Problems Identified	Magnitude of Impact			1332 Waiver Required	FFM Issues
	Population	State Budget[1]	Federal Budget[2]		
Basic Health Plan Problems					
(1a) Immigrants with less than 5 years residency under 200% FPL (Subsidy eligible) **Despite qualifying for substantial tax credits and cost-sharing reductions, people between 138-200% of the poverty line often struggle to afford premiums, deductibles, and other out of pocket costs. Subsidizing the premiums and/or out of pocket costs of people who qualify for heavy federal assistance in the form of tax credits and 87-94% actuarial value silver plans provides a relatively cost-effective way for the state to address affordability concerns and encourage enrollment. Costs would depend on the benefit offered (BHP variably proposed paying 50-100% of premiums) and method of implementation; one possibility is a wrap-around structure along the lines of the COFA premium assistance program.**	Low (4,000)	Low[3]/High	Low/Low	Depends on Approach[4]	No
(1b) Family Glitch*(Not subsidy eligible) * The Affordable Care Act's (ACA's) "family glitch" refers to how some low-to-moderate-income families may be locked out of receiving financial assistance to purchase health coverage through the new health insurance Marketplaces. Eligibility is not solely determined by income. It is also subject to whether a family has access to affordable employer-sponsored insurance. The problem is that the definition of "affordable"--for both an individual employee and a family--is based only on the cost of individual-only coverage and does not take into consideration the often significantly higher cost of a family plan. Families caught up in the glitch cannot qualify for premium tax credits to reduce the cost of a Marketplace plan or for cost-sharing reductions to lower their out-of-pocket payments for health services, even if the family cannot afford coverage otherwise.	High (69,000)	High[5]/High	High/Low	Depends on Approach[6]	Yes
(1c, 3a, & 4) Individuals under 200% FPL Despite qualifying for substantial tax credits and cost-sharing reductions, people between 138-200% of the poverty line often struggle to afford premiums, deductibles, and other out of pocket costs. Subsidizing the premiums and/or out of pocket costs of people who qualify for heavy federal assistance in the form of tax credits and 87-94% actuarial value silver plans provides a relatively cost-effective way for the state to address affordability concerns and encourage enrollment.	Low (12,000)	High[7]/High	High/Low	Depends on Approach[8]	No
(1d) Medicare Eligibles[9] Older persons who are ineligible for free Part A Medicare are currently eligible to be covered by QHPs. However, the ACA explicitly excludes them from coverage in a BHP. People who are ineligible for free Part A include seasonal or domestic workers and others in the cash economy, as well as unpaid	High (138,000)	High[10]/High	High/Low	Depends on Approach[11]	Yes

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[1] With a 1332/Without a 1332.
[2] With a 1332/Without a 1332.
[3] Assumes state pays for a portion of subsidies and CSRs (wrap around).
[4] No 1332 required for state wrap around.
[5] Assumes state pays for a portion of subsidies and CSRs (wrap around).
[6] No 1332 required for state subsidies
[7] Assumes state pays for a portion of subsidies and CSRs (wrap around).
[8] No 1332 required for state subsidies
[9] The Social Security Act prohibits a commercial insurer from knowingly selling a QHP to a Medicare beneficiary.
[10] Assumes a state contribution.
[11] No 1332 required for state subsidies

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Problems Identified	Magnitude of Impact			1332 Waiver Required	FFM Issues
	Population	State Budget[1]	Federal Budget[2]		
family caregivers and immigrants – who may have labored for years – but not at covered employment.					
Other Medicare Considerations[12]					
Non-BHP Problems					
(2&3) Individuals not eligible for premium subsidies and/or CSRs While individuals making over 400% FPL are not as sharply in need of financial assistance as those with lower incomes, the fact that they are not eligible for subsidy at all means they have no protection from very high premiums and large year-over-year premium increases. For people just above 400% FPL, especially those in the higher age bands, costs are very high, often higher than most (or all) other large expenses in their lives. There's reason to believe that healthy people in this group are especially unlikely to enroll, since the high costs will most likely seem worth it only to the sickest, and this dynamic likely raises costs for everyone and worsens the problem.	High	High[13]/High	High/Low	Depends on Approach[14]	Possibly
(5) Increase the use of the Coordinated Care Model in the private market	High	Low/Low	Low/Low	Unlikely	No
(7) Undocumented individuals allowed to purchase through the Marketplace (no subsidies)	High (103,000)	Low[15]/Low[16]	Low[17]/Low	Yes	Yes
(8 & 9) Transition between QHPs and OHP BHP had included a proposal for 12 month continuous eligibility in order to address the population that falls right along the 138% FPL line, in particular those with variable incomes who may fall above 138% one month and below the next. Under the current structure enrollees must report these changes in and switch plans every month, which is incredibly time consuming, can restart deductibles, and is severely detrimental to continuity of care.	Unknown	Unknown	Unknown	Depends on Approach[18]	Possibly
(10) Social Determinants of Health Research confirms that approximately 10% of a person's overall health can be attributed to the medical care that they receive, while about 40% of a person's overall health is influenced by one's lifestyle and behavior. The health care delivery system must work to address the issues that impact a person's health regardless of whether or not those issues traditionally fit within the traditional health care model. These issues include housing, food-insecurity and education.	High	Low/High	High/Low	Depends on Approach[19]	No

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[12] • In addition, with respect to Medicare, there is what I have called the "Medicare Shock" for those who signed up for QHPs and then find themselves thrust into Medicare at age 65, no longer eligible for QHPs. Many lower income Medicare recipients struggle with paying Part B premiums and out of pocket costs, especially if they can't afford a Medicare supplement policy;

• Younger people with disabilities who have achieved eligibility for Social Security Disability Insurance have to wait two years to become eligible for Medicare. Many of these people have very limited income, and this group may not qualify for Medicaid under MAGI rules, or may not have disabling conditions that make it possible for them to apply for Medicaid long term care services;

• Those people who are dually eligible, receiving both Medicare and Medicaid are in a good place from an affordability perspective. If they are members of a Coordinated Care Organization, there is also the promise of integration of services and person centered care. If they are in the fee for service program, there may be access and integration problems. Moreover, there have been uneasy discussions about integration of Long Term Care Supports and Services and managed care. While this is beyond our scope, it is still worth noting.

[13] Assumes state pays for a portion of subsidies and CSRs.

[14] No 1332 required for state subsidies

[15] Assumes state pays for a portion of subsidies and CSRs (wrap around).

[16] Assumes state pays for subsidies and CSRs.

[17] Assumes no federal subsidies or CSRs.

[18] No 1332 required for state subsidies

[19] No 1332 required for state subsidies

Problems Identified	Magnitude of Impact			1332 Waiver Required	FFM Issues
	Population	State Budget[1]	Federal Budget[2]		
(12) Individuals eligible for CSRs purchasing bronze plans instead of silver pans, thereby missing out on the cost-sharing reductions for which they would otherwise be eligible	**Low (~20,000)**	**Low/Low**	**NA**	**No**	**No**
(13) Adding CSRs to categories of care under bronze plans – Reduce cost-sharing under a bronze plan for some benefit categories (state or feds reimburse carriers)	**High**	**Low/High**	**High/Low**	**No[20]**	**No[21]**

Key

Population:

Low: Impacts 10% or less of individual market

High: Impacts 20% or more of individual market

State Budget:

Low: $5M or less

High: $10M or more

Federal Budget:

Low: Will require the state to find federal savings of $5M or less

High: Will require the state to find federal savings of $10M or more

FFM Issues:

It is not possible to make changes to the FFM. An idea that requires changes to the FFM will show, “Yes” in the FFM issues column.

[20] Assumes state reimburses carriers for CSRs.

[21] Assumes state reimburses carriers for CSRs.