U.S. Health Reform—Monitoring and Impact

Why Don't More Medicaid Insurers Sell Plans in ACA Marketplaces?

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By Rachel A. Burton, Erik Wengle, and Caroline Elmendorf

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at **www.rwjf.org** and **www.healthpolicycenter.org**.

SUMMARY

The number of insurers participating in the Affordable Care Act's individual insurance marketplaces has generally decreased over time, albeit with a slight uptick in insurer participation in 2019.[1] This is troubling because ACA marketplaces with fewer insurers tend to have higher premiums.[2] Plus, regions where at least one Medicaid insurer sells marketplace plans tend to have lower premiums.[2] This suggests that convincing more Medicaid insurers to sell marketplace plans could lower marketplace premiums. Participating in marketplaces can benefit consumers as well as insurers: several large Medicaid insurers are turning a profit on marketplace plans.[3,4,5,6]

Yet many other Medicaid insurers have chosen not to sell marketplace plans, even in states that might otherwise seem ripe for new entrants (e.g., markets with little competition and/or high marketplace premiums). To understand why this is, we interviewed insurers and associations of Medicaid insurers. The insurers we interviewed all offered Medicaid plans but had varied experiences with marketplace plans. Interviewees identified several reasons why some Medicaid insurers view Medicaid as a more attractive market than the marketplaces:

- Marketplace insurers need more sophisticated actuaries on staff to price plans (whereas states often set Medicaid insurers' capitated rates).
- Marketplace insurers must be able to collect premiums from consumers (whereas most Medicaid plans are available without a premium).
- Marketplace insurers must obtain special insurance licenses and maintain larger capital reserves to cover any unexpected financial losses.
- Marketplace insurers must compete for enrollees, which some Medicaid insurers do not have experience with because they are assigned enrollees or exclusive territories by some state Medicaid programs.
- Marketplace insurers face more financial risk, because marketplace rules and conditions have changed drastically from year to year, making it more difficult for insurers to predict how costly their enrollees will be (and leading some insurers to lose money on their marketplace business).

When asked about the idea of a Medicaid buy-in program, interviewees generally felt this would be more appealing to participate in than current marketplaces, if it would allow them to enroll new consumers without needing to meet the organizational requirements of becoming a marketplace insurer (listed above). Medicaid buy-in proposals can follow one of several distinct paths (Table 2). The first is a separate program, using either Medicaid fee-for-service or managed care organizations to expand coverage to individuals ineligible for Medicaid (as has been proposed in Massachusetts). Another allows Medicaid insurers to offer coverage in marketplaces (as in New Jersey). A third option combines features from each of these programs into a unique, new hybrid program—for example, plans administered by Medicaid insurers but funded through Affordable Care Act–style premiums and individual mandate fines (in Oregon). Our findings suggest that the closer Medicaid buy-in proposals hew to Medicaid program rules, the more likely that Medicaid insurers would participate in such programs.

"At the end of the day, the Medicaid [program] is much more stable and has a clear delineation of rules and regulations that gives you, the health plan organization, a fighting chance to make a profit. Whereas the marketplace—because of the dynamics of the risk that you're taking on in that population—the risk volatility is much higher in the marketplace versus that of the Medicaid [program]."

—Medicaid insurer that had entered, and then exited, the marketplace

INTRODUCTION

Insurer participation in the Affordable Care Act's (ACA's) nongroup insurance marketplaces has fluctuated significantly since their initial launch in 2014, with the number of participating insurers generally decreasing over time, albeit with a slight uptick in insurer participation in 2019.[1] This is concerning, because ACA marketplaces with fewer participating insurers tend to have higher premiums.[2] In addition, marketplace insurance rating regions where at least one Medicaid insurer sells coverage in the nongroup marketplace tend to have lower premiums.[2] Consequently, it is possible that convincing more Medicaid insurers to participate in the marketplaces could lower marketplace premiums. Medicaid insurers' participation in marketplaces can not only benefit consumers, but also has the potential to benefit these insurers: several large Medicaid insurers have spoken publicly about how profitable their marketplace business is and credited their marketplace participation as having helped them expand their footprints to new states and markets.[3,4,5,6]

Yet many insurers that offer Medicaid plans have opted not to sell marketplace plans, and this is true even in markets that might otherwise seem ripe for new entrants (e.g., markets with little competition and/or high premiums). We theorize that a Medicaid insurer should have a good chance of being profitable in the marketplaces of states where they have experience administering Medicaid plans and existing marketplace premiums are above the national average (making it easier for a new entrant to offer lower premiums), shown as the green rows in Table 1. Yet, as shown in the two right-most columns of Table 1, Medicaid insurers have not opted to sell marketplace plans in all of these states (fourth column) or in all regions of these states (fifth column). For example, states such as Nebraska, Iowa, and Delaware have marketplace premiums well above the national average and insurance companies with experience offering Medicaid plans in these states, yet no Medicaid insurers participate in these states' marketplaces. At the other end of the spectrum, the 10 states with the lowest-cost marketplace premiums all have Medicaid insurers selling marketplace plans in at least some regions of their state.

To better understand why Medicaid insurers have opted not to sell plans in some states' marketplaces, we interviewed three insurers that offer Medicaid managed care plans and two associations of Medicaid insurers. The Medicaid insurers we spoke to had varied experiences with marketplace plans: one sold marketplace plans in some states but not others, another never entered the marketplaces, and another had sold plans in some marketplaces but has since discontinued that line of business. Our interviews uncovered reasons why some insurers view Medicaid as a more attractive market than marketplaces, identified policy changes that could make marketplaces more attractive to Medicaid insurers, and explored Medicaid insurers' opinions on and interest in Medicaid buy-in proposals that would allow consumers who are ineligible for Medicaid under current law to purchase subsidized coverage through the Medicaid program, potentially as an alternative to purchasing marketplace coverage. Our findings give clues as to how Medicaid insurers would react to Medicaid buy-in proposals that do or do not include particular program features or requirements.

Table 1. Insurer Participation in State Medicaid Programs and ACA Marketplaces

State	Insurers administer Medicaid plans in this state[1]	Ratio of state's average marketplace benchmark premium to the national average[1,2] *(>1.0 reflects premiums that are higher than average)*	Medicaid insurers sell plans in the state's marketplace[3]	Share of a state's regions where Medicaid insurers sell marketplace plans[3]
Wyoming		1.84		
Nebraska	✓	1.76		
Iowa	✓	1.56		
Alaska		1.53		
Delaware	✓	1.46		
Oklahoma		1.41		
North Carolina		1.30	○	2/16
West Virginia	✓	1.25	○	9/11
New York	✓	1.22	●	8/8
Virginia	✓	1.19	○	1/12
Alabama		1.18		
Montana		1.18		
Tennessee	✓	1.17	○	2/8
Utah	✓	1.15	○	5/6
Maine		1.13		
Kansas	✓	1.13	○	1/7
South Dakota		1.12		
Mississippi	✓	1.11	●	6/6
Wisconsin	✓	1.11	○	4/16
South Carolina	✓	1.11	○	1/46
Vermont		1.10		
Idaho		1.08		
Hawaii	✓	1.07		
Colorado	✓	1.06		
Missouri	✓	1.05	○	6/10
Florida	✓	1.03	○	29/67
Illinois	✓	1.01	○	2/13
Connecticut		1.01		
Arizona	✓	0.99	○	2/7
Louisiana	✓	0.98		
Pennsylvania	✓	0.98	○	1/9
Georgia	✓	0.98	○	12/16
California	✓	0.95	○	14/19
Kentucky	✓	0.92	○	6/8
Oregon	✓	0.92		
Texas	✓	0.89	○	17/26
Maryland	✓	0.89		
Nevada	✓	0.88	●	4/4
New Hampshire	✓	0.86	●	1/1

State	Insurers administer Medicaid plans in this state[1]	Ratio of state's average marketplace benchmark premium to the national average*,[2] *(>1.0 reflects premiums that are higher than average)*	Medicaid insurers sell plans in the state's marketplace[3]	Share of a state's regions where Medicaid insurers sell marketplace plans[3]
North Dakota	✓	0.84		
D.C.	✓	0.84		
Arkansas		0.81	●	7/7
Washington	✓	0.81	●	9/9
Michigan	✓	0.80	○	15/16
Ohio	✓	0.78	○	16/17
New Mexico	✓	0.78	●	5/5
New Jersey	✓	0.74	●	1/1
Indiana	✓	0.72	●	17/17
Rhode Island	✓	0.72	●	1/1
Minnesota	✓	0.71	○	2/9
Massachusetts	✓	0.70	○	6/7

Sources: [1] Total Medicaid MCOs. Henry J. Kaiser Family Foundation website. https://www.kff.org/medicaid/state-indicator/total-medicaid-mcos/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. Published September 2018. Accessed April 15, 2019.

[2] Healthcare.gov and state-based marketplace websites; Census Bureau's 2017 American Consumer Survey, https://www.census.gov/programs-surveys/acs/data.html.

[3] An author's analysis of Healthcare.gov and state-based marketplace websites.

*Notes: *The third column is based on an author's calculations. The numerator for this ratio is the weighted average of each marketplace rating region in a state's second-lowest-cost silver (i.e., benchmark) marketplace premium, weighted by each rating region's population. The denominator for this ratio is the national average benchmark premium, weighted by rating region population.*

● = Yes, in all areas of the state; ○ = Yes, but only in *some* areas of the state.

FINDINGS

Medicaid insurers' varying actuarial expertise, operational capabilities, and financial resources were often cited as influencing decisions about whether to enter the marketplace.

Lack of deep actuarial expertise. Marketplace insurers rely on actuaries to estimate the amount of health care a plan's enrollees will use, and to then price premiums so that they are low enough to attract enrollees but high enough to cover the cost of enrollees' health care usage.[7] One interviewee felt that having an in-house actuary and the ability to do strong analytics would make insurers feel comfortable selling plans in the marketplace, and another interviewee felt that insurers with more limited actuarial capacity would not feel equipped to enter the marketplace. Medicaid insurers may not have sophisticated actuarial capabilities in house because Medicaid agencies often unilaterally set insurers' capitated rates, according to our interviewees. Even for an insurer with in-house actuaries, setting marketplace premiums was challenging in the initial years of marketplace coverage, because of a lack of data on individuals' health care utilization in this new market.

Concerns about collecting premiums. Another operational challenge keeping Medicaid insurers out of marketplaces is the need to bill individuals for premiums, a task with which many Medicaid insurers do not have experience, according to one interviewee. On a related note, Medicaid insurers may view collecting premiums from marketplace enrollees as challenging because many of these individuals have low incomes and may not prioritize paying their premiums, according to another interviewee. A third interviewee reported that some marketplace enrollees sign up for coverage, obtain health care, and then stop paying their premiums once their health care needs are met, given other competing demands on their limited resources.

Lack of necessary IT systems. To sell marketplace plans, insurers need to set up several back-end IT systems that Medicaid insurers would not otherwise need, such as an EDGE server that allows the Centers for Medicare & Medicaid Services (CMS) to access a marketplace insurer's enrollment and claims data as part of a federal risk-adjustment program. In some cases, purchasing the technology is not the costly part of setting up a new IT system—it's wading through the CMS guidance documents and figuring out how to comply with rules and technical specifications that can be labor intensive.[8]

Insurance company requirements. Commercial insurers have certain solvency and capital surplus requirements (the exact levels vary by state) to ensure that they have enough cash on hand to pay for all enrollees' health care claims.[9] Two interviewees advised that maintaining such capital reserves was a barrier preventing smaller Medicaid insurers from entering the marketplace. They also cited the requirement that insurers get a commercial license and submit to greater regulatory oversight as barriers to marketplace participation for small Medicaid insurers. A third interviewee thought that if marketplace plans allowed more insurers to limit the number of enrollees they take on, more small Medicaid insurers might enter the marketplace. That interviewee also suggested that CMS develop a manual for insurers interested in selling marketplace coverage, similar to the manual currently available for Medicare Advantage insurers.

Inexperience with competitive markets. Several interviewees pointed out that insurers offering Medicaid plans sometimes do not have experience competing with other insurers for business because a Medicaid insurer may be the only insurer assigned to a particular region of a state or may be assigned Medicaid members by a state. As a result, such insurers may feel ill equipped to compete with other insurers for marketplace enrollment. Similarly, one interviewee felt that Medicaid insurers may have avoided entering the marketplace in states where many insurers were already participating in the marketplace.

Insurers see the marketplace as risky. Several interviewees said the wide variation in marketplace plans' premiums from year to year may have dissuaded Medicaid insurers from entering the marketplaces. As one interviewee put it, "You don't know what you're getting" when you agree to sell plans in the marketplace. This interviewee said that Medicaid insurers may prefer to stick with the type of product they are familiar and comfortable with—Medicaid plans. Another interviewee agreed that Medicaid was appealing because it is not as risky as the marketplace: "At the end of the day, the Medicaid [program] is much more stable and has a clear delineation of rules and regulations that gives you, the health plan organization, a fighting chance to make a profit. Whereas the marketplace—because of the dynamics of the risk that you're taking on in that population—the risk volatility is much higher in the marketplace versus that of the Medicaid [program]." Another interviewee summed up the appeal of Medicaid programs this way: "Medicaid has low margins, but at least it's a consistent business—you're going to get your check from the state."

State-controlled factors that influence a marketplace's attractiveness to insurers. Interviewees cited a few state-controlled factors that also influence whether Medicaid insurers enter the marketplace. One such factor is how aggressively a state regulates insurers' proposed premium increases each year. One interviewee advised that Oregon closely scrutinizes (and sometimes limits) premium increases,[10] while Montana does not refuse insurers' premium increases—at most, it may identify particular insurers' premium increases as "unreasonable" on a state website.[11] Another factor interviewees mentioned is whether a state offers a reinsurance program to stabilize the marketplace; such programs can provide "an injection into the individual market to bring down premiums and encourage enrollment," according to one interviewee. A third factor is whether a state incentivizes Medicaid insurers to offer plans in the marketplace, as New York has done by prohibiting insurers who exit the marketplace from administering Medicaid plans.[12] (Though this strategy might produce a strong disincentive to leave marketplace coverage once an insurer participates, it might also create a significant disincentive for Medicaid insurers to begin to offer coverage in the marketplace.)

Marketplace volatility caused by recent federal policy changes. Insurers already participating in the marketplace were likely better able to "weather" recent changes in the marketplace, such as the elimination of the individual mandate, cost-sharing subsidies not being funded, and the nonpayment of risk corridor payments, according to one interviewee. This person speculated that for an outside observer not already participating in the marketplace, "I'm not sure that, year after year, these drastic changes make it a very attractive entry point." Indeed, another interviewee said that the elimination of the individual mandate had made the idea of selling marketplace plans an even riskier proposition than it had initially appeared to be. A third interviewee said that the elimination of the individual mandate was a "critical" factor for some insurers, because the mandate increased the likelihood that individuals would maintain coverage throughout the year instead of dropping their coverage once they had obtained the medical care they needed. This interviewee also felt that

allowing low-cost, pre-ACA plans (that do not meet the ACA's requirements) to continue to cover enrollees was another key problem with marketplaces because healthier, lower-cost individuals tend to stay in these "grandmothered" plans, leaving sicker individuals in the marketplace. (The interviewee had this view despite the fact that the number of people insured through grandmothered plans is decreasing.) Another interviewee said that Medicaid insurers were more concerned about the presence of short-term, limited-duration insurance products that do not comply with the ACA's requirements than the loss of the individual mandate, because such plans could attract healthier individuals, leaving sicker individuals in marketplace plans.

Medicaid Buy-In

Interviewees generally favored the idea of a Medicaid buy-in program and felt it would likely be more appealing to Medicaid insurers than selling marketplace plans. One interviewee thought Medicaid buy-in programs would likely allow Medicaid insurers to reach individuals who would otherwise purchase marketplace plans without requiring these insurers to engage in all of the activities that would otherwise be necessary to sell marketplace plans (such as acquiring deep enough actuarial expertise to price marketplace plans). Another interviewee liked the idea of a Medicaid buy-in program because she assumed such a program would allow Medicaid insurers to retain members year round who might otherwise come on and off insurers' Medicaid plans, as individuals' incomes rise and fall. Interviewees had conflicting views on whether insurers that offer Medicaid plans should be *required* to offer Medicaid buy-in coverage: one interviewee preferred this, but two others felt that offering Medicaid buy-in coverage should be optional, because Medicaid insurers "want control of their own destiny," as one of them put it. An interviewee also worried that premiums for individuals that remain in marketplace plans could increase if healthier-than-average individuals eligible for subsidized marketplace coverage shift into cheaper Medicaid buy-in coverage; this might occur if a Medicaid buy-in option offers more limited provider networks. Despite enthusiasm for the concept of a Medicaid buy-in program, Medicaid insurers said their decisions about whether to participate in such programs would ultimately be driven by the specific details of these programs.

CONCLUSION

Our findings help explain why a Medicaid insurer may not want to sell plans in the ACA marketplaces yet may favor the idea of a Medicaid buy-in program (see Table 2 for some bills currently under consideration). Although the consumers who end up enrolled in Medicaid buy-in coverage might be the same as would otherwise sign up for marketplace coverage, the organizational requirements that would apply to offerors of these two types of plans could end up being very different. If a Medicaid buy-in program used Medicaid's less stringent requirements, it could prompt organizations not currently offering marketplace plans to offer new coverage options to consumers. Conversely, Medicaid buy-in programs that ask participating Medicaid insurers to face some or all of the factors that have dissuaded many of them from participating in the marketplaces—e.g., more exposure to financial risk and competition, the need for sophisticated actuarial expertise, premium collection, and higher reserve requirements—might not see strong participation from Medicaid insurers. As lawmakers select features and requirements from Medicaid and the marketplace to create their Medicaid buy-in programs, they may want to consider Medicaid insurers' constraints in order to increase participation in the new programs.

Table 2. Example Medicaid Buy-In Bills Currently under Consideration

Bill	Eligible population	Benefits/plan design	Financing	Provider payment rates
United States S. 489/H.R. 1277[13]	Allows states to create Medicaid buy-in programs for any resident not concurrently enrolled in other health insurance coverage.	Separate benefit package for this population not specified. Coverage would be available through marketplaces.	Enrollee premiums would not exceed 9.5% of income, plus enrollee cost sharing (subject to the same limitations as qualified health plans). Enrollees entitled to ACA's premium tax credits and cost-sharing reductions. Federal matching funds available at same rate as under the ACA for Medicaid expansion populations (i.e., 100% in first three years, diminishing to 90% in seventh year and all years thereafter).	Unspecified. Raises the floor for Medicaid primary care services to Medicare rates permanently.
Massachusetts H. 1132[14]	Any individual or employer that meets eligibility standards set by the office of Medicaid.	The office of Medicaid must file a plan outlining expected benefits by 7/1/20. They may adjust benefits for the buy-in population but may not adjust benefits for the Medicaid population.	Office of Medicaid will set cost-sharing standards, which may be different than those of the existing Medicaid program. Premiums to be paid by enrollees and employers. Employers must pay ≥50% of the cost of their employees' premiums. Individuals getting insurance through their employer who would otherwise be eligible for Medicaid will have the same cost sharing, coverage, and benefits as Medicaid enrollees, and the office of Medicaid will be allowed to charge these enrollees' employers a larger share of the cost of coverage.	Surplus revenue from premiums and cost sharing may be used to increase provider payment rates in the new program and in Medicaid, or to otherwise support the Medicaid program.

Bill	Eligible population	Benefits/plan design	Financing	Provider payment rates
New Jersey S. 3380[15]	Children ages 0 to 18 (as long as they did not drop employer-sponsored insurance in the past six months), their parents/ caretakers, and adults without dependent children, if their income is too high to be eligible for Medicaid/CHIP. Also authorizes state to enroll children or parents/ caretakers who may otherwise be eligible for Medicaid if it will increase federal funds available to the state.	Benefits will equal or exceed the ACA essential health benefits plan. State Medicaid program may contract with a managed care organization to administer plan. Plan would be sold through Healthcare.gov. Also requires parents/ caretakers of children to purchase employer-sponsored insurance if available and provides premium support to help pay for this coverage.	Enrollee premiums and co-pays on a sliding income scale. Enrollees may receive the ACA's premium tax credits.	Unspecified.
New Mexico S.B. 405/H.B. 416	Individuals ineligible for Medicaid, Medicare, and ACA premium tax credits. After further study, the state may expand eligibility. Employers prohibited from dropping insurance for employees who would otherwise be eligible for Medicaid buy-in coverage.	Medical Loss Ratio consistent with Medicaid's ratio. Plan may be administered by a Medicaid managed care organization or a marketplace insurer, using open enrollment period at least as long as the marketplace.	Premiums and cost sharing based on income. At a minimum, enrollees <200% FPL eligible for subsidized coverage.	Medicaid provider payment rates. If available funds, state may increase rates.
Oregon H.B. 2009[16]	Individuals who are not eligible for Medicaid or the ACA's premium tax credits and either (a) have incomes of 139%–400% of FPL or (b) have incomes of 401%–599% of FPL and have been offered employer-sponsored insurance but have been asked to pay the full cost of such premiums.	Individuals would enroll in coordinated care organizations to receive services. (These organizations are Medicaid insurers in Oregon.)	Enrollee premiums plus collections from new state-imposed individual mandate fines of $5,000, or 9% of an individual's income (whichever is less). (Individuals must have coverage for at least nine months per year to avoid a fine, unless coverage would cost more than 9% of their income.)	Unspecified.

Notes: ACA = Affordable Care Act. CHIP = Children's Health Insurance Program. FPL = federal poverty level.

NOTES

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About the Authors and Acknowledgments

Rachel Burton is a senior research associate, Erik Wengle is a research analyst, and Caroline Elmendorf is a research assistant in the Urban Institute's Health Policy Center.

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