Options for Coverage of Gap Population Earning <100% FPL

	Option 1: **Status Quo**	**Option 3:** **State Plan Option**	**Option 4:** **Private Option (Waiver)**	**Option 5:** **Direct Primary Care Memberships**
Description	• Utilizes state/county tax dollars to fund incident-based health care costs • No primary care • No wellness focus • Administered by counties and state CAT fund • 10 year state and local net cost of $1.2B (no offsets) • SFY 2016 state and local net cost of $97.6 M.	• Utilizes primarily federal tax dollars with state share increasing from 0 to 10% by 2020 • Focus on Primary Care/Prevention/PCMH • Integrated, market-based approach • Uses contracted health plans equivalent to QHP coverage on the health insurance exchange. • Uses newly developed benefit design utilizing healthy behavior incentives, copays and other evidence based tools to engage enrollees in health decisions. • Provides essential health benefits for 102,873 Idahoans • 10 year state and local net cost of $73.4 M. • SFY 2016 state and local net savings of $43.9 M.	• Utilizes primarily federal tax dollars with state share increasing from 0 to 10% by 2020 • Integrated, market-based approach • Uses private QHP coverage via the health insurance exchange (silver level plan) • Federal/state dollars would fund premiums/cost sharing outside of what is allowable to charge enrollees per CMS criteria • Provides essential health benefits for 102,873 Idahoans • 10 year state and local net cost of $137.3 M. • SFY 2016 state and local net savings of $43.9 M.	• Utilizes state/county tax dollars to fund direct primary care memberships ($49 M) and Medical Procedures Fund ($10.8 M) • Focus on Primary Care/Prevention/PCMH • Provides direct primary care services to 77,719 Idahoans • 10 year state and local net cost of $1.2 B. (no offsets) • SFY 2016 state and local net cost of $97.6 M.
Strengths	• Does not require legislative change • Infrastructure currently in place	• Federal waiver allows for immediate discontinuation if program is not functioning as desired. • Elimination of county and state indigent programs and related taxation • Leverages federal tax funds back to Idaho to finance healthcare for working poor • Cost savings to state and counties • Comprehensive coverage including 10 essential health benefits • Proactively invests in primary care to keep individuals healthy • Incorporates healthy behavior incentives and personal accountability • State infrastructure support is already in place • Uses private industry and promotes competition & choiceCopays allowed for all participants on all services, within CMS limitations • Providers can make receipt of services	• 3-year demonstration waiver allows for sunset if program is not functioning as desired • Elimination of county and state indigent programs and related taxation • Leverages federal tax funds back to Idaho to finance healthcare for working poor • Cost savings to state and counties • Comprehensive coverage including 10 essential health benefits • Uses private industry and promotes competition & choice • Minimizes churn	• No federal waiver needed • State control of eligibility, benefits, cost-sharing • Minimizes dependence on federal funds • Proactively invests in primary care to keep individuals healthy

	Option 1: Status Quo	Option 3: State Plan Option	Option 4: Private Option (Waiver)	Option 5: Direct Primary Care Memberships
		conditional on payment of co-pay for those over 100% FPL • Minimizes churn		
Weaknesses	• State of Idaho would assume expenses of increasing health care costs • Double taxation continues • Administratively burdensome and inconsistent county/state indigent processes with associated litigation • No focus on wellness/prevention or primary care	• CMS limitations on cost sharing and eligibility	• Possible adverse selection in QHPs driving up annual rate increase • CMS limitations on cost sharing and eligibility • Budget neutrality requirement • Medicaid responsible for cost sharing in excess of federal limits	• State of Idaho would assume expenses for increasing health care costs • Double taxation continues • Requires establishing new state/county infrastructure to administer program • Requires negotiating primary care membership terms with providers • Undefined personal responsibility or healthy behavior drivers
Opportunities		• Connect newly covered Idahoans with medical homes to mitigate increase in ER utilization • Build in a sunset clause to end program if Congress decreases match rate • End double taxation: "Funded opportunity rather than unfunded mandate" • Cover people quickly once approved	• Connect newly covered Idahoans with medical homes to mitigate increase in ER utilization • Build in a sunset clause to end program if Congress decreases match rate • End double taxation: "Funded opportunity rather than unfunded mandate" • Cover people quickly once approved	• Could design something unique that no other state has tested • Eligibility determined through State Medicaid eligibility screening
Threats	• Rising percentage of county/state budgets dedicated to indigent care costs • Continued litigation of claims • Coverage gap population gets sicker, less productive • Disapproved claims contribute to rising uncompensated care, which drives up premium costs for insured population • Rising ER and corrections' costs due to untreated mental illness	• Congress could decrease matching rate (FMAP) in the future	• Inability to renew waiver after 3 year demo period • Congress could decrease matching rate (FMAP) in the future	• Significant delay in implementing due to extensive legislative and rule changes, as well as infrastructure/process development • Continued indigent program cost burden until transition occurs • Possible lack of provider participation depending on membership terms • Rising uncompensated care costs due to insufficient funding to support necessary hospitalizations & treatment not prevented by primary care focus ($10.8 M. for medical procedures fund) • Costs to administer program unknown

NOTE: Option 2—Redesigning the County Indigent and State Catastrophic programs was eliminated from consideration by the Governor's Medicaid Redesign Workgroup in 2012.