the Marketplace. Some Medicaid buy-in proposals, however, risk decreasing affordability for the lowest income enrollees, reducing benefits, and making it more expensive for the state to cover existing Medicaid enrollees. Furthermore, Medicaid buy-ins are a clearly inferior substitute for Medicaid expansion. Advocates should proceed carefully to ensure that proposed buy-ins do not undercut important existing protections for Medicaid enrollees.

This issue brief analyzes the opportunities and challenges posed by Medicaid buy-ins and suggests guardrails to avoid harming the lowest-income enrollees.

II. DISCUSSION

A. Legal Framework

Current federal law does not explicitly offer states the option to implement a Medicaid buy-in. Accordingly, the statutory language in proposed buy-in bills generally requires states to seek any "necessary federal waivers." Two types of waivers are potentially implicated. First, Section 1332 State Innovation Waivers allow the federal Department of Health and Human Services (HHS) to waive certain provisions of the Affordable Care Act (ACA) in narrow circumstances.[3] Second, Section 1115 Medicaid Demonstrations allow HHS to grant waivers of certain provisions of the Medicaid Act if states undertake experimental, pilot, or demonstration projects that are likely to promote the objectives of the Medicaid Act.[4]

1. Section 1332 of the Affordable Care Act: Waivers for State Innovation

Several provisions of the ACA are incompatible with buy-in proposals. For example, to allow individuals to use PTCs to purchase Medicaid, it would be necessary to waive the ACA rule that PTCs can only be used towards coverage in a Qualified Health Plan (QHP) because Medicaid is not a QHP.[5]

While the ACA allows states to waive certain provisions that apply to individual and small group plans, waiver applications are subject to stringent criteria designed to prevent waiver requests that would have the effect of reducing the coverage gains achieved through the law's reforms. Section 1332 waiver requests must meet the following conditions:

- The state plan provides coverage at least as comprehensive as coverage required by the ACA, including coverage of the ten Essential Health Benefits (EHBs);[6]
- The state plan provides cost-sharing protections against excessive out-of-pocket spending, making coverage at least as affordable as under the ACA;
- The state plan provides coverage to at least a comparable number of residents; and
- The state plan will not increase the federal deficit.[7]

States are also required to provide a "comprehensive description" of how the waiver meets the above requirements based on sufficient data.[8]

2. Section 1115 of the Social Security Act: Medicaid Demonstration Projects

If a state seeks any Medicaid federal financial participation for the buy-in, the state is bound by the requirements of the Medicaid Act. That is, if the "product" the person is purchasing is not solely funded through premiums and state contributions but also with Medicaid funding, the state must abide by federal Medicaid requirements.[9] Several common components of buy-in proposals are simply inconsistent with fundamental Medicaid Act protections. For example, a buy-in, by definition, contemplates the imposition of premiums, but as discussed below in Section B.1, Medicaid protects low-income enrollees from the imposition of premiums, and such protections should not be waived.

Section 1115 allows HHS to waive some requirements of the federal Medicaid Act so that states can test novel approaches to improving medical assistance for low-income individuals.[10] However, HHS's authority to approve such waiver requests is limited and states' requests are subject to a stringent review process.[11] First, Sec. 1115 authorizes HHS to waive only those requirements found in 42 U.S.C. Sec. 1396a.[12] Requirements found outside of Sec. 1396a cannot be waived. Moreover, all Sec. 1115 waivers must be limited to the extent and period needed to carry out the experiment or demonstration.[13] By longstanding practice, waivers must also be budget neutral to the federal government.[14]

Perhaps the two most important requirements for states seeking Sec. 1115 waivers are that each waiver must seek to (1) implement an experimental, pilot, or demonstration project that is (2) likely to promote Medicaid's objectives.[15] The first requirement means that states must conduct a genuine experiment of some kind. It is not sufficient that the state seeks to simply save money through a Sec. 1115 waiver; the state must seek to "test out new ideas" and ways of addressing problems faced by enrollees.[16] Second, Medicaid's objectives are to furnish medical assistance and rehabilitation and other services to eligible individuals.[17] A waiver that does not promote access to coverage would not be permissible. Advocates should examine each component of a proposal individually to determine if it complies with the requirements of Sec. 1115.[18]

B. *Necessary Guardrails: Affordability, Mandatory Benefits, and Program Integrity*

1. Medicaid Buy-Ins Must Protect Affordability for Low-Income Populations

In some states, Medicaid buy-ins are being targeted to individuals below 138% of the Federal Poverty Line (FPL), as substitute for Medicaid expansion.[19] **Medicaid buy-ins are a clearly inferior substitute for Medicaid expansion.** Buy-ins as a substitute to Medicaid expansion implicate serious affordability concerns for low-income consumers. If states are seeking a way to expand coverage, the prudent way to proceed is to expand Medicaid.

Buy-ins are unaffordable for enrollees under 138% FPL, even if HHS allows the use of PTCs and cost-sharing reduction (CSR) payments to be used for buy-ins. Enrollees between 100-138% FPL are subsidized in the Marketplace and are expected to pay approximately 2% of their income for insurance premiums.[20] But even premiums at 2% of income create substantial barriers to coverage for individuals at 100-138% FPL.[21] Individuals with incomes below 100% FPL are not eligible for PTCs and CSRs in the Marketplace, unless authorized by a Sec. 1332 waiver. These individuals would have to pay full price for a Medicaid buy-in, making coverage completely unaffordable. Even if they had the Marketplace level of subsidies (e.g., premiums at 2% of income), individuals living in poverty would face major barriers to maintaining coverage.

A buy-in, by definition, contemplates imposing premiums on participants. Conversely, the Medicaid Act protects affordability by prohibiting states from imposing premiums on individuals

below 150% FPL.[22] And some populations may never be charged a premium, regardless of income level.[23] For low-income enrollees, the premiums in a buy-in are simply a terrible policy and create barriers to coverage – thus, Medicaid expansion is the better path.

The Medicaid Act also limits other cost-sharing mechanisms to nominal amounts.[24] These provisions should not be waived under Sec. 1115, because they lie outside of § 1396a.[25] But even if HHS *could* waive these cost-sharing provisions under Sec. 1115, any such wavier of cost sharing would have to comply with Sec. 1396o(f) in addition to having an experimental value and promoting the objectives of Medicaid.[26] Any premiums imposed must also be subject to the limitations found in 42 U.S.C. Sec. 1396o-1, which may not be waived under any circumstances. The cost-sharing protections in Medicaid are designed to ensure care is actually affordable to enrollees, and thus this too favors Medicaid expansion over a buy-in for populations below 138% FPL.

If a buy-in is marketed to those above income levels for Medicaid expansion who are not otherwise eligible for Medicaid, Sec. 1332 requires a state seeking a waiver of the default Marketplace affordability protections to demonstrate that the new plan "will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of this title would provide."[27] At the very least, affordability means that the buy-in proposal should not have the effect of reducing PTCs and CSRs available to those who receive subsidies, whether those individuals opt into the buy-in or not.

2. Buy-Ins Should Not Worsen Covered Benefits

Although referred to as a "Medicaid buy-in," some states have proposed benefit packages for the buy-in that differ from Medicaid. Individuals should not end up with worse benefits because they are in a buy-in. This means that: (1) Individuals who could be eligible for Medicaid should be enrolled in Medicaid and always receive the benefits that they are entitled to; and (2) Marketplace enrollees that opt for the Medicaid buy-in should still receive a benefit package that includes all 10 EHBs—that is, a benefits package that meets the minimum standards in the Marketplace.

Medicaid requires coverage of a benefits package specifically designed for low-income individuals. The Medicaid Act requires states to cover mandatory services for most enrollees in the program, including inpatient and outpatient hospital services, laboratory and X-ray services, Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services for enrollees under age 21, and physician services.[28] Medicaid also requires coverage of other services, such as non-emergency medical transportation (NEMT), for all enrollees.[29] Under a Medicaid expansion, states can offer an alternative benefits package, but this package too includes many minimum coverage requirements (including all 10 EHBs) and must cover additional services such as NEMT. Populations eligible for Medicaid should be covered through Medicaid because it offers the best coverage for those individuals. Furthermore, if a state seeks Medicaid federal financial participation for the buy-in, the state *must* cover mandatory Medicaid benefits for those in the buy-in.

For example, despite Medicaid's coverage requirements, Nevada's Medicaid buy-in excluded NEMT benefits from the plan, without explaining why such an exclusion falls into the narrow exceptions permitted by a Sec. 1115 demonstration project, including how the exclusion would promote the objectives of the Medicaid Act.[30] NEMT is a required Medicaid service that addresses a significant barrier to access to care for low-income individuals who are more likely to lack transportation to take them to and from medical providers.[31] Advocates should remain vigilant that Medicaid buy-in programs are not used to eliminate Medicaid benefits that would otherwise be required for Medicaid eligible individuals.[32]

Advocates should also consider state law requirements for Medicaid, and work to have those requirements applied to buy-ins (whether federal funding is used or not) to ensure that Medicaid protections and benefit requirements apply.

Last, advocates must also guard against reductions to EHBs. Medicaid buy-ins should provide coverage of the ten EHB categories included in the ACA if a state seeks to allow individuals to use PTCs and CSRs to purchase this coverage.[33] If states are using a traditional Medicaid benefits package for their buy-in, states should consider adding EHB services that may not be in the Medicaid state plan package. For example, the ACA requires plans to cover substance use disorder and mental health services.[34] While required by the ACA for Marketplace plans, these services are not available in every state's traditional Medicaid state plan.[35]

3. Medicaid Should Not Subsidize Insurance for Non-Medicaid Buy-In Populations

Medicaid buy-ins have the potential to increase overall costs in Medicaid by, intentionally or unintentionally, altering the Medicaid risk pool (*i.e.* the group of individuals insured). The size and diversity of a health insurance risk pool determines how health care costs are distributed across a group.[36] In general, the bigger the risk pool, the easier it is to spread the high cost of one individual's serious needs across a broader population. In a managed care context, a bigger risk pool may mean a state can negotiate a lower per member per month rate. If those buying into the program are healthier than those already covered by Medicaid, merging the traditional Medicaid risk pool with the Medicaid buy-in risk pool would lower costs to the state. However, if the Medicaid buy-in population is more costly than the Medicaid risk pool, it could increase the cost of insurance in that risk pool. This could in effect lead to Medicaid subsidizing health care for the buy-in population. This scenario is very plausible because if the Medicaid benefits coverage is better than the Marketplace coverage, it might attract individuals with significant health conditions (even if they have to pay a little bit more for the buy-in). Some proponents of buy-ins have suggested doing this intentionally--shifting expensive enrollees into Medicaid's risk pool to reduce premiums in private insurance risk pools. By allowing individuals with high needs to "use" Medicaid's risk pool, the buy-in could have the effect lowering the costs for private insurance while adding costs to the Medicaid program.[37]

To protect the integrity of current Medicaid programs, states should be careful to guard against unanticipated use of Medicaid as a de-facto high risk pool.[38] Nevada's statute did not contain

any safeguards. Wisconsin's proposed statute contains language directing the state to implement mechanisms to ensure the long-term financial sustainability of Wisconsin's current Medicaid program, and requiring "[r]eimbursement mechanisms for addressing potential increased costs" to Wisconsin Medicaid – language which presumably seeks to address this risk.[39] The Minnesota proposed statute contains similar language to protect the Minnesota Basic Health Plan.[40] However, neither Wisconsin's nor Minnesota's plan provides details regarding specific mechanisms or strategies to achieve this directive. Advocates should push states to think through the potential consequences of buy-ins and protect state Medicaid programs from unanticipated or unintentional cost increases.[41]

C. Buy-In Opportunities and Solutions

While Medicaid buy-ins pose substantial risks, these buy-ins could allow states to expand coverage in areas where there are few (or no) Marketplace plan options, provide more comprehensive services for individuals with complex medical needs, and/or provide a less expensive alternative to private insurance.

1. Buy-Ins Could Expand Choice in Some Geographic Areas

Approximately 1,500 counties nationwide have only one plan offered in the health care Marketplace; approximately 30% of the U.S. population lives in a county with only one option.[42] Buy-in programs could create more options in counties where limited insurers participate in the Marketplace. However, if a Medicaid buy-in is less expensive than other options in the Marketplace, buy-ins could make it difficult for private issuers to compete, potentially limiting the number of choices available in counties. For this reason, insurers might oppose buy-in legislative efforts.[43] One possible solution is to limit Medicaid buy-ins to counties that have difficulty attracting insurers or where costs are particularly high. In this way, the buy-in could become a stabilizing force, filling in gaps in the private market, without undercutting the private market. However, if a buy-in program is geographically restricted, that might affect the size of the risk pool, and therefore the cost of the buy-in option. States will need to grapple with their own unique demographics and needs, and determine to what extent, if any, a buy-in program should be geographically restricted.

2. Buy-Ins Could Offer More Comprehensive Coverage to Individuals with Complex Medical Needs

As noted above, traditional Medicaid provides substantial mandatory benefits, and many states offer a robust package of additional benefits. If a buy-in is based on a state's traditional Medicaid plan, Medicaid may provide a more comprehensive package of benefits than private insurance. For example, traditional Medicaid (that is, Medicaid for the non-expansion population) must cover nursing facility services, which is not considered an Essential Health Benefit.[44] Furthermore, many state Medicaid plans offer extensive optional services that private insurance generally does not cover, such as personal care services or private duty nursing.[45] If the buy-in is designed based on the state's traditional Medicaid state plan, buy-ins

may be beneficial for older adults or individuals with chronic conditions who do not otherwise qualify for Medicaid, but who may be better served via a Medicaid benefit package.

If the buy-in is based on the Alternative Benefit Plan (ABP) established for the state's Medicaid expansion population, the coverage available via a buy-in is likely to be similar to coverage available in the Marketplace. However, for both ABPs and traditional Medicaid, some additional services, such as transportation to and from medical appointments – a benefit that falls outside the definition of "Essential Health Benefits" – must be covered.[46]

3. Buy-Ins Could Save Enrollees Money

While individuals under 400% FPL receive subsidies on the Marketplace (on a sliding scale), subsidized coverage may still be expensive. And of course, individuals over 400% FPL pay the full cost of insurance. Preliminary estimates of Medicaid buy-ins suggest it is possible these plans may be able to be offered at a lower cost than plans in the Marketplace. For example, the Minnesota Governor's office claims the Minnesota buy-in would cost $469 per month, or 13% less than the average cost of private insurance.[47] Fully realizing these savings will rely on providers' willingness to serve this new population at the same payment rates they currently serve the Medicaid population. Medicaid provider payments have been historically lower than Medicare, employer sponsored insurance, and private insurance, and providers may demand higher rates if a significant portion of enrollees shifts from private insurance to the buy-in.[48] Furthermore, if the health care needs of the Medicaid buy-in population are greater than the needs of current Medicaid enrollees, the cost per enrollee in the Medicaid buy-in would rise, which might in turn lead the state to raise the buy-in premium. States seriously considering buy-in proposals should undertake actuarial analyses to determine buy-in premiums and consider provider capacity to serve buy-in enrollees. Advocates should also study what impact, if any, the buy-in option might have on underlying Marketplace subsidies.

III. CONCLUSION

Buy-ins are a creative option for states seeking to expand coverage. Caution, however, is key. Medicaid buy-ins are not appropriate substitutes for Medicaid expansion. Buy-ins contemplate the imposition of premiums, which is not permitted in Medicaid for individuals under 150% FPL, and would make coverage unaffordable for very low-income individuals, particularly those under 100% FPL who are not eligible for CSRs and PTCs. Similarly, some buy-ins contemplate limiting required benefits in a way that runs afoul of Medicaid law, and fail to meet the health needs of low-income individuals, and therefore should not be permitted via a Sec. 1115 waiver. Third, states seeking to combine Medicaid and buy-in risk pools should take care to address the risk of increased costs to the Medicaid program.

States may also need a Sec. 1332 waiver to implement buy-ins. When requesting Sec. 1332 waivers, states must be able to demonstrate that the proposed project would provide coverage to at least the same number of people, would provide coverage as comprehensive, and would provide similar protections against cost-sharing and out-of-pocket costs as under current law.

Finally, there are important design considerations that states must keep in mind when implementing a buy-in program. States must be able to set premiums in a way that protects the program against high costs. In addition, states must keep in mind the impact that a buy-in program would have on private insurers in the Marketplace and may want to consider limiting the programs to counties that lack robust insurer participation in the Marketplace.

Appendix A
Past experience: Connecticut's Charter Oak Health Plan

In 2008, Connecticut implemented a public medical insurance program for individuals not eligible for Medicaid. The Charter Oak Health Plan (COHP) provided insurance for Connecticut residents age 19 through 64 who did not qualify for other public health insurance programs and had been uninsured for at least six months prior to enrollment. Because the program was established before the ACA was enacted, the COHP statute explicitly prohibited discrimination based on preexisting conditions.

While there was no income or asset limit for participation in COHP, enrollees were required to pay monthly premiums, annual deductibles, copayments, and coinsurance. Monthly premiums were set at $307, but the statute authorized COHP to provide premium assistance to eligible enrollees whose gross annual income did not exceed 300% of the FPL. The COHP statute also established limits on other out-of-pocket costs and utilization controls that varied depending on the individual's gross annual income, and limits on coinsurance payments and emergency room fees. COHP also required tiered copayments for prescription drugs.

In practice, COHP coverage was delivered through three managed care organizations (MCOs). Even though these insurers participated as MCOs in the state's Medicaid program, COHP was established as a separate program, with separate risk pools and separate, independently calculated capitation rates.

COHP ended in 2012 after the program resulted in a death spiral and the legislature repealed the program's enabling statute. The program's unsustainability is explained by three main factors. First, the state failed to perform appropriate actuarial analyses to determine appropriate premiums for COHP. The premiums collected were insufficient to cover the actual costs of the program.[49] Second, before the ACA, private insurers could deny coverage for individuals with preexisting conditions. As a result, a significant number of uninsured individuals in Connecticut had a preexisting condition. Because the COHP statute prohibited the program from excluding eligible individuals with preexisting conditions, most of these high-cost individuals quickly enrolled in COHP. Third, without an individual mandate, a large number of healthier individuals in Connecticut opted to remain uninsured. If healthy individuals had to enroll in insurance, presumably a large number of these individuals would have enrolled in COHP, making the program's risk pool healthier overall. Without a balanced risk pool, however, premiums in COHP skyrocketed and enrollment rapidly declined from a maximum of 14,579 in 2010 to 5,699 in 2013.[50] Those who remained in the program were mostly older individuals with high medical costs, which led to additional premium increases and extended the death spiral. As Connecticut's experiment with Charter Oak demonstrates, a plan that disproportionately attracts individuals with high needs will eventually skyrocket in price, undermining affordability.[51]

Appendix B
Recent Proposals

1. Nevada – Nevada Care Plan

In 2017, the Nevada Legislature passed a bill that would have allowed anyone in the state to buy directly into the state's Medicaid program. A.B. 374 created the Nevada Care Plan (NCP), available to individuals buying insurance through the Silver State Health Insurance Exchange.[52] With the exception of NEMT, the coverage provided in NCP was the same coverage provided to enrollees of traditional fee-for-service Medicaid.[53] The bill also authorized the state to request all the necessary waivers from the federal government to establish the new program.[54] For example, the state would have needed a Sec. 1332 waiver to allow individuals to use federal PTCs to purchase NCP coverage.[55] Similarly, Nevada may have intended to request Sec. 1115 waiver if the state intended to create a single risk pool consisting of Medicaid and NCP enrollees or waive mandatory benefits. It is unclear from the bill's language whether Nevada intended to create a single risk pool or maintain separate risk pools for both types of enrollees. Citing the need for more research and further implementation details, Governor Brian Sandoval vetoed AB 374 in June 2017.

2. Wisconsin – BadgerCare for All

While not a Medicaid expansion state, Wisconsin's "BadgerCare Plus" program includes a Sec. 1115 waiver that covers nearly all childless non-elderly adults with incomes below 100% FPL.[56] Unlike many states that did not expand, Wisconsin has no coverage gap for individuals under 100% FPL, but those between 100-138% must still seek coverage in the Marketplace.[57] On July 26, 2017, a bill was introduced in the Wisconsin legislature, nicknamed "BadgerCare for All," that would allow individuals who are over-income for the BadgerCare Plus program to buy into coverage.[58] The proposal requires the new program to include the following: 1) a premium rate similar to that which the state pays for managed care; 2) an actuarial value of no less than 87%; and 3) benefits equal to those currently offered under BadgerCare Plus. Like all Medicaid buy-in bills to date, the bill directs the state Medicaid authority to apply for any waivers necessary to allow the use of PTCs and CSRs with these plans. Lastly, the bill directs the department to "implement mechanisms" to ensure the long-term financial sustainability, while "minimizing adverse selection, the state financial risk and contribution, and negative impacts to premiums in the individual and group insurance markets."[59] Despite the national attention the bill has garnered, it has no Republican co-sponsors, and is not likely to move forward in the near future.

3. Minnesota – MinnesotaCare Buy-In

In January 2017, SF 58 was introduced, a bill that would have allowed Minnesotans to purchase coverage under the state's Basic Health Program (BHP), MinnesotaCare. Minnesota is one of two states (New York is the other) that operates a Basic Health Program, a public alternative to Marketplace coverage for low-income individuals (below 200% FPL) who are not

eligible for Medicaid.[60] While not specifically a "Medicaid buy-in," the Minnesota proposal shared many of the same hallmarks: an annual enrollee premium set at the average the state pays to managed care plan contractors and an actuarial value of at least 87%. It also directed the commissioner to seek federal waivers to: 1) allow individuals over 200% FPL to purchase coverage through the BHP; 2) to allow individuals to use PTCs and CSRs to purchase coverage through the BHP; and 3) have the coverage purchased through MinnesotaCare count as QHP for purposes of the individual mandate.[61] The drafters of SF 58 provided additional details about how they envisioned it working: health plans that currently contract with Minnesota's Department of Human Services to provide coverage under Medicaid or the BHP would be required to offer a buy-in option as well. The buy-in option could either be delivered via either a MCO or an accountable care organization.[62] However, like the Wisconsin proposal, the bill was "not seriously considered by the Republican-controlled legislature."[63]

ENDNOTES

[1] A.B. 374, 79th Leg. (Nev. 2017). *See* Appendix B for more information on Nevada's proposed Medicaid buy-in.
[2] At the time of publication at least three states (Minnesota, Wisconsin, and Massachusetts) have pending Medicaid buy-in legislation while legislators in at least five other states were either planning to introduce legislation or were seriously considering legislation. In Massachusetts, a provision was incorporated into a larger health care affordability bill that would allow the state Medicaid office to make Medicaid available in the individual market or as employer-sponsored insurance. Senate Bill 2202 allows the agency to impose premiums and cost-sharing and to seek any federal waiver necessary for individuals to use PTCs and CSRs against premiums and cost-sharing in the program. S.B. 2202 § 125, 190th Leg. (Mass. 2017). Importantly, the legislation would exempt individuals who are currently eligible under the Medicaid expansion from premiums and cost-sharing requirements even if the individual enrolls in the expanded option through an employer. Additionally, New Mexico's legislature introduced a memorial requesting that the interim Legislative Health and Human Services Committee analyze the policy and fiscal implications of offering a Medicaid buy-in plan to non-Medicaid eligible New Mexico residents to increase low-cost health coverage options. S. Memorial 3, 53rd Leg. (N.M. 2017). *See* Appendix B for more information on current proposals.
[3] 42 U.S.C. § 18052.
[4] 42 U.S.C. § 1315(a). For more information, *see* Jane Perkins, Nat'l Health Law Prog., *Background to Medicaid and Section 1115 of the Social Security Act* (Apr. 3, 2017), http://www.healthlaw.org/publications/browse-all-publications/background-to-medicaid-section-1115-social-security-act#.WlOwtd-nE2w.
[5] Medicaid, by definition, is not a QHP. A QHP is a plan that is certified by the Health Insurance Marketplace, provides essential health benefits, agrees to offer at least one silver level plan and one gold level plan, and meet other requirements of the Affordable Care Act. 42 U.S.C. § 18021. Medicaid plans, by contrast, are designed to meet the needs of a lower-income population. 42 U.S.C. § 1396-1. Medicaid covers benefits defined by the state, within the contours of federal statutory requirements and is not offered in the Marketplace. 42 U.S.C. § 1396a.
[6] The ten categories of EHBs mandated by the ACA are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. 42 U.S.C. § 18022.
[7] 42 U.S.C. § 18052(b)(1).
[8] 42 U.S.C. § 18052(a)(1)(B)(i).
[9] Federal Financial participation (FFP) could take a variety of forms. One possibility is that the premiums could be capped at a certain amount or percent of income, and anything over that amount necessary to cover medical costs would then be to be split between the federal and state government at the state's Federal Medicaid Assistance Percentage (FMAP).
[10] Section 1115(a) of the Social Security Act, 42 U.S.C. § 1315(a), provides, in relevant part:

> In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid program], in a State or States--
> (1) the Secretary may waive compliance with any of the requirements of section [...] 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project, and
> (2)(A) costs of such project which would not otherwise be included as expenditures under section [...] 1396b of this title, as the case may be, [...] shall, to the extent and for the period prescribed by the Secretary, be regarded as expenditures under the State plan or plans approved under such subchapter, or for administration of such State plan or plans, as may be appropriate [...].

[11] For example, when proposing a new § 1115 waiver program, states must ensure meaningful public input and stakeholder engagement by providing at least a 30-day public notice and comment period and by holding at least two public hearings prior to submission to HHS. Waiver applications must include a description of the proposed health care delivery system, eligibility requirements, benefit coverage, financing or cost-sharing changes; an estimate of expected annual enrollment and expenditures; a description of the research hypothesis that the demonstration will test and a plan for evaluating the hypothesis; and written documentation of the state's compliance with public notice requirements. Once submitted, CMS must also provide a 30-day federal public notice and comment period. For more information on § 1115 demonstration approval process, *see* Jane Perkins &

Catherine McKee, Nat'l Health Law Prog., *Sec. 1115 Waiver Requests: Transparency & Opportunity for Public Comment* (Apr. 28, 2017), http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-waiver-requests-transparency-opportunity-public-comment#.WegmSxNSwxd.

[12] 42 U.S.C. § 1315(a)(1).

[13] *Id.*

[14] For a demonstration to be budget neutral, actual Medicaid service expenditures – plus the cost of any expenditure authorities authorized under the demonstration – cannot be greater than the projected "without waiver" expenditures. *See* Eliot Fishman, CMS, *Budget Neutrality for Section 1115(a) Medicaid Demonstrations – New Adjustments in Methodology* (May 12, 2016), https://www.medicaid.gov/medicaid/section-1115-demo/downloads/about-1115/all-state-presentation.pdf.

[15] 42 U.S.C. § 1315(a).

[16] *See Beno v. Shalala*, 30 F.3d 1057, 1069 (9th Cir. 1994) (finding that § 1115 "was not enacted to enable states to save money or to evade federal requirements but to 'test out new ideas and ways of dealing with the problems of public welfare recipients.' [...] A simple cut, which might save money, but has no research or experimental goal, would not satisfy this requirement." (*quoting* S. Rep. No. 1589, 87th Cong., 2d Sess. 20, *reprinted in* 1962 U.S.C.C.A.N. 1943, 1961.)).

[17] 42 U.S.C. § 1396-1.

[18] Under § 1332(a)(5) of the ACA, HHS is required to develop a process for coordinating § 1332 and § 1115 waiver requests. 42 U.S.C. § 18052(a)(5). While no state has proposed a coordinated waiver to CMS thus far, depending on the framework of the proposed program, states contemplating Medicaid buy-in proposals where the design requires waivers under both § 1332 and § 1115, may submit coordinated waiver requests. However, while such waivers may be coordinated, the § 1115 waiver is still an independent waiver that must meet all the requirements of § 1115, and § 1332 waivers offer no authority to waive provisions of the Medicaid Act.

[19] Nevada's buy-in proposal gained momentum due to fear that the Medicaid expansion may be repealed by Republicans. *All Things Considered*: *Nevada May Become First State to Offer Medicaid to All, Regardless of Income*, NPR (June 13, 2017) http://www.npr.org/sections/health-shots/2017/06/13/532783189/nevada-may-become-first-state-to-offer-medicaid-to-all-regardless-of-income.

[20] 26 U.S.C. § 36B.

[21] Samantha Artiga *et al.*, Kaiser Family Found., *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (June 1, 2017), http://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/.

[22] 42 U.S.C. § 1396o(a)(1); (c)(1).

[23] 42 U.S.C. § 1396o(b)(2); 42 C.F.R. § 447.56.

[24] 42 U.S.C. § 1396o(a)(3). *See also* 42 U.S.C. § 1396o-1. General limits to premiums and cost-sharing are contained in 42 C.F.R. §§ 447.52-56.

Family Income	Premiums and Enrollment Fees	Cost-Sharing	Aggregate Premium and Cost-Sharing Limit
< 100% FPL	Not permitted	Limited to nominal amounts	Not to exceed 5% of family's monthly income
100% FPL - 150% FPL	Not permitted	Not to exceed 10% of cost of service	Not to exceed 5% of family's monthly income
> 150% FPL	Permitted for some populations	Not to exceed 20% of cost of service	Not to exceed 5% of a family's monthly income

[25] Only provisions in 42 U.S.C. § 1396a may be waived under the Secretary's § 1115 authority. The cost-sharing protections in 42 U.S.C. § 1396o, fall outside § 1396a, and therefore cannot be waived under § 1115.

[26] This prohibition is in 42 U.S.C. § 1396o, and therefore falls outside § 1396a, and cannot be waived under § 1115. Pursuant to § 1396o(f), the enrollment fees and cost-sharing provisions of the Medicaid Act may only be waived if the Secretary of HHS finds, after public notice and opportunity for comment, that the premiums or fees:

- Will test a unique and previously untested use of copayments;

- Are limited to a period of not more than two years;
- Will provide benefits to recipients of medical assistance which can reasonably be expected to be equivalent to the risks to the recipients;
- Are based on a reasonable hypothesis which the demonstration is designed to test in a methodologically sound manner, including the use of control groups of similar recipients of medical assistance in the area; and
- Are voluntary, or make provision for assumption of liability for preventable damage to the health of recipients of medical assistance resulting from involuntary participation.

[27] 42 U.S.C. § 18052(b)(1)(B).
[28] 42 U.S.C. §§ 1396a(a)(10)(A); 1396d(a)(1-5), (17), (21).
[29] 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53.
[30] A.B. 374, 79th Leg. (Nev. 2017).
[31] 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53. *See also* Samina T. Syed, Ben S. Gerber & Lisa K. Sharp, *Traveling Towards Disease: Transportation Barriers to Health Care Access*, 38 J. Community Health 976, 989 (2013).
[32] Although we are not aware of any proposals that seek to waive Medicaid's comprehensive coverage of family planning services, advocates should remain vigilant against any such abrogation. The Medicaid Act requires states to provide coverage for family planning services without cost-sharing, including contraceptive methods, services, and counseling; sexually transmitted infections and cervical cancer tests; and human papillomavirus (HPV) vaccination. *See* 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. § 441.20. *See also* 42 U.S.C. §§ 1396o(b)(2), 1396o-1(b)(2) (exempting family planning services and supplies from copayments). Similarly, the Medicaid program includes protections for enrollees in managed care organizations (MCOs) that, among other things, guarantee them the right to obtain covered family planning services from the qualified Medicaid provider of their choice, regardless of whether that provider is in-network or out-of-network. 42 U.S.C. §§ 1396a(a)(23)(B), 1396n(b). *See also* Catherine McKee, Nat'l Health Law Prog., *Medicaid Managed Care Final Regulations and Reproductive Care* (June 23, 2016), http://www.healthlaw.org/issues/reproductive-health/Brief-5-MMC-Final-Reg-Repro-Health#.Wmi_MainE2w. It is critical that buy-in proposals maintain these reproductive care protections afforded to MCO enrollees.
[33] 42 U.S.C. § 18022.
[34] *Id.*
[35] 42 U.S.C. § 1396a(a)(10)(A); 42 U.S.C. § 1396d(13).
[36] Linda Blumberg and John Holahan, *Don't Let The Talking Points Fool You: It's All About The Risk Pool*, Health Affairs (Mar. 15, 2016), http://healthaffairs.org/blog/2016/03/15/dont-let-the-talking-points-fool-you-its-all-about-the-risk-pool/.
[37] *See* M. Musumeci, Kaiser Family Found., *10 Things to Know about Medicaid: Setting the Facts Straight* (May 9, 2017), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/ (stating that Medicaid acts as a high-risk pool by covering a population with high rates of disease and disability compared to the population covered by private insurance).
[38] On a limited basis, states "use" Medicaid's risk pool like this all the time, when adding optional categories of coverage. A state may cover certain adults over 138% FPL, as technically there is no upper limit to Medicaid coverage. However, when a state makes that decision, those individuals become actual Medicaid enrollees – they are not simply using Medicaid's risk pool to lower costs without fully participating in the program. It is also possible that specific federal authority to create a buy-in could be granted. *See e.g.,* Ticket to Work and Work Incentives Act of 1999, which added two additional optional categories of eligibility to Medicaid: those who would be eligible for Supplemental Security Income (SSI) based on disability but for excessive earnings; and those who were eligible for SSI based on disability, but whose condition medically improved and whose income, assets, and resources are below state-designated limits. 42 U.S.C. § 1396a(a)(10)(ii)(XV), (XVI). The statute authorizes states to charge these new eligible individuals premiums on a sliding scale, with certain restrictions, and the full cost of the premium as long as their income is above 250% FPL and $75,000 in 2000 dollars (adjusted yearly). 42 U.S.C. § 1396o(g). Congress allowed higher earners to buy into Medicaid because it found that "Social Security Disability Insurance and Supplemental Security Income beneficiaries risk losing [M]edicare or [M]edicaid coverage that is linked to their cash benefits, a risk that is an equal, or greater, work disincentive than the loss of cash benefits associated with working ... " and therefore wanted to "encourage States to adopt the option of allowing individuals

with disabilities to purchase [M]edicaid coverage that is necessary to enable such individuals to maintain employment." Ticket to Work and Work Incentives Act of 1999, Pub. L. No. 106-170, 113 Stat. 1862-63 (1999).
[39] A.B. 449, 2017-2018 Leg. (Wisc. 2017).
[40] S.F. 58, Subd. 2, 90th Leg. (Minn. 2017), https://www.revisor.mn.gov/bills/bill.php?f=SF58&y=2017&ssn=0&b=sen.
[41] Managed Care Organizations that receive capitated payments from states must also ensure that those payments are made for the "benefit of individuals eligible for benefits under this subchapter" and payments must be made on "an actuarially sound basis […]" 42 U.S.C. § 1396b(m)(2)(A). Payments to MCOs for Medicaid services should not subsidize costs for the buy-in population.
[42] CMS, *County by County Analysis of Plan Year 2018 Insurer Participation in Health Insurance Exchanges* (Oct. 20, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/2017-10-20-Issuer-County-Map.pdf.
[43] Evan McMorris-Santoro, *AHIP Calls Public Option 'A Roadblock To Reform'*, Talking Points Memo (Oct. 27, 2009), http://talkingpointsmemo.com/dc/ahip-calls-public-option-a-roadblock-to-reform; Jonathan Cohn, *Health Insurers Fire Volley In New Battle Over The Public Option*, Huffington Post, (Sept. 20, 2016), http://www.huffingtonpost.com/entry/public-option-fight-insurance_us_57e03a66e4b08cb140974781.
[44] 42 U.S.C. §§ 1396a(10)(A); 1396d(a)(4)(A).
[45] 42 U.S.C. §§ 1396d(8), (24).
[46] 42 U.S.C. § 1396a(a)(4)(A); 42 C.F.R. § 431.53.
[47] Office of Governor Dayton, *Frequently Asked Questions, MinnesotaCare Buy-In*, http://mn.gov/gov-stat/pdf/2017_02_13_FACTSHEET_faqs_minnesotacare_buy_in.pdf. It is unclear if the premiums cited in this FAQ are the average cost of all plans, or if this is comparing the costs for a specific demographic and county. Similarly, proponents in Wisconsin contend that when co-pays and deductibles are factored in, individuals in the buy-in would save 30% on their health care costs compared to statewide averages in the private market. However, estimates of the cost per person of the buy-in appears to be estimates of the average the state pays managed care providers to provide coverage per person (with some additional administrative costs added on). Press Release, Citizen Action of Wisconsin, *New Legislation Creates BadgerCare "Public Option" to Immediately Lower Health Costs* (July 5, 2017), http://urbanmilwaukee.com/pressrelease/new-legislation-creates-badgercare-public-option-to-immediately-lower-health-costs/. The Wisconsin Legislative Bureau concluded that the average monthly cost per enrollee already in Badgercare Plus is $602 for adults and $248 for children. *See* Letter from Jon Dyck, Supervising Analyst, Wisconsin Legislative Fiscal Bureau (June 2, 2017) (on file with author).
[48] Lisa Clemans-Cope and John Holahan, Urban Institute, & Rachel Garfield, Kaiser Family Found., *Medicaid Spending Growth Compared to Other Payers: A Look at the Evidence* (Apr. 2016), http://files.kff.org/attachment/issue-brief-medicaid-spending-growth-compared-to-other-payers-a-look-at-the-evidence.
[49] Personal communication with Ellen Andrews, Ph.D., and Sheldon Toubman, J.D., August 2017.
[50] Connecticut Health Policy Project, *What Can Charter Oak Teach the CT Health Insurance Exchange?* (Mar. 2013), http://www.cthealthpolicy.org/briefs/201303_charter_oak_vs_hix.pdf. *See also* Conn. Dept. of Social Servs., Council on Medical Assistance Program Oversight, *Enrollment Reports* (2010, 2013) https://www.cga.ct.gov/med/mh-meetings.asp?sYear=2013.
[51] Connecticut Health Policy Project, *What Can Charter Oak Teach the CT Health Insurance Exchange?* (Mar. 2013), http://www.cthealthpolicy.org/briefs/201303_charter_oak_vs_hix.pdf.
[52] A.B. 374, 79th Leg. (Nev. 2017), https://www.leg.state.nv.us/Session/79th2017/Bills/AB/AB374_EN.pdf.
[53] *Id.* at § 3(2).
[54] *Id.* at § 2.
[55] *Id.* at § 2(2). For the requirement that PTCs be used for purchase of QHPs sold in the Marketplace *see* § 1402 of the Affordable Care Act, 26 U.S.C. § 36B. While A.B. 374 would have amended Nevada's definition of QHP to include this new plan, the new plan would not have been in compliance with the ACA's definition of QHP, which, among other things, requires plans to offer at least one QHP in the silver level and at least one plan in the gold level in the Marketplace. A.B. 374 did not contemplate different coverage levels within the plan. Thus, the plan would not have been a QHP for the purpose of PTCs. 42 U.S.C. § 18021(a).
[56] CMS, *Wisconsin BadgerCare Reform Demonstration Amendment Approval* (Dec. 5, 2017) https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/wi/wi-badgercare-reform-ca.pdf.

[57] Alexandra Gates and Robin Rudowitz, Kaiser Family Found., *Wisconsin's BadgerCare Program and the ACA* (Feb. 25, 2014), http://www.kff.org/medicaid/fact-sheet/wisconsins-badgercare-program-and-the-aca/.
[58] A.B. 449, 2017-2018 Leg. (Wisc. 2017).
[59] *Id.*
[60] 42 U.S.C. § 18051; 42 C.F.R. § 600.1.
[61] S.F. 58, 90th Leg. (Minn. 2017), https://www.revisor.mn.gov/bills/bill.php?f=SF58&y=2017&ssn=0&b=senate.
[62] Office of Governor Dayton, *Frequently Asked Questions, MinnesotaCare Buy-In*, http://mn.gov/gov-stat/pdf/2017_02_13_FACTSHEET_faqs_minnesotacare_buy_in.pdf.
[63] Lynn Blewett, *MinnesotaCare Buy-In: Maybe not a Long Shot*. HealthAffairs Blog (Aug. 2, 2017), http://healthaffairs.org/blog/2017/08/02/minnesotacare-buy-in-maybe-not-a-long-shot/.