Delaware and the Patient Protection and Affordable Care Act (ACA)

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By

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EXISTING HEALTH BENEFIT EXCHANGES

Background

With the passage of the Patient Protection and Affordable Care Act, there were requirements for each state to form an American Health Benefit Exchange (AHBE). States must complete certain requirements to form an AHBE that best serve their needs. States have several options to choose from with respect to the type of exchange they will develop:

1. merge individual and group markets
2. limit small business participation in the exchange
3. have single state exchange, multi-state exchange and multiple exchanges within the state

Either option will affect the cost of the insurance premiums. The decision made by states on how to ultimately structure their exchanges will have a direct effect on the population who opt to participate in the exchange.

Prior to a decision on the type of AHBE to form, it is likely that each state will need to pass legislation which requires assessing data needs, and the selection of a state agency that will be responsible for collecting the required data. The major component of any legislation that best serves the need sof states and its constituents for implementing the AHBE is data collection. Implementation of the AHBE in each state necessitates determining the number of individuals eligible to purchase insurance as well as the number who will actually purchase insurance.

The deadline for either a state or nonprofit agency to establish an AHBE is January, 2014. If this deadline for establishing an AHBE is not met by the state, the US Department of Health and Human Services will establish an AHBE or select a non-profit entity to fulfill this requirement. Individuals who qualify to purchase insurance through an ABHE will be offered

subsidies to purchase insurance. Insurance companies can also receive subsidies only if they are a member of the ABHE. The existence of subsidies does not preclude other insurance plans from competing in the marketplace.

Requirements

The requirements of the American Health Benefit Exchange:

1. All AHBEs must have an initial open enrollment, annual open enrollment and special open enrollment.
2. All AHBEs must also be "interoperable" with Medicaid and other health and human services programs which means that enrollees must be screened for eligibility in DHHS programs. This requirement will require states to determine their data needs and make sure that this can be achieved.
3. All AHBEs must provide essential benefits, be licensed, and offer the same prices for services within and outside of the exchange.

There will be five levels of coverage within the AHBEs:

a. Bronze (60% of the benefit cost of the plan)
b. Silver (70% of the benefit cost of the plan
c. Gold (80% of the benefit cost of the plan)
d. Platinum (90% of the benefit cost of the plan)
e. Catastrophic

All AHBE plan levels must be within Health Savings Account (HSA) out of pocket cost levels. The HSA refers to the tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan. The Catastrophic level differs from the other levels in that it provides Catastrophic coverage with two exceptions (prevention

benefits and coverage for three primary care visits exempt from the deductible). The Catastrophic level will only be available to those who are up to age 30, or those who are exempt from the mandate to purchase coverage, and will only be available in the individual market. The AHBEs will also offer a Small Business Health Option (SHOP) that is designed for small businesses with 1-100 employees; however, the state can redefine this as 1-50 employees until January 2016.

State Experiences

For comparison purposes, we summarized the current American Health Benefit Exchanges (AHBE) that are operational in four states including Massachusetts, Utah, Washington and California. The first review focuses on Massachusetts because this is the first state that successfully implemented a Health Benefit Exchange prior to passage of the Patient Protection and Affordable Care Act (ACA). The Massachusetts experience with the HBE began in 2006, and was named the Commonwealth Health Insurance Connector Authority. The Massachusetts HBE is an independent organization with both government and private sector legal characteristics that provides assistance to small businesses and individuals to purchase insurance on their own. The Massachusetts HBE is governed by an 11 member board that hires the key positions including those of the executive director. Duties of the board included the initial implementation of the exchange and the establishment of procedures to select and approve private plans to be included in the HBE, and developing enrollment procedures. The HBE executive director was tasked with appointing key staff and employees for the smooth operation of the HBE.

The Massachusetts HBE manages two health insurance programs including Commonwealth Care which is a subsidized program for adults who do not have employer sponsored insurance; and Commonwealth Choice which offers commercial insurance plans for individuals ineligible for care as well as small business employers. Up until 2009,

Commonwealth Care was only offered through four health plans. The Massachusetts HBE structure and function is similar to the requirements of the Patient Protection and Affordable Care Act (ACA) in that levels of coverage are offered based on their actuarial value (i.e. bronze, silver and gold).

The Federal Poverty Level (FPL) [300% of FPL] requirements that Massachusetts established for their HBE are slightly different than those of the ACA requirements with sliding scale premiums for individuals greater than 100% FPL. The individuals in Massachusetts who are over the 300% FPL aren't subsidized. A similar provision included in the ACA specifies that subsidized insurance will be offered at between 139 and 400% of the FPL. The Massachusetts HBE also facilitates enrollment, regulates the plans that are offered, conducts outreach programs and is involved in administrative policy decisions that are related to Massachusetts health reform law. The Massachusetts HBE was initially funded with a $25 million appropriation from the state general fund; however, it is now a self-sustaining operation primarily from health insurance plan fees. On the surface from an economic standpoint, the HBE encountered challenges. There has been an increased demand for services in medically underserved areas, and despite a significant increase in the numbers of people with insurance coverage, there were approximately 21% of residents without needed care in 2008 due to unaffordable premiums. The greatest barriers to care to the HBE were being disabled, being poor, and having fair health.

A significant challenge for states which develop exchanges is the loss of state revenues. In Massachusetts, the increased success in enrolling people in Commonwealth Care increased the need for additional funding. To address the issue of reducing revenue, Massachusetts ended automatic enrollment, reenrollment for certain individuals, and terminated coverage for 300,000 legal immigrants. However, in July 2009, the state allocated $40 million to serve the health needs of this group through MassHealth and Safety Net, which are other programs offered through the state.

While there was an increased need for funding to accommodate the increasing uninsured population, at least one public health agency, Harbor Health Services, Inc. (four community health centers) had to increase the starting salaries by $50,000 over a three year period. It also increase its incentive pool by $50,000 over three years. These monetary increases were due to an increased need to focus on retention and recruitment of primary care providers. At the same time that the provider, had to increase salaries, they dealt with space constraints, and increasing the workday to accommodate the increased demand. All of the above factors are important when considering what is likely to affect providers in Delaware as the influx of patients seeking insurance increases. Although the Massachusetts HBE became self-supporting, other agencies providing services to uninsurable clients experienced serious financial restraints. This was due to increased demand for behavioral health services from primary care patients, administrative burdens that were not reimbursed, and the need to increase salaries and incentives for primary care providers.

An important lesson learned from Massachusetts is that during the establishment of an insurance exchange, all involved providers should be at the table for the discussion. Groups that must be communicated with include, but are not limited to, consumer groups, hospitals, professional societies/ associations, legislators and state agencies. It is also expected that whatever insurance model is established will lead to problems including enrollment delays, auto-assignment and even credentialing. Although the system of enrollment will be based online, clients and providers will need to feel a personal touch. This means that staff members will have to be properly trained and prepared for a complete change in the process to ensure insurance claims are properly processed at the provider level.

Massachusetts' Division of Insurance was awarded a planning and implementation grant from the US Department of Health and Human Services. These planning grants awarded by HHS to each of the majority of states were for different purposes depending on the needs of that state. In Massachusetts, the purpose of the $1 million planning grant is to ensure that the existing Commonwealth Health Insurance Connector Authority meets federal requirements with the inception of the ACA. There are also various other goals that center on ensuring that research is conducted on insurance both prior to and after the HBE are officially implemented.

Utah's HBE was implemented with passage of HB 133 and HB 188 in 2008, which appropriated money for funding of the HBE. The Utah Health Exchange is administered and facilitated by the Office of Consumer Health Services with limited rule-making authority over the exchanges. Utah's HBE works collaboratively and cooperates with the Insurance Department, the Department of Health, and the Department of Workforce Services. The primary purpose of the Utah HBE is to provide an internet portal to connect consumers to the information that they need to make health choices. Utah's HBE has been available since the fall of 2009, on a pilot basis to allow employees of small employers to compare, select and enroll in commercial health insurance through an online internet based process. In the fall of 2010, this HBE was opened to all small employers and large employers on a pilot basis. The HBE features 146 plans which include both required and optional plans. Utah's HBE mainly relies on partnering with the private sector. Employers are allowed to determine their contribution level, and employees are permitted to aggregate contributions from multiple employers, including employers of other household members. Utah is currently developing a blueprint for how the HBE will operate under the ACA with some federal grants that the state has received to align the HBE with provisions in the ACA.

Utah was also awarded a planning grant in the amount of $1 million from the Department of Health and Human Services. This funding provided to the Governor's Office of Economic Development will be used to assist Utah in continuing its efforts to improve the current exchange in place as well as develop a web based tool that can be used by individuals seeking insurance to determine their eligibility. Another goal for the use of these planning funds is to expand the reach of the current health insurance exchange to potential consumers by conducting additional research.

A 2007 law, HB 1569, established the Washington Health Insurance Partnership. From May 2007 to September 2010, the Washington HBE was not implemented due to budget deficits. On September 1, 2010, enrollment began in this HBE. Washington's HBE will offer administration of benefits to small employers and individuals. The small businesses must have at least one employee who earns less than 200 percent of the federal poverty level. Washington's HBE is set up for small businesses if they meet three specific requirements:

1. 50 or fewer employees
2. Do not currently offer insurance
3. 50 percent of their workforce earns no more than 200 percent of the federal poverty level each month.

Washington's HBE provides a sliding-scale premium subsidy to individuals who earn less than 200 percent of the federal poverty level. (It is important to note that while Massachusetts' cap for the FPL subsidy was 300% and the ACA requires a cap of 400%, Washington established that individuals must earn less than 200% of the FPL to qualify for subsidies). Washington's HBE's regulations authorize the evaluation of the inclusion of additional health insurance markets in the HBE. This HBE was funded by a federal grant from the Department of Health and Human Services State Health Access Program (SHAP).

Washington State was awarded a Planning and Implementation Grant by the Department of Health and Human Services of almost $1 million. This funding will be used to assist in the establishment of an HBE, even though the Washington States' Health Insurance Partnership is currently functional. The grant funds will go towards a variety of areas including a review to determine if there will be a need for legislation to develop a state based health insurance exchange. An implementation plan will be completed using the funds by September 30, 2011. Some other uses for the funding will be to assess the IT infrastructure and cost containment.

California is unique among the four states reviewed in that it passed SB 900 and AB 1602 and implemented its HBE after the passage of the ACA. California's HBE is governed by a five member board appointed by the governor and the legislature who are in place between now and the end of 2013. The board members, who are not paid includes two members appointed by the Governor, one by the Senate Rules Committee, one by the Speaker of the Assembly and one by the Secretary. The board is responsible for hiring the key positions for the exchange. This exchange for now will keep individual and small group markets separate.

Some features of the California exchange include:

1. A website that provides standardized comparison information on qualified health benefit plans/options
2. A calculator for applicants to compare costs across plan options
3. A web-based eligibility portal to link individuals to health coverage options available to them
4. A toll-free consumer assistance hotline.

The California HBE has regulations in place to reduce adverse selection, promote completion and transparency. All of the carriers that participate in the exchange must offer at least one product within each of the following four levels of coverage both inside and outside the exchange (i.e. bronze, silver, gold and platinum). The Catastrophic Plan is only available on the individual market and carriers that do not participate in the HBE are not permitted to sell the catastrophic plan coverage outside the exchange.

The California Health Facilities Financing Authority can authorize up to $5 million for HBE operations. The $5 million includes a plan assessment limited to one year's approved operating budget, and the HBE must reduce the charges in the following fiscal year if the assessments equal or exceed that amount. No state general funds were given or allowed in the California HBE. The goal for the California plan is that once the exchange is functional, it is expected to be self-sustaining through qualified health plan fees and charges, which will be set by the board.

Like the other states mentioned in this paper, California was also awarded a $1 million planning grant. This funding has been and will be used to collect demographic data on both the current and projected population, determine how the ACA would change the total number of uninsured individuals in California and analyze the current public and private insurance markets among other goals.

States Decision Points about American Health Benefit Exchanges (AHBE)

Each state must answer specific questions to ensure compliance with federal regulations for the ACA that best fits the needs of their state residents. A few states have made major decisions that will need to be addressed before health benefit exchange implementation. The first decision a state must make is whether it will establish an AHBE. Various organizations have debated the pros and cons of state versus federal AHBEs. If the federal government establishes the AHBEs for states, the latter would lose its ability to target specific populations and be required to provide oversight of the AHBE.

After deciding whether to operate an AHBE, states must also decide what type of entity will operate the exchange (non-profit entity, within or attached to an existing state agency, or a quasi-governmental non-profit), the type of governing structure and the responsible authority. States also need to determine if they will combine both the small group and the non-group exchange. States will have the option of either combining SHOPS with the individual plans or keeping individual plans offered through the exchange and the SHOP separate. A significant question that Delaware will need to answer when determining how to structure the SHOP is will premiums go up if both markets are combined.

After states make the above decisions, they will have to ensure that health plans in the AHBEs are no different than plans outside the AHBE. States also need to determine what will be the role of the HBEs in the health insurance market. One of the final decisions that states will need to make when working on establishing an AHBE is whether or not to participate in a regional exchange. The remainder of this summary provides details made at present for some states that have already begun working on complying with the requirements of the AHBEs.

It is helpful to look at California, the first state to establish an AHBE under current federal guidelines, in order to gain some insight into their experience with establishing an AHBE. California decided to operate its AHBE as an **independent state agency**. When determining how to structure the small business health option (SHOP), California opted to form an entity that is separate from exchange activities and related to the individual's market. However, although the SHOP entity would be separate from exchange activities, it would not be run by a separate entity. The ACA requires only that states have a choice for consumers of qualified health plans that meet the silver or gold criteria. California opted to provide a choice of qualified health plans at each of the five federally specified levels with carriers offering a minimum of one product at each level. Carriers outside the exchange are only permitted to sell products that conform to the four federal coverage levels in the current legislation and they cannot offer catastrophic coverage. As of May 2011, the California Health Benefits Exchange Board held three meetings to work on planning the states HBE.

Massachusetts passed its own health reform law in 2006, and is currently updating its law to comply with the current federal regulations with the assistance of a federal planning grant. Massachusetts is operating an **independent quasi-governmental non-profit** that is governed by an eleven member board and run by an independent state agency. Massachusetts is combining small group and the non -group exchange into one plan. Massachusetts Commonwealth Care is a subsidized program for adults who do not have employer sponsored coverage, and Massachusetts Commonwealth Choice offers commercial insurance plans to both small business employers and adults who are ineligible for care. Massachusetts has decided to participate in a regional exchange with regards to the information technology framework. Massachusetts was awarded an early innovator cooperative agreement in February of 2011 that will enable it to develop multi-state consortia which includes both individuals and small businesses in Connecticut, Maine, Massachusetts, Rhode Island and Vermont. The goal of this consortia is for consumers from each of these states to shop for, select, and purchase affordable and high quality health plans.

Washington State has determined that with Senate Bill 5445 passed on May 11, 2011 it will establish an HBE. Washington's HBE will be a **public private partnership** separate and distinct from the state. The exchange development board will be governed by seven members appointed by the governor and chaired by the Health Care Authority (HCA) administrator. Washington state legislation proposed for 2011 is to have one administrative exchange operating in both the individual and small group exchange. Washington currently has in place a Health Insurance Partnership that provides small employers with access to the same health insurance coverage that is available to the small group health insurance market.

When looking at smaller states more likely to mirror Delaware, we analyzed the decisions made by Maine, Connecticut and Indiana. Similar to California, Washington and Massachusetts, these states made decisions appropriate for their populace's needs on how to structure the HBEs. Interestingly the HBEs across the country do not show a consistent structure. In Maine, the Advisory Council on Health Systems Report on December 17, 2010, recommended that Maine establish a **state based exchange** and take advantage of the existing infrastructure and capacity of its state agencies currently operating to perform some of the functions of the exchange. The Advisory Council's guidance suggests that Maine should establish a single exchange that serves both the individual and business markets. While the decision process is ongoing, the consensus from Maine is that Maine should pursue establishment of its own exchange and work with other New England states to collaborate on certain exchange functions. Maine's involvement in the early innovator cooperative agreement awarded to Massachusetts gives some direction as to the areas that it will collaborate on with other states.

Connecticut is also a participant in the early innovator cooperative agreement with other New England states. The following data is based on recommendations from the Connecticut Health Care Reform Advisory Board Final Report on June 30, 2010. Connecticut has decided to establish a state exchange that is a **quasi-state authority** similar in structure to the Massachusetts Connector. Connecticut's advisory board concluded that its exchange will need flexibility with regards to administering functions while broader policy issues including

regulation of the market should remain with the Governor, General Assembly and Department of Insurance. The Health Care Reform Advisory Board (HCRAB) recommendations state that the health benefit exchanges should have a multi-stakeholder Board of Directors made up of individuals with diverse expertise and viewpoints. In order to ensure that these viewpoints are expressed, the HCRAB recommended that membership on the board include "Secretary of the Office of Policy and Management" (ex-officio) who will be chair. The board should also include an "actuary, health plan benefit specialist, health care economist, representatives from a small business, large business and labor, representatives from the insurance industry, providers, consumers and the commissioners of social services, public health, insurance and the state comptroller or their designees (voting, ex-officio)." The HCRAB also recommended that the director of the health benefit exchange report annually to the Governor and the General Assembly on the effects of health care reform in Connecticut. Connecticut is also part of the early innovator cooperative agreement with Massachusetts.

Indiana's Governor Mitchell Daniels, Jr. established the Indiana Health Benefit Exchange through Executive Order 11-01. The Governor decided to operate this exchange as a **non-profit entity**. The initial establishment and operation of the exchange will be conducted by the Indiana Family and Social Services Administration. The latter will work with other state agencies to establish the exchange as well as operate the Indiana Insurance Market. The executive order determined that the Secretary of the Indiana Family and Social Services Administration or his/her designee will serve as the incorporator of the exchange. The HBE will have a board of directors that will oversee the exchange and include representatives from other state agencies and the general assembly.

Draft legislation has been developed which establishes the Wisconsin Health Exchange Authority. This draft legislation calls for the AHBE to be established as a **quasi-public entity** that is accountable to, but also independent of, state government. Although this entity will be independent of state government, it will have a board which will consist of three nonvoting and an undetermined number of voting members. The nonvoting members will consist of Secretaries

of employee trust funds and health services and the Commissioner of Insurance, while the voting members will be "nominated by the Governor with the advice and consent of the Senate, and appointed for a undetermined number of years. The voting members of the board will consist of individuals representing labor or union coalitions, business and employer organizations, the self-employed, health care consumer organizations, health plans and the insurance industry, hospitals and the public."

On April 12, 2011 Senate Bill 182 and House Bill 166 were passed with established Maryland's HBE. The AHBE to be operated in Maryland will be a **public corporation that is an independent unit of state government**. Maryland's Health Care Reform Coordinating Council (HCRCC) formed through an executive order by the governor to advise the current administration on how to best implement federal health reform was instrumental in gathering input to make this decision. Initially the HCRCC considered various options for the final structure of the AHBEs, and this committee's final report did not indicate that a specific recommendation has been made with regards to the final structure of the AHBE. "The HCRCC believes that the Exchange's start-up functions and wide-ranging influence over private sector entities and markets, as well as public sector funds and services, require the transparency and accountability of an independent public entity. It also recognizes, that while the attributes of a public entity will be clear in the early incubator phase of the AHBE, it may turn out that spinning it off into a **nonprofit** makes sense later on (Maryland Health Care Reform Coordinating Council Final Report)." Maryland was one of the states awarded the Early Innovator Grant. Included in the states grant application is a desire to augment and bridge legacy eligibility development systems. Upon the launch of the project proposed in their early innovator grant, Maryland has stated that it will issue a letter of invitation for broader state participation to include a diverse range of perspectives from different states. The goal for the technology that is being developed in Maryland is so that the technology can be replicable in other states which could prove to be beneficial to the State of Delaware.

On June 1, 2011, Colorado passed a Health Benefit Exchange Act with Senate Bill 200. This act established the Colorado Health Benefit Exchange as a **nonprofit unincorporated public entity of the state**. Plans are for the AHBE to be governed by a twelve member board that will be appointed by the following: governor, president of the senate, minority leader of the senate, speaker of the house and minority leader of the House of Representatives. The Health Benefit Exchange Act states that the board will not be permitted to participate in the process of purchasing insurance. A decision has not yet been made whether or not the AHBE will separate or combine individual or small employer markets. The exchange will be funded with existing appropriations and no separate appropriation of state funding will be provided.

The formal name for the Hawaii AHBE will be the Hawaii Health Connector. This AHBE will be formed as a **nonprofit entity** that is to be governed by a board of directors appointed by the governor with the "advice and consent of the senate." The board of directors will include fifteen members who will be picked to represent the interested parties and stakeholders in the AHBE. Two examples of those included on the board of directors are someone representing a federally qualified health center and three members representing health or dental insurance plans that provide insurance through the state. The Hawaii Health Connector AHBE will be designed to work with the Hawaii Prepaid Health Care Act to ensure the preservation of existing benefits for residents. The Hawaii Prepaid Health Care Act was passed on January 1, 1975. This law established a requirement that nearly all employers must provide health insurance to their employees who worked 20 hours or more a week for four consecutive weeks. It is expected that the connector will be self-sustaining by January 1, 2015, and assessment or user fees can be charged to participating health and dental carriers.

One May 26, 2011, Vermont formally enacted legislation that passed House Bill 202. This AHBE will be established as a **Division of the Department of Vermont Health Access**. The Vermont AHBE will be headed by a deputy commissioner. One of the goals of the Vermont AHBE will be to establish a navigator program to assist individuals and employers enrolling in a qualified health benefit plan. This AHBE will receive its funding from Green Mountain Care

which will assume responsibility for funding provided through federal programs. Additional decisions on funding of this AHBE will be ongoing between the Green Mountain Board, Secretary of Health Care Administration and the Vermont Legislature. Vermont is also a part of the Massachusetts early innovator grant and will be part of a multi-state consortia for consumers to shop for, select, and purchase affordable and high quality health plans.

On April 5, 2011, the West Virginia's state legislature established the West Virginia Health Benefit Exchange as a **governmental entity within the offices of the Insurance Commissioner**. A board comprised of ten members will govern the HBE. This board will consist of representatives from a variety of organizations including the Director of the West Virginia Children's Health Insurance Program and an elected member by a group of health care providers. This AHBE will be pursue federal funding and will also be permitted to accept gifts, grants and bequests.

Conclusion

Approximately eighteen states including Illinois, Nevada, North Dakota, Oregon, Utah and Virginia have passed legislation to begin the implementation process of the HBE. It is important to understand that while AHBEs must be implemented by each state or region, the current exchanges that are operating or in the planning stages are all very different. The federal government has given states the option to establish a state run agency, a quasi-governmental agency or a non-profit corporation. The data on states enacting bills to implement AHBEs is constantly changing as states move forward to comply with the requirements of establishing a AHBE. All states are required to have their plans in place for development of their HBE by January 1, 2013. HHS will be able to determine which states will be willing and able to establish a HBE by January 1, 2014.

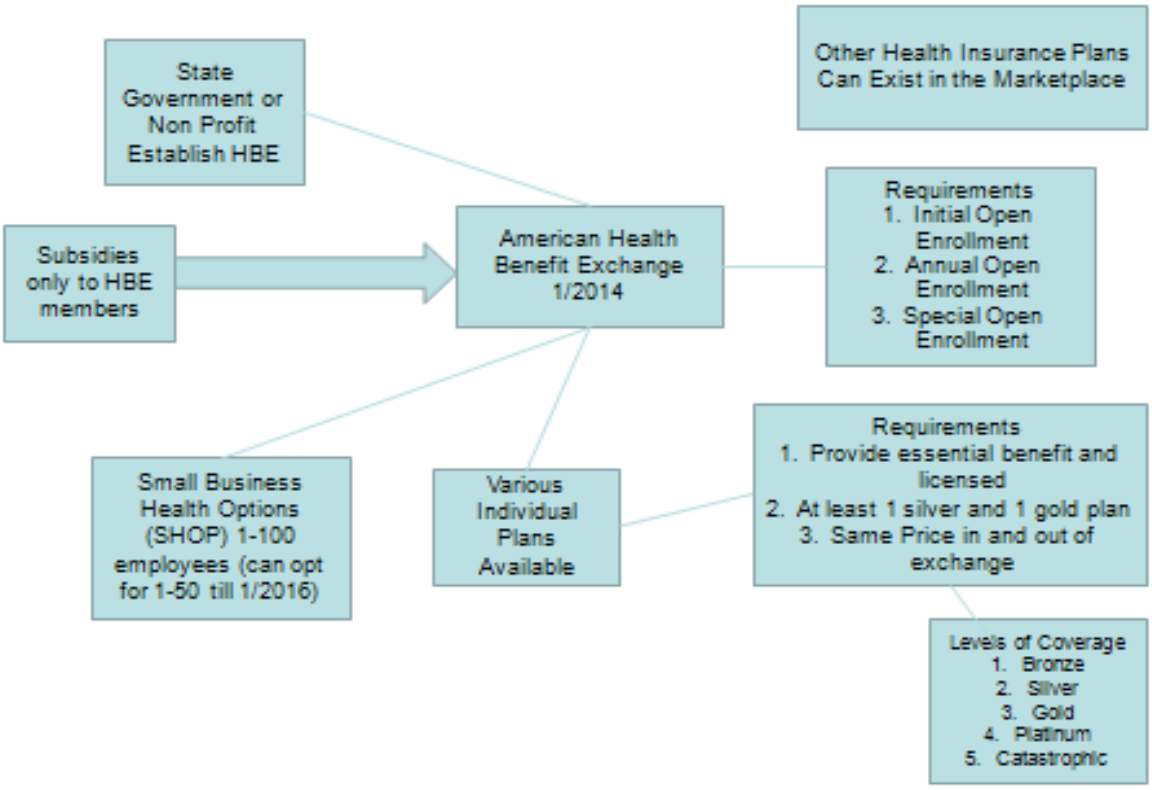
Table 1.0 Summary of State Decision Points: Health Benefit Exchanges:

State	Bills Passed: Health Benefit Exchange/Health Care Exchange/ Health Insurance Exchange	Type of Health Benefit Exchange	Recommendation / Decision/Draft Legislation/Executive Order	Regional Health Benefit Exchange
Arkansas	Enacted, HB 1226, 4/4/11	Appropriation of funds only	No final decision	
California	Enacted, SB 900 and AB 1602, 8/24/10	Independent State Agency	Decision	No
Colorado	Enacted – SB 200 6/1/11	Non Profit Unincorporated Public Entity	Decision	
Connecticut	Enacted – SB 921, 7/1/11	Quasi State Authority, will be a department, institution or agency of the state	Decision	Yes, Multi State Consortia
Hawaii	Enacted - SB 1348, 7/8/11	Private, Non-Profit	Decision	
Illinois	Enacted – SB 1555, 7/14/11	2 separate pools for individuals and small employers, No decision on type of exchange	Decision	
Indiana	Executive Order 11-01, 1/3/11	Non Profit Entity	Executive Order	No

Maine	Pending – Carryover Last action 4/15/11, HB 1098	State Based Exchange	Recommendation	Yes, Multi State Consortia
Maryland	Enacted - SB 182 & HB 166, 4/12/11	Public Corporation and independent unit of the state government	Decision	Possible
Massachusetts	Previously Existing Version, Chapter 58 of Acts of 2006	Independent Quasi-Governmental Nonprofit	Decision	Yes, Multi State Consortia
Montana	Adopted – House Joint Resolution -4/28/11		No final decision	
Nevada	Enacted – SB 440, 6/16/11		Decision	
North Dakota	Enacted – HB 1126, 5/9/11	State Based Exchange	Decision	
Oregon	Enacted – SB 99, 6/17/11		Decision	
Pennsylvania	Pending – Carryover Last action 2/14/11,x HB 627	Independent Public Authority or Regulated Non-Profit Marketplace	Recommendation	
Utah	Previously existing version, HB 133 and HB 188, 2008	Administered and Facilitated by Office of Consumer Health Services (existing state agency)	Decision	
Virginia	Enacted – HB 2434, 4/6/11		Decision	

Vermont	Enacted, HB 202, 5/26/11	Department of Vermont Health Access will establish the exchange	Decision	Yes, Multi State Consortia
Washington	Enacted – SB 5445, 5/11/11, Previously Existing Version HB 1569, 2007	Public Private Partnership separate and distinct from the state	Decision	No
West Virginia	Enacted – HB 1569, 4/5/11	Governmental Entity within the office of the Insurance Commissioner	Decision	
Wisconsin		Quasi-Public Entity	Draft Legislation, No final decision	No

Flowchart 1.0 Operation of Health Benefit Exchanges



Source: Center for Applied Demography & Survey Research

ACA: MEDICAID AND CHIP

Introduction

The Patient Protection and Affordable Care Act (ACA) will have significant implications for both Medicaid and the Children's Health Insurance Plan (CHIP) in the State of Delaware. The first portion of this summary focuses on Medicaid and the effect of the ACA on this program. By January 1, 2014, Medicaid will be fully expanded to include benefits at 133 percent of the Federal Poverty Level (FPL) which is $14,404 for a single adult or $29,327 for a family of four in 2010. The aged and disabled, parents, certain legal aliens and childless adults eligibility expands to 133% in Medicaid from levels much lower. This expansion alone will have a huge impact on health care because almost half of the uninsured (approximately 21 million people) live in households with incomes that are less than 133% FPL. The Centers for Medicare and Medicaid Services (CMS) is playing a significant role with regards to implementation of the ACA with both the federal government and states. Their goal is to assist with complying for guidance in the ACA. According the Congressional Budget Office, by 2019 both Medicaid and CHIP will constitute the second largest source of health insurance coverage nationwide for individuals under 65 years old. Employer sponsored coverage will be the only type of coverage that surpasses Medicaid and CHIP with regards to the number of individuals enrolled. The Congressional Budget Office (CBO) estimates that the federal government will bear the majority of the costs (95%) for Medicaid from 2014 to 2019. After the first three years, federal funding for Medicaid will decrease but to no less than 90% in 2020. CMS estimates that state and local expenditures will increase by approximately 1% for Medicaid and CHIP programs, while federal funds to states will increase by 20%. The number of people covered will increase by 33%.

Preventing Illness to Reduce Costs

One major component of the ACA which will directly affect individuals applying for Medicaid is the goal to use preventive care and incentives to improve the health of individuals who are on Medicaid. Delaware recently applied for funding for one of these programs; Incentives for Prevention of Chronic Diseases in Medicaid which was allocated $100 million in funding under ACA. With this funding, 10 states will receive between $5 and $10 million to provide incentives to Medicaid recipients to stop unhealthy behaviors. The reason behind some of the preventive health programs that were included in the ACA is that the highest concentration of Medicaid spending falls within a very small percentage of Medicaid recipients. Current Medicaid numbers nationwide show that only 1% of Medicaid beneficiaries use 25% of Medicaid spending while 5% of Medicaid beneficiaries use 54% of Medicaid spending. This means that the individuals with the majority of health problems cost the most federal dollars in terms of providing their health care through Medicaid. CMS estimates that reducing the average cost of care by 10% for the top 5 percent of health care users could potentially save $15.7 billion dollars on the state and federal level. Some other provisions included in the Affordable Care Act that will have an impact on promoting preventive medicine within the Medicaid program include: Improving Access to Preventive Services for Eligible Adults in Medicaid, and Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid.

Medicaid Expansion and the ACA

Medicaid expansion alone will potentially do more to increase the number of people with health insurance than any other provision in the ACA. While Medicaid increases the number of individuals who qualify for insurance, several states, including Delaware already have expanded eligibility. Delaware currently allows parents of dependent children to receive Medicaid, however most states including Delaware have income eligibility that is well below the federal poverty level. In Delaware, adults with dependent children are eligible for Medicaid if their

gross income is less than or equal to 185% of the TANF Standard of Need (Delaware's main cash assistance program for low-income families,) and Countable Income (consists of both unearned and earned income) is less than the TANF Standard of Need. The TANF Standard of Need in Delaware is 75% of the federal poverty level (FPL). In the majority of states childless adults are not eligible for Medicaid, however, Delaware has a pilot program that allows childless adults at or below 100% of the FPL ($10,830 single adult or $22,050 for a family of four) to receive Medicaid through the Diamond State Health Plan.

States such as Delaware (Diamond State Health Plan) that already have expanded coverage for childless adults and parents up to or above 100% of the Federal Poverty Level are eligible to receive an increase in their Federal Medical Assistance Percentages (FMAP) for childless adults. FMAPs are used to determine the amount of federal matching funds for state expenditures for assistance payments for certain social services, state medical and medical insurance expenditures. This adjustment in the FAMP is done so that states with expanded Medicaid coverage will receive the same enhanced match rate for childless adults up to 133 percent of the FPL by 2019. "Each expansion state will receive an increase that is equal to 50 percent of the gap between its regular Medicaid match rate and the enhanced match rate provided to other states in 2014, 60 percent in 2015, 70 percent in 2016, 80 percent in 2017, 90 percent in 2018, and 100 percent in 2019 and subsequent years. All states will receive their regular FMAP for parents eligible for coverage under the rules in place on March 23, 2010." There are specific provisions in the ACA which state that as of March 23, 2010 no states are allowed to roll back Medicaid eligibility standards, policies or procedures. Although states are not permitted to roll back Medicaid eligibility standards, policies or procedures, the ACA does not prevent states from reducing services to Medicaid members. For example, in July 2011, Delaware Medicaid no longer provided routine vision care and eyewear to individuals twenty-one and over in an effort to reduce costs. This is likely to become an issue leading up to the implementation of the ACA, with Medicaid scaling back services due to cost, to serve the increased patient load.

CHIP Expansion and the ACA

The ACA will extend CHIP beginning on September 30, 2015. Previous CHIP enrollees who are under 133% move to the Medicaid program and Chip expands above 134% to 200%. When the ACA was enacted, it required states to maintain current income eligibility levels for CHIP through September 30, 2019 and prohibited states from implementing eligibility standards, methodologies or procedures that are more restrictive than those that were in place as of March 23, 2010 (for example, scaling back income eligibility, dropping coverage for an entire eligibility category). The ACA included one exception that allowed state governments to change procedures for children on waiting lists. The law also created a new requirement for states that can't cover eligible children because of enrollment caps. This requirement mandated that states must provide a screening process that determines whether children on waiting lists are eligible for Medicaid (by 2014) or tax credits (state-based exchanges). The ACA also created a new federal matching rate increase of 23% that is capped at 100% used to fund program enrollment and outreach.

Medicaid and CHIP Potential Loss of Benefits

There are strict requirements to prevent the loss of benefits for individuals who have already qualified for both Medicaid and CHIP. However, states are permitted certain measures to afford both of these programs, and the new ACA requirements do not prevent states from cutting Medicaid or CHIP by reducing provider reimbursement rates and/ or eliminating optional benefits in the interim. For example, in July 2011 Delaware cut routine vision care and eye wear to Medicaid recipients twenty-one and over. Beginning in 2013, "states will be required to increase Medicaid reimbursement rates for primary care physicians (PCPs) to the same level as the applicable Medicare payment rates for 2013 and 2014."

Medicaid Churn

Income fluctuations among individuals who are eligible for Medicaid are a common occurrence. This churning on and off of Medicaid is likely to disrupt coverage that will be

applied under the ACA. The shifting of individuals from Medicaid will differ from the current issue of shifting coverage in that individuals will be able to shift to the new Health Benefit Exchanges (HBE) in 2014. Eligibility for both Medicaid and the subsidies available through the HBEs will be based on income. A recent study focusing on changes in eligibility found that it is likely that movement back and forth between Medicaid and the HBEs will affect millions of the current and newly insured individuals affected by the law. This study "*Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges*" by Benjamin D. Sommers and Sara Rosenbaum used national survey data to determine how income fluctuations are likely to affect adults. The results found that 35% of the adults in the sample were likely to experience a change in eligibility in six months while 50% of the sample would experience a change in one year. The eligibility changes are due to income fluctuations of the adults analyzed. The authors determine that beginning in 2014 there will be millions of individuals nationwide that will move between Medicaid and the HBEs after they are initially enrolled in either program. The authors point out that normally when individuals lose eligibility for Medicaid due to income fluctuations, they normally lose insurance. However the ACA contrasts with this original paradigm in that this legislation will serve as a safety net for families so that they do not experience a lapse in coverage when their income changes. The authors also address the important question of "How to mitigate the potential harm of transitions between Medicaid and the exchanges?"

Sommers and Rosenbaum point to various methods that are likely to prevent individuals who experience income fluctuations from facing a disruption in insurance coverage for any period of time. Their recommendations to help prevent a disruption in coverage are the following: reduce the likelihood of frequent eligibility changes, provide support services for the shift, align coverage and benefits, align markets and provider and monitor accessibility and quality of care.

With regards to reducing the likelihood of frequent eligibility changes, Sommers and Rosenbaum suggest that "states can promote guaranteed eligibility periods by using annual redetermination procedures instead of more frequent eligibility verification, to reduce the likelihood of mid-enrollment shifts. The authors also state that support services should be provided "when implementing both Medicaid and exchange reforms, states should clarify that the source and size of the subsidy is sensitive to income." Another means of providing support services to reduce the likelihood of a disruption in health insurance coverage is to ensure that the "exchange navigators" which are required under the ACA, are knowledgeable about both Medicaid and the HBEs and their services should be available to consumers. Sommers and Rosenbaum also suggest that to ensure there is not a lapse in coverage for individuals who move from Medicaid to a HBE, states might need to require that enrollment in health insurance plans through the HBEs be retroactive to the date of first eligibility or extend Medicaid coverage until the HBE coverage takes effect. A major concern raised by the authors is the potential effect of income fluctuation on both the quality and continuity of care for people that shift between Medicaid and HBE coverage. They suggest that states consider developing products that are certified to operate in both the Medicaid and HBE market by collaborating with Medicaid plans and health insurers. Sharing common coverage terms, provider networks, administrative systems, consumer and patient protections and quality and performance means are all areas that the authors believe will prevent a lapse in care for the individuals affected.

Information Technology and Medicaid/CHIP

The eventual goal with the introduction of the ACA is for Medicaid and CHIP to no longer serve as a safety net but to become a full partner in assuring coverage for all. Combined Medicaid/CHIP, Employer Coverage and the Health Benefit Exchanges will ideally become part of a system of coverage and care. One of the most important components to ensure that the individuals who qualify for Medicaid and CHIP will be routed to the correct programs is the IT structure that states have in place to determine eligibility for the correct health care program. CMS is currently working to develop various types of guidance to ensure that states are able to make this possible. The Center for Consumer Information and Insurance Oversight (CIIO

formerly OCIIO) Early Innovator Grants were awarded as a means of putting the states who received the funding under the spotlight so that other states can learn from them as they are developing their IT structures. While IT applications will allow for individuals to apply for Medicaid and CHIP online, traditional applications for these state programs will still be made available.

Health Care Reform and State Health Insurance Costs

The following section includes data on projections for the eventual expense and/or savings for Maryland, Connecticut, California, Illinois, Montana and Texas under the ACA. Each description includes estimates of expenses and savings as well as population estimates for individuals who will be newly enrolled in Medicaid during 2014 and 2020. Since each of the state projections only ranged from 2011 to 2020, we highlighted data from 2014 and 2020. We selected 2014 as the first year to highlight in the projections because this was the first year for expansion to Medicaid for individuals who are 133% of the Federal Poverty Level (FPL). We then compared those numbers to the projections that were provided for 2020 since that is the last year that projections were provided for each of the states highlighted.

Maryland developed a health care reform modeling tool to predict estimates about what eventual costs will be to the state for health care reform. The State of Maryland's interim report from the Health Care Reform Coordinating Council includes these projections and the eventual cost to the state as a direct result of the ACA. Projections for expenses range from 2011 to 2020, and were calculated by the Hilltop Institute. Nine different elements are highlighted as cost to the state while seven categories represent programmatic savings to Maryland. The dollar amounts that will be listed in this summary include projections for FY 2014 and FY 2020 state funds only. In 2014, it is estimated that 151,879 individuals will be added to the State of Maryland's health care system and by 2020, this number will have increased to 358,710.

The 2010 Census population count for the State of Maryland was 5,773,552. Estimates of the cost of Medicaid expansion while accounting for the new enrollees who will become eligible for Medicaid in 2014 and beyond are some of the factors highlighted. Overall the estimated increase in health insurance costs (excluding savings) in 2014 is $49 million, and by FY 2020 the estimate of the increase of costs is projected to be $504 million. Maryland currently has a program where parents who have incomes that are below 116% of FPL are eligible for the State's Medicaid program. Therefore the only individuals that were included in this projection were those parents who qualified for Medicaid and whose income ranged from 116 – 133% of FPL, and childless adults whose income was below 134% of FPL. Estimated savings for Maryland Medicaid coverage expansion is $42 million beginning in FY 2014 (Medicaid expansion enrollment projection 59,245) however, as of FY 2020 (Medicaid expansion enrollment projection 137,839) this figure would have increased to a cost of $198 million for Maryland.

The authors of this report cite research that demonstrates there are knowledge gaps among parents, which possibly accounts for why some children in low income families who should qualify for SCHIP are not enrolled. This "woodwork effect" will in theory lead to an increased cost of expenses to the state. The belief is that individuals who are already eligible for MCHP (Maryland Children's Health Program) but not currently enrolled will be enrolled in Medicaid in 2014, leading to an increase in cost to the state beyond the added expense of the newly eligible individuals. In 2014, the "woodwork effect" costs are expected to be $12 million (Medicaid "woodwork effect" enrollment projections 4,125). By 2020 the "woodwork effect" costs are expected to be $127 million (Medicaid "woodwork effect" enrollment projections 34,114).

Administrative costs including costs for outreach, enrollment and eligibility determinations of MCHP are also expected to increase costs for Maryland. The projections point to the reduction in fee-for-service pharmacy drug rebates, and a reduction in Medicaid

Disproportionate Share Hospital (DSH) expected to be an additional cost for the state of Maryland of $67 million between 2014 and 2020. The ACA states that all AHBEs should be self-sustaining by January 2015; this means that there will be additional administrative costs associated with operating the AHBEs. According to the Hilltop Institute, state employee/retiree health insurance will be an additional expense for Maryland. Administrative costs specifically for state outreach activities are also expected to affect other agencies that are not affiliated with the Maryland Department of Health and Mental Hygiene (DHMH). Another projected expense is the transfer of six to 19 year olds who currently have family incomes between 100% to 133% of FPL from the MCHP program to Medicaid and thus a federal reimbursement rate reduction from 62.5% to 50%.

The areas where savings are expected in Maryland as a result of health care reform included the following: enhanced Title XXI (SCHIP) match rate, hospital assessment: MHIP-Related (Maryland Health Insurance Program – state high-risk health insurance pool), Rate Stabilization Offset: 100% Medicaid PCP (federal funding will reimburse Medicaid payment rates to 100% of Medicare payment rates for 2013-2014). Maryland had previously developed a plan to increase Medicaid PCP rates to be equal to Medicare so that funding will instead be savings for the state. Additional areas of expected savings include, Medicaid: Rx rebates extended to managed care organizations, Medicaid: Breast & Cervical converts to insurance, reductions in state-only programs/grants and seniors prescription drug assistance (SPDAP). Taking all of these savings into account will lead to estimated savings of $148 million for Maryland in 2014, while savings in 2020 are estimated to be $356 million.

After adding costs and saving projections associated with the ACA implementation in 2014, it is projected that the State of Maryland will save approximately $133 million. The projections provided in the report produced for the State of Maryland highlight that initially there will be significant costs savings as a result of health care reform. However, it is projected that by 2020 the cost savings would have reversed and the amount of state funds spent will be $46 million dollars more than was spent prior to the implementation of health care reform.

Connecticut most closely mirrors Delaware in type of health care that is provided to its lower income residents. The 2010 Census count determined that the population in Connecticut is 3,574,097. Connecticut currently has a program that extends public health insurance coverage to low-income adults who do not qualify for traditional Medicaid (SAGA – Medical Assistance). With all of the costs paid for by state funds, these funds will be offset by the new federal subsidies for this population which is expected to save Connecticut a significant amount. Delaware's Diamond State Health Plan has expanded coverage for childless adults and parents up to or above 100% FPL.

Projections highlight at least two different groups of people who will become newly enrolled in Medicaid in Connecticut beginning in 2014. The two groups expected to enroll in Medicaid include the newly eligible under the expansion of Medicaid to 133% of the FPL, and individuals who previously qualified for Medicaid but were not enrolled. Individuals previously qualified but not enrolled in Medicaid will likely enroll to comply with the mandate to maintain health insurance. Some of the newly Medicaid-eligible individuals will opt to take up employer sponsored insurance (ESI) instead of Medicaid, which is also expected to impact costs to the state.

RAND Health estimate is that without health care reform, 340,000 individuals would be uninsured, but with health care reform that number will be reduced to 170,000. Additionally, once the law is fully implemented, it is expected that Medicaid enrollment will increase by 31 percent. The authors estimate that by 2014, 120,000 additional Connecticut residents will be enrolled in Medicaid, and in 2020 130,000 additional residents will be enrolled in Medicaid. It is estimated that as a result of health care reform the total number of individuals who are enrolled in Medicaid in Connecticut in 2014 will be 520,000. By 2020 that number is expected to reach 550,000. The authors also estimate that 40,000 individuals will be enrolled in the AHBEs during both 2014 and 2020.

With regards to state spending on health insurance in 2014, it is expected that state spending on Medicaid will increase by $30 million while SAGA spending will be reduced by $270 million (50,000 less individuals). The expected state spending on health insurance in Connecticut as a result of health care reform is expected to be $240 million in 2014. The authors estimate that by 2020, the additional expense for Medicaid spending under the ACA will be $130 million. Interestingly, it is estimated that costs for SAGA will be reduced by $390 million (50,000 less individuals), while state health insurance costs will decrease by $30 million. The authors estimate that Connecticut state spending on health insurance in 2020 will decrease by $290 million.

Projections demonstrate that once the ACA is fully implemented, Medicaid in California will have increased by 58 percent with the majority of new individuals on Medicaid encompassing the newly eligible as a result of the increase to 133% of FPL qualified for Medicaid. The 2010 Census count determined that California's population count was 37,253,956. We will again look at 2014, the year that the ACA is expected to be fully implemented, and 2020 which is the last year of the projection provided in the RAND Health analysis. RAND Health projects that by 2014 an additional 3,390,000 individuals will be newly eligible for Medicaid. The newly eligible added to the projected number of individuals already enrolled for Medicaid in 2014 without the ACA is expected to result in 9,400,000 individuals enrolled in Medicaid in California. In 2020, it is expected that an additional 3,960,000 will be added to the 6,710,000 that were projected to be enrolled in Medicaid without health care reform. By 2020 it is expected that approximately 10,670,000 individuals will be enrolled in Medicaid under health care reform. With regards to California state spending on health insurance in 2014, it is expected that state spending on Medicaid will increase by approximately $1 billion by 2014, and will increase by approximately $4 billion by 2020.

Cost projection estimates indicate that Illinois State spending on health care will increase as a result of the ACA. The US Census count for 2010 data lists Illinois population count as 12,830,632. The majority of the increase in expenses will be a result of the previously eligible joining Medicaid. In 2014, approximately 720,000 additional individuals will enroll in Medicaid, as a result of the ACA, for a total of 2,280,000. By 2020 it is projected that 790,000 additional individuals will be enrolled in Medicaid under the ACA for a total of 2,400,000. Illinois state spending on Medicaid is expected to increase by $550 million. The projection estimates that the additional Medicaid expenses will be a result of individuals who were previously eligible for Medicaid joining the state rolls. The projection also estimates that state health insurance expenses will decrease in Illinois by $10 million. Projections show that by 2014, Illinois state spending on health insurance will be $540 million higher under health care reform than without implementation of the ACA. In 2020, it is estimated that Illinois will spend an additional $930 million for individuals who were previously eligible for Medicaid, and $340 million for individuals who were newly eligible for Medicaid. Projections estimate that by 2020 additional costs associated with health care reform and Medicaid in Illinois will be approximately $1.3 billion more under health care reform than without implementation of the ACA. By 2020, it is estimated that the total cost of Illinois state spending on health insurance will be $9.2 billion.

Presently, Texas has the highest rate of uninsured in the nation; this is due to the low rate of ESI coverage. The 2010 Census population count in this state was 25,145,561. Due to the large number of newly eligible individuals in Medicaid, it is expected that state spending on health care will significantly increase. Based on the RAND Health analysis there will be a huge increase in the rate of insurance in Texas. Current projections show that under ACA implementation, the number of newly enrolled individuals to Medicaid during 2014 will increase by approximately 2.6 million over the number of individuals who would have been enrolled in Medicaid without health care reform for a total of 5.8 million individuals enrolled in Medicaid. By 2020, it is estimated that the number of newly enrolled individuals to Medicaid will be 2.8

million higher than without implementation of the ACA for a total of 6.3 million individuals enrolled in Medicaid. The majority of changes to Medicaid spending will be a result of the previously eligible enrolling. The previously mentioned group joining Medicaid will result in expenses increasing by $510,000,000 in 2014. Additional enrollment of individuals to Medicaid will add about $1.1 million for previously eligible individuals, while increasing expenses by approximately $1.6 million for newly eligible individuals. Texas state spending on health insurance is projected to be $580 million more under the ACA than without the ACA in 2014, which will result in health insurance spending totaling approximately $10 billion. In 2020, the amount that Texas is expected to spend under the ACA will be roughly $2.8 billion more than without implementation of the ACA for a total of $16.9 billion spent on health insurance.

Findings from RAND Health's projection on the impact of the ACA on state health expenditures demonstrate that health care spending in Montana will increase. Current population counts in Montana are 989,415 according to the 2010 Census. Projections show that with the implementation of the ACA in 2014, 60,000 additional individuals will be newly insured under Medicaid and that number will remain the same in 2020. Total enrollment in Medicaid under the ACA is predicted to be 170,000 in 2014 and 2020. Detailed projections don't highlight an increased expense of health care spending for Montana in 2014. However, under the ACA, total state spending on health insurance will be $10 million higher under health care reform than without health care reform. In 2020, it is estimated that $20 million more will be spent for the newly eligible under Medicaid and $10 million more will be spent for state health insurance with Montana spending $40 million more under health care reform than without health care reform. The total cost of Montana state spending on health insurance in 2014 is expected to be $420,000,000 in 2014 and $620,000,000 by 2020.

Summary of State Expansion of Medicaid

Medicaid coverage expansion is the primary area that will insure the majority of uninsured once the ACA is fully implemented in 2014. It is also estimated to be one of the major costs associated with health care reform. Delaware's population size (2010 Census pop. 897,934) most closely mirrors Montana; however, Connecticut's health care system is more similar due to the fact that both states currently have programs in place that extend public health care coverage to individuals who do not qualify for traditional Medicaid. The existing health plans will initially reduce expenses for the states as a result of federal subsidies.

The authors of the reports produced by RAND Health point out that even though substantial subsidies will be offered to states to offset their increased expenses, in the long run states will need to pay 10 percent of the Medicaid costs of the newly eligible population. Although the amount paid per Medicaid recipient will be significantly lower than the traditional state share of Medicaid funding, overall the dollar amount spent by many states will be higher because they will be insuring a much larger number of individuals.

It is also important to point out that although the expansion of Medicaid will be 133% FPL, there are also individuals who previously qualified for Medicaid but were not enrolled. These individuals are likely to enroll in Medicaid for the first time and will contribute to the additional cost of expanding Medicaid. Projections also demonstrate that while Medicaid enrollment and costs will generally increase in all cases, other benefits from the ACA will help offset some of these expenses. It is important to note that while these projections are provided for 2011 to 2020, there is no data provided that allows comparison on what expenses will be for states after 2020.

Table 2.0 Medicaid Only - Enrollment Expansion Projection

	2014	2020
California	3,390,000	3,960,000
Texas	2,570,000	2,840,000
Illinois	720,000	790,000
Montana	60,000	60,000
Connecticut	120,000	130,000
***Maryland**	63,370	172,240

*Data from Maryland Health Care Reform Modeling Tool and RAND Health Analysis (CA, TX, IL, MT, CT)

Table 2.1 Medicaid Only – Additional Cost Projection

	2014	2020
California	$1,080,000,000	$4,000,000,000
Texas	$510,000,000	$2,670,000,000
Illinois	$550,000,000	$1,270,000,000
Montana	$0	$20,000,000
Connecticut	$30,000,000	$130,000,000
***Maryland**	$4,000,000	$413,000,000

*Data from Maryland Health Care Reform Modeling Tool and RAND Health Analysis (CA, TX, IL, MT, CT)

Delaware Enrollment Projections for Medicaid and CHIP in 2014

The ACA requires that the provisions relating to Medicaid and CHIP be implemented by 2014. While the impact on the state's budget will not be fully felt until 2016, it is important to understand the fiscal impact of these provisions. This section provides such enrollment projections first for the base case, i.e. Medicaid and CHIP as they are currently implemented and then the additional enrollment mandated by the ACA.

The data used in these projections is derived from the following sources:

1) Quarterly time series data on enrollees from 1999 through 2009;
2) Age distribution data from the 2010 decennial census;
3) The 2009 American Community Survey for Delaware;
4) The 2007-2010 Current Population Survey data for Delaware;
5) Population projections from the Delaware Population Consortium;

Several different methodologies were considered in producing the projections:

1) Standard growth model for the entire period and split at 2004;
2) Classic ARIMA time series model;
3) A time series model using the Prais-Winsten procedure;
4) Ordinary least squares (OLS) including time, poverty, unemployment claims, and income.
5) Demographic methods using the share of specific age groups enrolled in Medicaid over time.

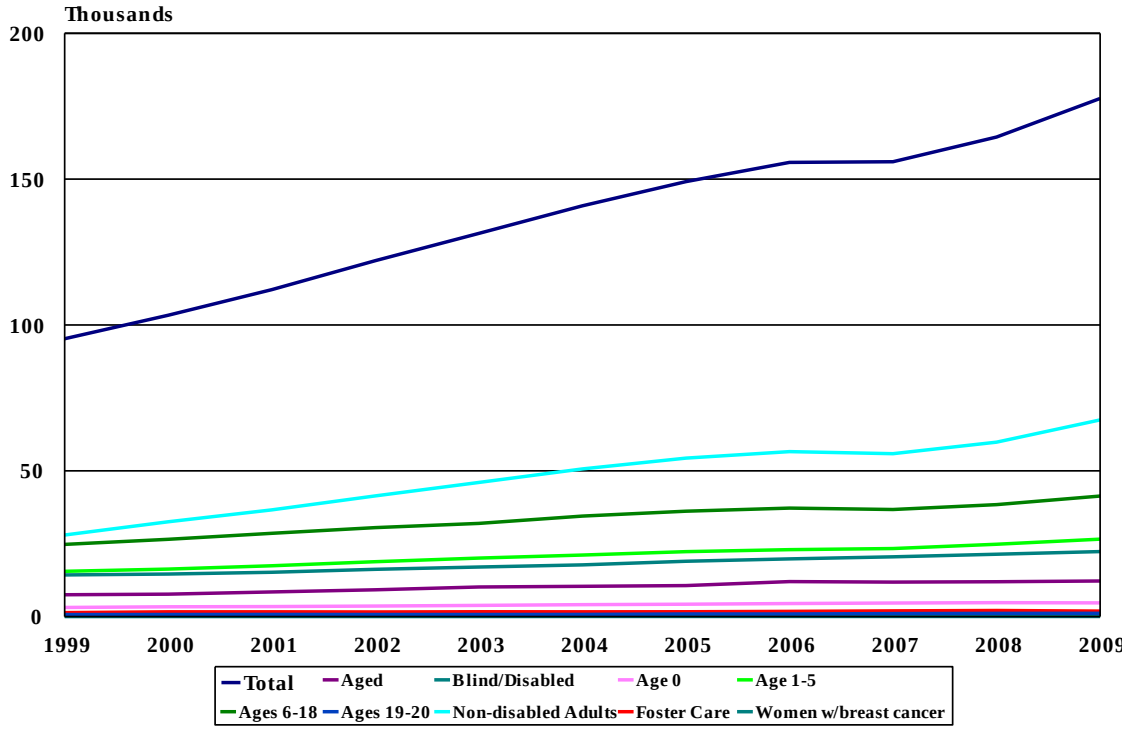
The analysis begins with the data supplied by Delaware's Medicaid agency. The data consisted of enrollment by quarter from the fourth quarter of 1998 through the third quarter of

2009. Each of the 44 quarters represents a single observation in the analysis. The agency supplied the total eligible persons for the quarter and a breakdown by each of the sub-groups that become eligible through separate parts of the regulations. The sub-groups that meet the poverty criteria include the following:

1) Aged persons qualifying for Medicaid in addition to Medicare;
2) Blind/disabled persons;
3) Newly born children age less than one year;
4) Children age one to five;
5) Children age 6 to 18;
6) Young adults age 19 or 20;
7) Non-disabled adults;
8) Foster care children;
9) Women with breast cancer.

The figure below shows the total number of persons served by Medicaid from 1999 through 2009 and the total in each of the sub-groups.

Figure 2.0
Total Persons Receiving Medicaid Services
by program 1999-2009

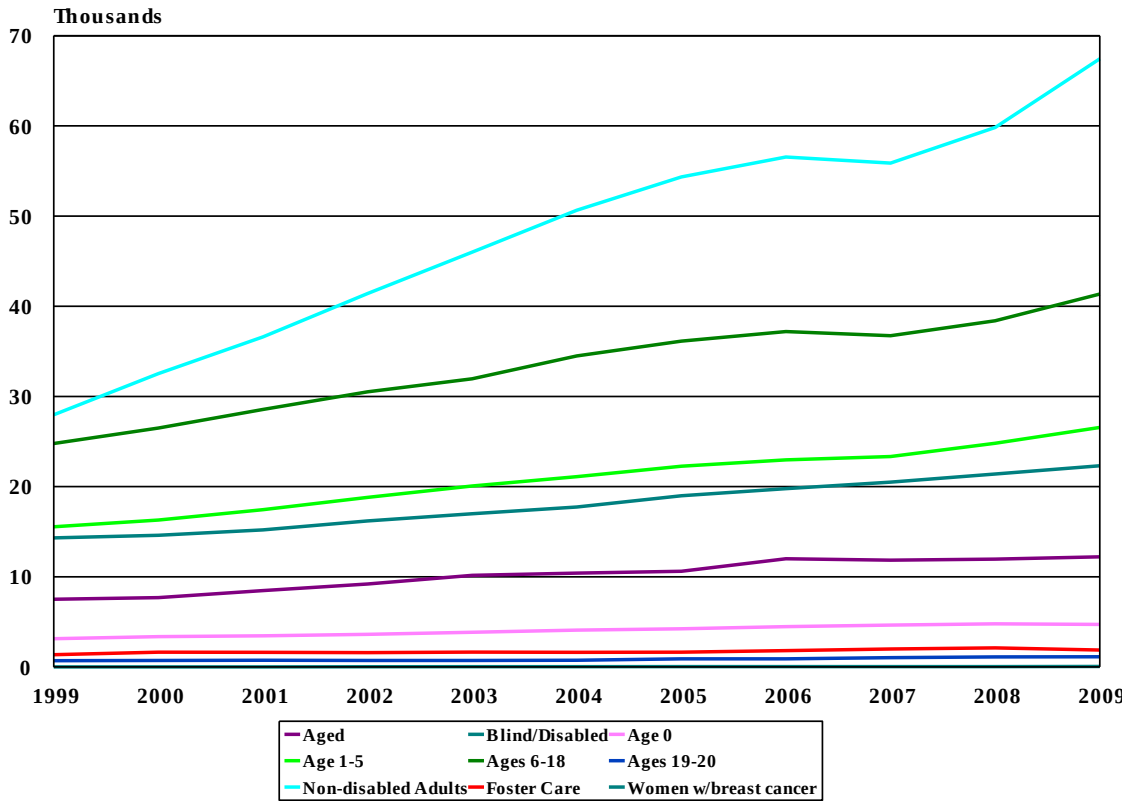


Source: Center for Applied Demography & Survey Research, University of Delaware
Delaware Division of Medicaid and Medical Assistance

The chart has been simplified by showing only the 4th quarter of each year covered in the analysis. The top line which aggregates all of sub-groups shows strong and regular growth throughout the period. The only exception occurs at the peak of the last economic expansion in 2006, but quickly resumes growing at the onset of the recession in 2008. Even with an unemployment rate of less than 5% from 2000 through 2006 and frequently under 4%, the Medicaid population was rising. This suggests that with current unemployment rates exceeding 8%, Medicaid growth is unlikely to slow when Delaware recovers. Population growth over the period was 1.36% annually while Medicaid expanded at 6.4% annually. General population growth does add predictably to the Medicaid population but it is the composition of the population that is the predominant driver.

In the next figure, the total number of recipients has been suppressed to more clearly show the differential rates between the components of the total. Clearly the non-disabled adult group is driving growth at an annual rate of 9.4% over the period. The annual rate in 2008 exceeded 10%. The other groups have annual growth rates in the range 4%-7%.

Figure 2.1
Persons Receiving Medicaid Services
by program 1999-2009

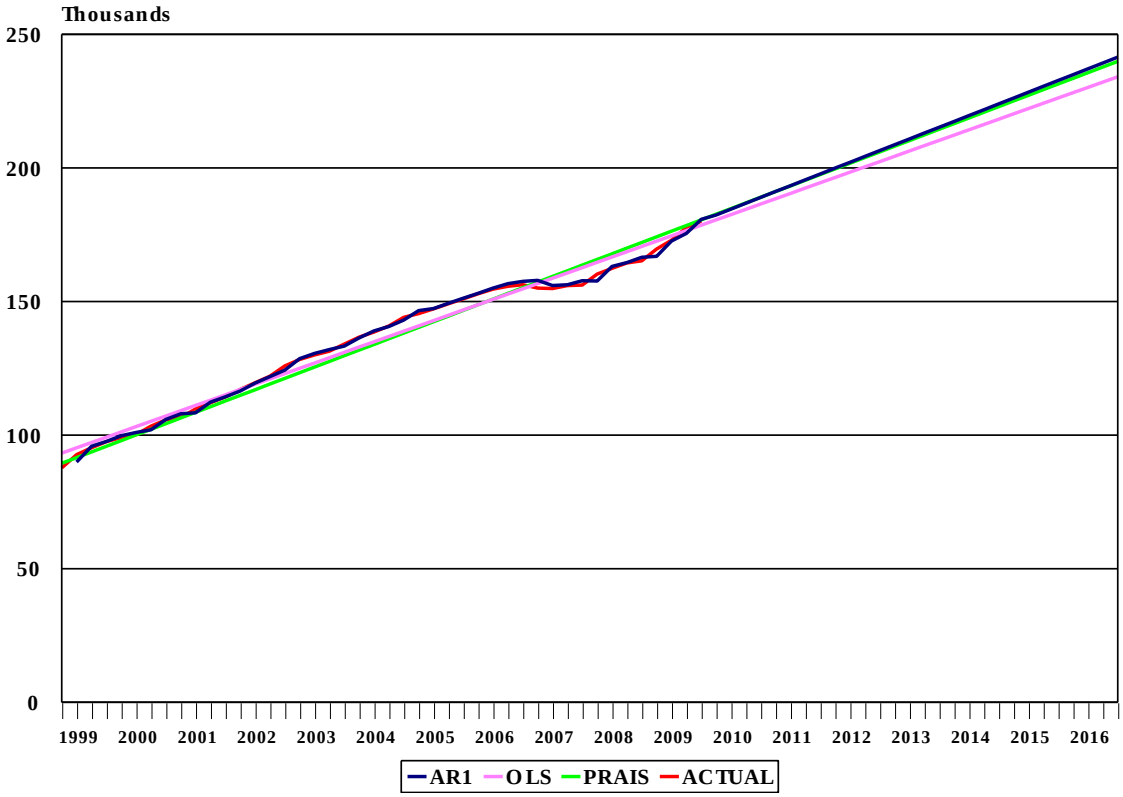


Source: Center for Applied Demography & Survey Research, University of Delaware
Delaware Division of Medicaid and Medical Assistance

The results for the three time series analyses are shown in Figure 2.2. The pink line represents the forecast using ordinary least squares method. The light green line is the model

using the Prais-Whiten procedure. The dark line represents the results from the ARIMA method. The actual data is shown in red but is covered for the most part by the ARIMA result. All three models give similar forecasts, although the OLS model is slightly lower than the other two. The OLS approach also underestimates the standard error and thus the accuracy of the projection because of serial autocorrelation present in the dataset. This means that in general the OLS approach will provide reasonable estimates of the slope of the line but underestimates the standard error and thus the variability of the forecast. The actual baseline forecasts are provided in Table 2.x below.

Figure 2.2
Forecast of Baseline Enrollment in Medicaid
2010-2016



Source: Center for Applied Demography & Survey Research, University of Delaware

The baseline forecast for 2014 is approximately 223,000 taken from the PRAIS column in QTR 64. It is essentially the average estimate for calendar year 2014 referred to in the ACA legislation. The forecasts are considered baseline since they do not as yet incorporate the

additional uninsured adults who will now be eligible by being under 133% of the poverty guideline. It also does not as yet incorporate current CHIP participants who are under the 133% guideline and will be incorporated into Medicaid.

In order to complete this task, two estimates are required. The first is the number of adults over the age of 18 who will reside in Delaware in 2014. This was obtained from the latest Delaware Population Consortium projections from October 2010. The number of people in that age group who are currently uninsured and are between 100% and 133% of poverty is also needed. That can be obtained from an analysis of the 2008, 2009, and 2010 Current Population Survey data files. Rates can then be calculated and applied to the adult population anticipated in 2014.

Table 2.2
Forecast of Baseline Enrollment in Medicaid

2010-2016

Year	QTR	AR1	OLS	PRAIS	Actual
2009	42	172641.8	174599.3	176327.9	172949
	43	175515.3	176582.8	178446.4	177678
	44	180748.1	178566.4	180565	180120
	45	182394.9	180550	182683.6	
2010	46	184611.7	182533.5	184802.1	
	47	186808.4	184517.1	186920.7	
	48	188998	186500.7	189039.2	
	49	191185.1	188484.3	191157.8	
2011	50	193371.4	190467.8	193276.3	
	51	195557.4	192451.4	195394.9	
	52	197743.3	194434.9	197513.5	
	53	199929.2	196418.5	199632	
2012	54	202115.1	198402.1	201750.6	
	55	204300.9	200385.6	203869.1	
	56	206486.8	202369.2	205987.7	
	57	208672.7	204352.8	208106.2	
2013	58	210858.5	206336.3	210224.8	
	59	213044.4	208319.9	212343.3	
	60	215230.2	210303.5	214461.9	
	61	217416.1	212287	216580.5	
2014	62	219602	214270.6	218699	
	63	221787.8	216254.2	220817.6	
	64	223973.7	218237.7	222936.1	
	65	226159.5	220221.3	225054.7	
2015	66	228345.4	222204.9	227173.3	
	67	230531.3	224188.4	229291.8	
	68	232717.1	226172	231410.4	
	69	234903	228155.6	233528.9	
2016	70	237088.8	230139.1	235647.5	
	71	239274.7	232122.7	237766	
	72	241460.5	234106.3	239884.6	

Source: Center for Applied Demography & Survey Research, University of Delaware

Table 2.3
Poverty, Age, and Health Insurance Status
2009

Poverty	0-18 All	0-18 No HI	19+	19+ No HI
Not Measured	1148	378	0	0
under 0.50	16158	4706	24150	8982
0.50 to 0.74	9680	1270	14285	3728
0.75 to 0.99	7724	1030	18410	4595
1.00 to 1.24	13589	1789	24451	5239
1.25 to 1.49	9421	1263	29982	5919
1.50 to 1.74	9601	1010	24595	3549
1.75 to 1.99	9398	1993	28388	6351
2.00 to 2.49	21084	1283	55282	8446
2.50 to 2.99	18761	1284	60368	9648
3.00 to 3.49	16191	1234	50643	6977
3.50 to 3.99	13704	459	42673	4060
4.00 to 4.49	13298	673	39044	3799
4.50 to 4.99	12703	335	36531	3262
5.00 & over	49311	1249	199191	8264
Total	221771	19956	647992	82820

Source: Center for Applied Demography & Survey Research, University of Delaware
Current Population Survey 2008, 2009, 2010 US Bureau of Census

From the Table 2.3, we estimate that there are 11,518 uninsured adults in the 1.00-1.50 category. Obviously those in 1.00-1.24 would all be included. Assuming an equal distribution in the group 1.25 to 1.49, 1894 will be in the interval 1.25 to 1.33. The estimate is then 7,133. That is approximately 1.32% of the 2009 19-64 population of 538,897. (The 65+ group is assumed to be covered by Medicare, although there is an overlap between Medicare and Medicaid for those under the poverty level of 1.0).

From the DPC projections for 2014, the total 19-64 population is expected to be 557,229. If the current distribution of poverty remains similar to today, then the updated estimate for adults gaining eligibility to Medicaid in 2014 is 7,355. If we look at the same calculations five years ago, the estimate would have been 1.01% of the 19-64 population are in this category. This suggests that there is some movement in poverty or in the measurement of poverty that should be considered. If the poverty distribution shifted as much as it did in the past five years, then 1.68% (9,361) of the 19-64 age group would be qualified. This would seem to be a more prudent estimate and adds 4% to the baseline forecast of Medicaid.

For the CHIP addition, a similar process is used. From the Table 2.3, we estimate that there are 3,052 uninsured children in the 1.00-1.50 category. Those in 1.00-1.24 would all be included. Assuming an equal distribution in the group 1.25 to 1.49, 404 will be in the interval 1.25 to 1.33. The estimate is then 2,193. That is approximately 1.01% of the 2009 0-18 population of 217,909.

From the DPC projections for 2014, the total 0-18 population is expected to be 222,634. If the current distribution of poverty remains similar to today, then the updated estimate for children gaining eligibility to Medicaid in 2014 is 2,249. If we look at the same calculations five years ago, the estimate would have been 1.1% of the 0-18 population are in this category. This suggests that there is some movement in poverty or in the measurement of poverty that should be considered. If the poverty distribution shifted as much as it did in the past five years, then 0.93% (2,070) of the 0-18 age group would be qualified. This would seem to be a more prudent estimate and adds 1% to the baseline forecast of Medicaid.

The forecast for 2014 Medicaid enrollment is 222,936+9,361+2,070=234,367.

The forecast for CHIP is 9,723 – 2,070=7,753

ACA: THE YOUNG UNINSURED

Introduction

The Patient Protection and Affordable Care Act (ACA) includes numerous provisions that will directly and indirectly affect the young uninsured group defined as individuals from 19 to 26 years of age. Three areas that most likely will have a significant and direct impact on the young uninsured group include the provision which allows young uninsured adults to remain on their parents health plans up to age 26. The provision includes a tier of coverage in the American Health Benefit Exchange with a catastrophic plan and changes to health savings accounts.

The ACA established a new standard for medical expenses which states that health savings accounts can only reimburse the cost of over-the-counter medicines or drugs if they are purchased with a prescription. The law also requires the young uninsured be insured or pay a penalty of $95 initially which increases to $695 by 2016. The provision enabling the young uninsured group to remain on their parent's health plan took effect September of 2010. According to 2010 data from the United States Departments of Health and Human Services, Labor and Treasury, 3.4 million of the 6.6 million uninsured young adults had parents who had employer based health insurance coverage. DHHS data estimates that 1.7 million young adults will be covered under their parent's employer based health insurance coverage by 2013 with one million of the estimated 1.7 million estimated to be previously uninsured 19 year old to 26 year olds.

Catastrophic Health Plan comparison to Massachusetts Young Adult Plan

The American Health Benefit Exchange Catastrophic Plan provides catastrophic coverage only at the level of the Health Savings Account (HSA). The HSA is a tax-advantaged medical savings account available to taxpayers in the United States who are enrolled in a High Deductible Health Plan. The notable exceptions to catastrophic coverage requirements under the law is that individuals can receive prevention benefits as well as coverage for three primary care visits that would be exempt from any deductible. The catastrophic plan is specifically tailored to the young uninsured group in that it is only available up to age 30, and those exempt from the insurance mandate are eligible to purchase the catastrophic plan.

The catastrophic plan is only available on the individual market which points out that its purpose is to make sure that the young uninsured group who might not be working are covered in the event of a catastrophic event. The establishment of a catastrophic plan under the American Health Benefit Exchange is similar to the Young Adult Plan that was developed under the Massachusetts health plan. In Massachusetts, the young adult plan was intended to make sure more individuals would choose to receive insurance coverage. However, another goal was to make sure generally healthy young adults would opt to join one of the offered health plans as opposed to not seeking health insurance coverage and paying a penalty. The latter refers to those individuals who were deemed able to pay, but did not buy health insurance. The penalties for not buying insurance have varied from year to year in Massachusetts. The 2007 penalty was the loss of the personal income tax exemption worth $219. The majority of individuals uninsured during that year were under 40, and two thirds of that population were men. The maximum 2008 penalty for those who did not purchase insurance was $912 and $1,068 for 2009.

The Massachusetts Young Adult Plan (YAP) is for families that are above 300 percent of the Federal Poverty Level. The benefit package is less than that offered for the other plans and is offered through Commonwealth Choice. Commonwealth Choice offers commercial insurance plans for individuals whose income is too high to qualify for subsidized health care through Commonwealth Care.

One third of the enrollees in Commonwealth Choice are 18 to 26 years old and of that one third, approximately 84% are enrolled in a Young Adult Health Plan. It is important to note that there are instances where individuals acquire insurance just before they file their taxes to avoid a tax penalty and then drop their insurance as soon as their taxes are filed. Massachusetts found that it was beneficial to establish a trust fund for these individuals at the state level to make sure that health care centers are reimbursed for the care of these individuals.

To reflect on how the ACA will affect the young uninsured group, it is important to reflect further on how young people were affected with the reform of health care in Massachusetts. One study *"The Importance of Young Adult Provisions in Massachusetts' Health Reform"* compared health insurance coverage for young adults in Massachusetts both before 2005-2006 and after 2007 -2008. This study compared pre and post reform time periods basing the time periods on the year that Massachusetts implemented health insurance reform. Some of the initial reform went into effect in October 2006, but the post reform period using the Current Population Survey for the purposes of this study began in 2007.

This study analyzed data from 2006 through 2009 in the Current Population Survey and gathered data on eight hundred and twenty-seven young adults from age 19 to 26 years of age. The study measured data across population groups and states by comparing Massachusetts to New York State. Other factors that could have affected insurance status were controlled for including but not limited to race, sex, citizenship and family income. The findings of the study were that more than one in five young adults was uninsured prior to health reform in

Massachusetts. Between pre-reform (defined as 2005-2006) and post-reform (2007-2008), the uninsurance rate for young adults fell from 21.1 percent to 8.2 percent which was a drop of more than 60 percent. Ultimately, it was found that the expanded coverage for 18-26 year olds on their parent's health insurance and the Young Adult Plan played an important role in the expansion of coverage for this group.

There are other provisions of the ACA which will have an indirect effect benefitting the young uninsured group although they are not specifically targeted to that group. Provisions that will have an indirect effect on the young uninsured group include: a ban on lifetime limits on insurance policies, no exclusions for insurance due to preexisting conditions, expansion of Medicaid eligibility to all adults below 133 percent of the Federal Poverty Level and the imposition of shared responsibility for large employers who don't offer health insurance coverage or those who offer poor insurance coverage.

Individual Penalty for Lack of Coverage

The ACA currently has in place a section of its legislation that has been highly debated titled "Requirement to Maintain Minimum Essential Coverage." To date, this portion of the ACA has been the most unpopular with the majority of Americans. This individual mandate requires that all individuals that can afford to purchase health insurance make this purchase. This issue is going through federal appeals courts (there are 12 circuit courts), and the final decision is likely to be made in the Supreme Court. The argument regarding the constitutionality of the health insurance mandate centers on the Commerce Clause in the US Constitution (Article 1 Section 8 Clause 3): "Congress shall have power to regulate commerce with foreign nations and among the several states and with Indian Tribes," (it is common to see the clause referred to as the Foreign Commerce Clause, the Interstate Commerce Clause or the Indian Commerce Clause) and the tenth Amendment (Bill of Rights) to the Constitution "the powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

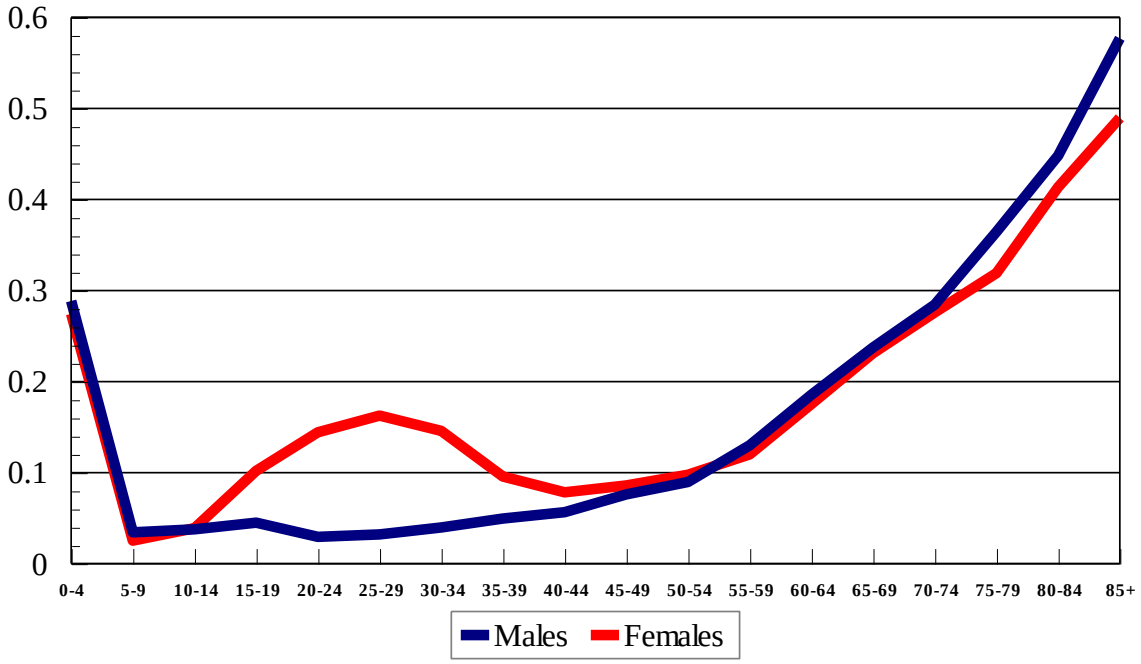
The current ACA guidelines state that the full penalty for not complying with the required insurance mandate will be phased in by 2016. Penalties will only apply to those individuals who go more than three months of the year without health insurance. While the penalty will begin in 2014 at $95 or 1% of income for adults, the full penalty in 2016 will be $695 for individuals and up to $2,085 per family, or 2.5% of household income (whichever is greater). The law stipulates that the penalty will increase annually based on the change in the cost of living.

There will be some exceptions to the requirement to maintain minimum coverage including: those individuals whose income is below a specific level or for whom the least expensive insurance is 8% of the person's income, people in prison, those objecting on recognized religious grounds and members of Native American tribes. This penalty will not be treated as a tax with the ACA law stating that there will be no criminal sanctions for those who fail to pay the penalty, nor does the law allow liens or levies on property. However, those individuals who are due a tax refund could be in danger of having the government recover the penalty from their tax refund should they not pay the required amount.

In Delaware, the 19-34 age group accounts for 8,241 of the uninsured population as measured in the 2008-2010 Current Population Survey. The average family income of that population is just under $30,000. A subset of those are single (5,265) and will only have to pay at most the $695 penalty if it is levied. Given the cost of the individual policies in the market place, it seems to be unlikely that these individuals will buy insurance unless it is heavily subsidized.

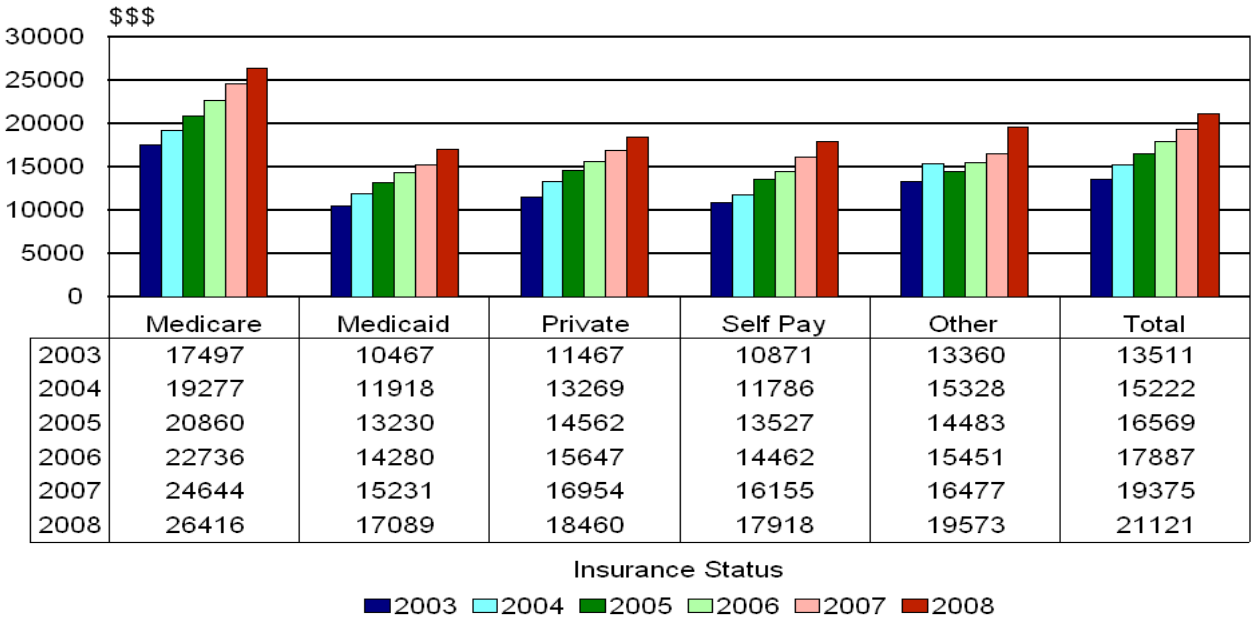
Those that are uninsured in this group who are not single (2,976) may be in the market since the penalty is higher ($2,085) and may be within reach of an Exchange product.

Figure 3.0 Delaware, Likelihood of Hospitalization by Age and Gender



Source: Center for Applied Demography & Survey Research
Delaware Health Statistics Center

Figure 3.1 Delaware, Cost of Hospitalization by Source of Payment



	Medicare	Medicaid	Private	Self Pay	Other	Total
2003	17497	10467	11467	10871	13360	13511
2004	19277	11918	13269	11786	15328	15222
2005	20860	13230	14562	13527	14483	16569
2006	22736	14280	15647	14462	15451	17887
2007	24644	15231	16954	16155	16477	19375
2008	26416	17089	18460	17918	19573	21121

Source: Center for Applied Demography & Survey Research,
Delaware Health Statistics Center

The two charts above give some insight into the calculus that might be used by the individual in deciding whether to pay the penalty or buy insurance. For a typical young person the likelihood that they will have a need for hospitalization (excluding pregnancy) during a given year is relatively small, under 4%. The average cost (charges) for a person who is uninsured and is hospitalized is $17,918. Those are charges and are certainly open to negotiation. The expected value of that event is roughly $800 or equivalent to the penalty. In all likelihood, these individuals will assess their risk to be lower than 4% and thus will choose to pay the penalty. However, as the family size increases so too does the probability of a hospitalization within that family. This applies equally well to other age groups within the family.

This calculus gets even more complex as the size of the employer grows. For those that work for small employers with less than 25 employees, the employer only has to pay 50% of the cost. The question for the employee is "what is that cost relative to any penalty that will be levied"?

For the younger part of this group (19-26), we identified individuals who were working full-time, were above 133% of the poverty level and were uninsured. There were 5,225 individuals in this group of which 78% were single and 27% (1,355) were most likely candidates for inclusion on their parents insurance. This was based on the fact the young person was living in a household where they were neither the head of household nor the spouse. There will be some that are single and living alone (873) that may qualify. Finally, there is a complex group (1,635) that is in the household, but not related to the head of household. This is most likely a roommate/partner. Estimates from other studies the probability at 25% and that will depend upon the cost to the parent(s) and their ability to pay.

The annual wages of for the entire group averaged $17,300. They work for a variety of businesses. Some 57.5% (3,009) work for businesses with more than 100 employees. Roughly 14.8% (771) work for employers with 26-100 employees. The final group of 1,445 (27.7%) work for employers with 25 or fewer employees.

It is highly unlikely that this group will be able to afford the employee share of an employer sponsored plan given they are making just over the minimum wage. The more likely option is that they will pay the $695 penalty and take the small risk that they will need major medical assistance. The other two groups are likely to make the same decision. The 16% who are married may have a more complex decision to consider but may also have a second income in the family.

ACA: EMPLOYER SPONSORED HEALTH INSURANCE

Introduction

The overwhelming consensus is that companies including mid, large and jumbo size employers are less likely to drop health insurance coverage. Smaller firms are more likely to drop coverage so that their employees have to obtain health insurance through the American Health Benefit Exchanges (AHBE). Companies are going to look closely at the cost and value of dropping their existing employer sponsored insurance (ESI) especially as it relates to employee morale and retention. Some companies are currently paying more for health insurance per employee than the cost of the 2014 penalties for not providing health insurance. However, paying the penalties while not providing health insurance could lead to problems with decreasing morale and reduce the ability to retain and attract the employees they are seeking. They are waiting to see what other companies will do and how the legislation will pan out prior to making final decisions on what they will do with regards to ESI.

Affordability Determination for Employer Sponsored Insurance

The ACA allows for an affordability determination for ESI. This affordability determination is defined as follows; health insurance must require an employee contribution of less than 9.5 percent of family income for a plan that covers at least 60 percent of medical costs on average. This also applies to dependents who are eligible to enroll. Beginning in 2014, employers face a penalty if they do not offer coverage, require a health insurance contribution of more than 9.5%, or offer a plan that covers less than 60% (on average) of medical costs. The coverage that must have an "actuarial value" of at least 60% is referred to as comprehensive coverage. The 60 percent reflects the average amount that the employer pays of the total health care expenses while the employee pays the remaining 40% of health care expenses in the form of deductibles and copayments.

Employer Penalties

Companies that do not comply with the requirements under the ACA will be required to pay penalties depending on their level of non-compliance. The ACA defines large employer as having at least 50 full time equivalent employees or more (defined as an average of 30 hours or more per week) or seasonal (working fewer than 120 days in a calendar year). Hours worked by part-time employees (less than 30 hours per week) are **included** when calculating if an employer is considered a large employer, however part-time employees are **not** considered when determining the amount of penalty even if the employee received a premium credit in the exchange. Full-time seasonal workers (under 120 days a year) are not included when calculating full-time employees. However a large employer can be subject to a penalty if a seasonal worker receives a premium credit for the month that the seasonal worker is full-time.

When large employers do not offer coverage with at least one employee receiving subsidies in the exchange, they must pay $2000 multiplied by the number of full-time non seasonal employees. For the large employers that do offer coverage but have at least one employee receiving subsidies in the exchange, they are required to pay the lessor of either $3,000 multiplied by the number of full-time non seasonal employees receiving subsidies or $2,000 multiplied by the total number of full-time non seasonal employees. According to the regulation, the first 30 employees do not have to pay penalties, and the penalties do not apply to employees using the free choice vouchers. In instances when an employer sponsored insurance plan is not comprehensive, the employer will also need to pay penalties.

Free Choice Voucher and Form 1099 Reporting Requirement Repeal

In April 2011, President Obama signed the Comprehensive 1099 Taxpayer Protection Act and the Continuing Appropriations Act which repealed the Form 1099 reporting requirement and free choice vouchers. The 1099 reporting requirement would have required employers to issue a Form 1099 for any vendor who provided at least $600 worth of goods or services in a calendar year. A free choice voucher would have been offered by employers to employees who qualified,

equivalent to the amount the employer would have contributed to job-based coverage for the employee or family. These free choice vouchers had an eligibility determination as follows: premium cost to the employee was between 8.0 and 9.5 percent of family income and if the family income was below 400 percent of the federal poverty level ($43,560 - individual, $89,400- family of four - 2011). The employee would then have been able to use the voucher to purchase insurance through the HBEs that will be available in 2014.

Urban Institute Health Insurance Policy Simulation Model (HIPSM)

When researching Employer Sponsored Insurance (ESI) and the Patient Protection and Affordable Care Act (ACA), the Urban Institute Health Insurance Policy Simulation Model (HIPSM) is a good place to start. The HIPSM gives an estimate of how the ACA would affect ESI and employer health care costs. This model developed predictions of the impact on small, medium and large firms and how ESI would be impacted. The ultimate findings from the data processed found that under the ACA, ESI coverage would not differ significantly from what coverage would be if there was not healthcare reform. The HIPSM looks at the impact on their definition of small (100 or fewer workers), medium (101 to 1,000 workers) and large firms (more than 1,000 workers) separately.

Small Firms

Based on HIPSM estimates, small firms ESI coverage will almost be unchanged. In fact, the total spending by small firms will be approximately 8.7 percent lower under the ACA. Small firms will receive savings due to the new ESI Small Business Health Options (SHOP). SHOP will provide access to the HBE for employers with one to 100 employees although, up until January of 2016 small businesses with one to 50 employees will be able to join SHOP. Small businesses with 25 full time equivalent employees or less with average wages of no more than $50,000 from 2010 to 2013 will be eligible for tax credits of up to 35 percent of employer premium contributions. To be eligible for these tax credits, small businesses must also contribute at least 50 percent to premiums. Starting in 2014 the tax credit pays up to 50 percent

of employer contributions. Although the total spending by small firms is 8.7 percent lower the average employer contribution per person covered by ESI would decrease by 7.9% due to the introduction of more effective coverage through these SHOP exchanges.

Medium and Large Firms

The total spending by medium firms would increase by 11.8 percent, while the average employer contribution per person covered by ESI would decrease by 1.1 percent. The total spending by these medium firms would increase due to new assessments that are required by employers with workers who choose to independently buy subsidized insurance through non group exchanges. Significant assessments could occur for firms that do not offer ESI and those firms that offer a health insurance plan that their low income workers are unable to afford. Spending by large firms would not change significantly with the average employer contribution per person covered by ESI decreasing by 3.1 percent.

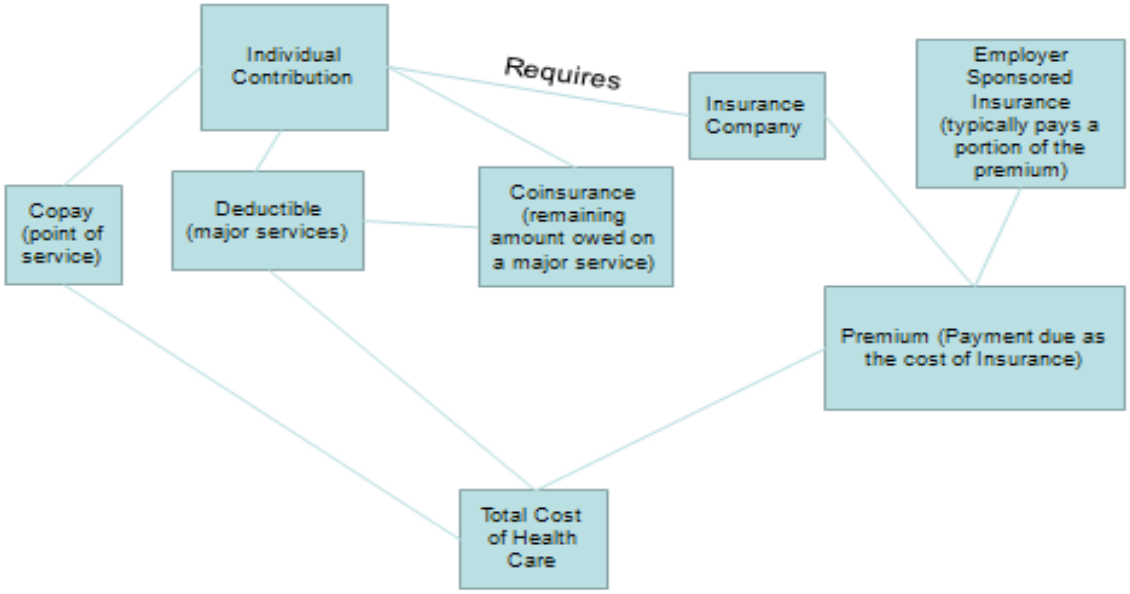
Booz and Co. Study

This study was conducted to determine how employers were likely to respond to the ACA. While the HIPSM used a model simulation to determine the changes in employer spending due to the ACA, this study used interviews and focus groups to gather data. The Booz and Co. Study resulted in interviews of more than 150 executives and managers at employers of various sizes, industries and regions. The study also included employer focus groups and surveys from almost three hundred employers of varying sizes. It found that a very small proportion of employers will stop providing health insurance coverage to their employees and switch them to employer-paid exchange plans that will offer federal subsidies for those earning up to 400% of the federal poverty level (FPL). The authors' analysis found that between five and seven million individuals will exit the ESI market by 2016. Based on their research, they found that employers would respond to both cost and other factors such as risk to reputation and ability to attract and retain talent when making the decision of whether or not to drop employer sponsored insurance.

Conclusion

Overall based on data collected by the Urban Institute Health Insurance Policy Simulation Model (HIPSM) and the Booz and Co. Study, ESI under the ACA would not differ significantly from what coverage would be without health care reform. ESI coverage offered by small and medium firms would be almost unchanged, while large firm ESI will increase by just over 2%. The total employer spending for all types of firms for premium contributions, assessments and vouchers would be approximately .6 percent lower under the ACA than without reform. Under the ACA employers are still permitted to purchase health insurance coverage outside of the AHBE.

Flowchart 4.0 Health Insurance



Source: Center for Applied Demography & Survey Research

ACA: HEALTH CARE WORKFORCE

Provisions affecting the Physician Workforce

The ACA includes various titles to address the future health professional shortage that is likely to result as more individuals seek primary care. Over five years the ACA will provide $1.5 billion in new and dedicated funding for the National Health Service Corps (NHSC). The additional funds for this and subsequent years will be added to the existing $142 million in discretionary funding that was allotted for FY 2011 to FY 2015.

Another way that the ACA attempts to address the issue of the need for additional health care providers is with the development of a Teaching Health Centers Title VII Development Grants Pogram that was authorized under Title VII of the Public Health Service Act. Awards will be made of up to $500,000 for up to three years and will go towards teaching health centers to establish new accredited or expanded primary residency training programs. If Thomas Jefferson University or the Delaware Institute for Medical Education and Research procure some of this grant funding, then the State of Delaware will potentially benefit by having more trained primary care professionals eventually return to the state to practice. Although funding has not yet been allocated, the ACA expects to authorize $25 million in FY 2010 and $50 million in FY 2011 and FY 2012 as part of this grant funding allocation.

The ACA also appropriates $230 million for FY 2011 to FY 2015 for the Title III Payment Program. Through this program, payments are made for direct and indirect expenses associated with training primary care residents to qualified teaching health centers. The Prevention and Public Health Trust Fund also allocated $5 million for states to develop innovative solutions to increasing their primary care work force.

The ACA makes changes allowable for the redistribution of unused Medicare Graduate Medical Education (GME) slots. Other provisions in the ACA increase the Medicare payments for certain primary care services provided by primary care physicians, nurse practitioners, clinical nurse specialists and physicians assistants by 10% for services that are furnished from January 1, 2011 to January 1, 2016.

From FY 2013 to FY 2014, Medicaid payments for primary care physicians will be increased to 100% of the enhanced Medicaid rates with a federal subsidy provided for this increase although states will be responsible for maintaining this increase after FY 2014. Finally, National Health Care Service Corps loan repayments awards and certain state loan repayment or forgiveness efforts from income taxes will be exempt from income taxes.

Provider Shortages

Based on estimates by the Health Resources and Services Administration (HRSA) "if the current supply trends continue, the number of FTE primary care physicians engaged primarily in patient care is projected to grow approximately 18 percent between 2005 and 2020." Although this is the case, HRSA estimates that the demand for general physician services will increase by 22% during this time period due to the growth and aging of the population. Additionally, as a result of health care reform, HRSA estimates that there will be a need for a 30% increase in primary care physicians between 2005 and 2020 when looking at a high growth scenario. One option that states will have to consider, with the increasing need for physicians after the implementation of the Patient Protection and Affordable Care Act, is the increased use of non-physician clinicians. HRSA estimates project that 90,000 fewer physicians will be needed in 2020 with an increase in these non- physician clinician. Non physician clinicians are considered to be nurse practitioners, certified nurse midwives, certified midwives and physician assistants.

Delaware Physicians

Based on the Council on Graduate Medical Education (CGME), it is acceptable to have a ratio of 1,250:1 for persons per primary care provider. In 2008, Delaware had a ratio of 1,187:1 person per primary care physician not including non-physician providers and international medical school graduates. The growth rate in primary care physicians in the state has been about 2% per year which exceeds the growth rate of population in the state. That does not account for the increased medical demands of an aging population which is significant over the next 20 years.

As of 2008, Delaware had an adequate number of individuals per physician; however, there are still shortages depending on the areas where individuals live. For example, in Delaware Obstetricians/Gynecologists typically are located in relative close proximity to hospitals. This means that women who do not live close to hospitals tend to have to travel further to reach an OBGYN. There was also a significant wait time for patients to receive appointments when needed from Primary Care Physicians. In 2008, the average wait time for established patients in Delaware was almost fourteen days while the average wait time for new patients was almost 15 days in Delaware. At the county level the average wait time for a physician appointment has increased in all three counties since 2006. Based on 2008 data, the wait time in Kent County was 21.1 days, New Castle 12.4 days, and 14.9 days in Sussex County.

Another important consideration to keep in mind is that while there appears to be an adequate number of physicians to the ratio of persons in Delaware, the percent of primary care physicians who accept new Medicare and Medicaid patients (70-65%) is lower than those physicians who accept new patients with private insurance (85%). This is a critical issue as federal budgetary issues affect payment schedules for Medicare and Medicaid patients. At current growth rates, 40% of the patients and a larger percentage of utilization will fall into one of these two groups.

Delaware's Nursing Shortage

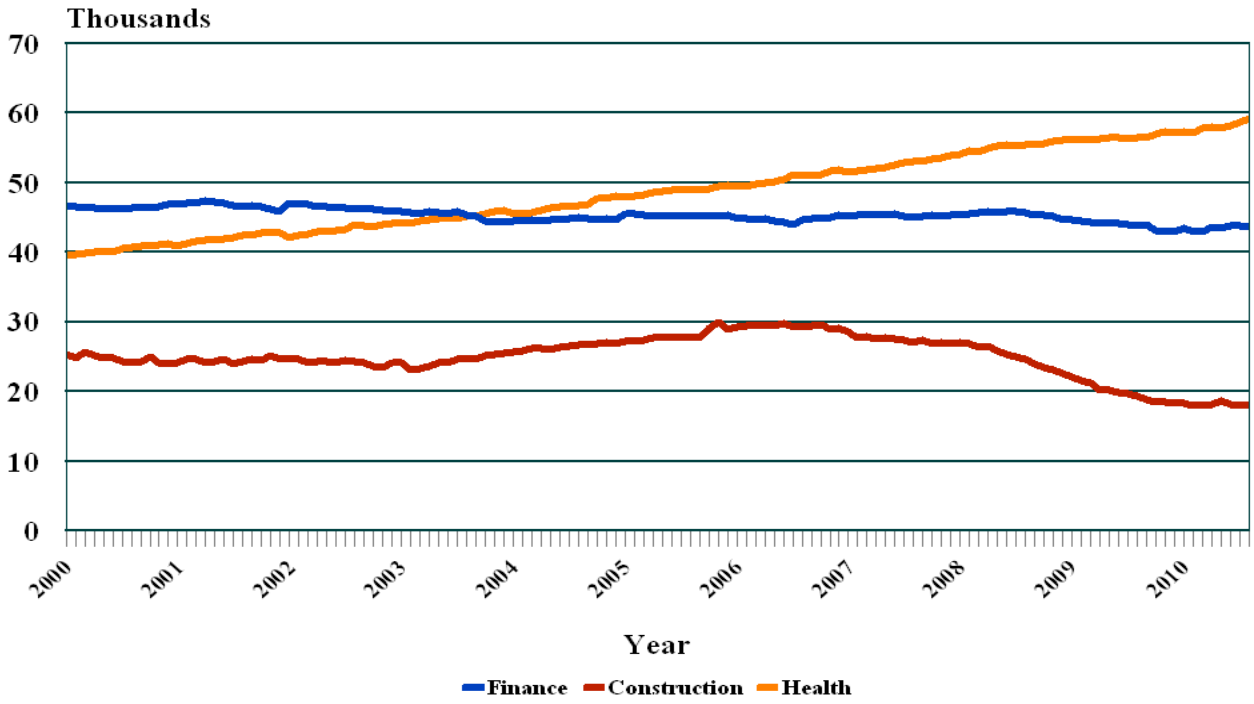
In 2002, the Delaware Health Care Commission: Committee on Nursing Workforce Supply published a report titled "*Solving the Nursing Shortage in Delaware*." The report found that Delaware is currently experiencing vacancies in the number of nurses primarily in long-term care nursing, emergency departments, critical care units and hospital operating rooms. As recently as 2001, vacancies in all of the nursing areas in the State of Delaware ranged from a vacancy of 3.48% for Certified Nurse Assistant to a vacancy of 10.14% for Licensed Practical Nurses. Vacancies among hospital affiliated long-term care facilities were even higher for certified nursing assistant positions. There was a vacancy of 12.62% while the vacancy proportion of registered nurses was 15.99%.

The Delaware Health Care Facilities Association conducted a survey on staff vacancy and turnover and provided data on the proportion of vacancies in private long-term facilities that were not affiliated with the Delaware Healthcare Association. The numbers from this study showed an even higher vacancy proportion ranging from 13.8% for Certified Nursing Assistants to 19.5% for Registered Nurses. Data from state health care facilities in Delaware also points to similar vacancies including a vacancy of 19% for RN psychiatric nurse positions to a vacancy of 20% for RN long-term care positions.

The DHCC report points out that there are numerous causes for the nursing shortage in the state including diminished perceptions of the attractiveness of health careers, the aging nursing workforce, the decision of women to choose other careers, as well as a decline in nursing school enrollments, a shortage of qualified nurse educators (which decreases the number of students that can be enrolled in a nursing program), job dissatisfaction, difficulty retaining nurses, more nurses needed as a result of the aging population and less people of working age available to work as nurses. It has also been noted that job competition from other industries makes it more difficult to recruit potential nurses into the field. This data points to the likely event that with the increase of individuals seeking access to health care in with the implementation of the ACA there will be an even greater shortage of nurses.

These shortages are likely to persist as the population increases and along with the overall of the population from now through 2040. As is shown in the figure below, jobs in the health care industry have increased steadily while other industries are either flat or falling. The fact that there are still shortages indicates that the existing labor force is not trained or is unsuitable to the work required. These types of mismatches are numerous in today's labor market as rapid structural change progresses.

Figure 5.0 Delaware, Number of Jobs by Selected Industries 2000-2010



Source: Center for Applied Demography & Survey Research, University of Delaware
US Bureau of Labor Statistics 2000-1010

Results of Massachusetts Physician Workforce Study After Implementation of Universal Health Care

When looking at the ACA and its effect on the availability of health care workers, it is important to look at Massachusetts and how their health care delivery system was affected with the transition to a system of universal health care. The first portion of this response will focus on Massachusetts and how their transition to increase the availability of health care to more

individuals impacted the existing health care workforce. As of 2010, Massachusetts had increasing physician shortages in a number of different areas. Two areas, Family Medicine and Internal Medicine both classified as primary care faced a critical shortage while dermatology, emergency medicine, general surgery, orthopedics, neurology, psychiatry, urology and vascular surgery all faced severe shortages with regards to the physician workforce.

It is also important to look at access to care. Access to care relates to the availability of health care workers for individuals needing medical care. In a fall 2008 update on health reform in Massachusetts, there was an increase in health care use from the fall of 2007 to the fall of 2008. The increase in health care pointed to additional indications that some adults were also having difficulty in obtaining care in fall 2008 and fall 2007. During the fall of 2008, approximately 31.8% of respondents to the Physician Workforce Study indicated that at some point during the past 12 months they did not receive needed care for some reason. During the study from fall 2007 – 2008, there were indications of increased demand for care. This was determined based on responses that indicated an increase in both use and an unmet need for some types of care. This increased use and unmet need can be attributed to attempts by newly insured adults to obtain coverage for the first time, attempts by adults with newly covered benefits to access the benefits, and the increased demand for follow-up care based on initial visits.

Individuals in Massachusetts experienced multiple barriers to care as demonstrated by the one in five adults who reported that they were told that a doctor's office or clinic where they sought care was not accepting patients with their type of coverage. Of the individuals reporting this specific problem, 67% faced the problem when seeking primary care which includes family and internal medicine. Forty-three percent of the individuals had this problem when seeking specialty care. Individuals with lower income were more likely to have difficulties finding a provider when compared to individuals with a higher income 29% and 15% respectively. Additionally, those individuals with public coverage (32%) had a harder time finding a provider than those with private coverage (16%). Not surprisingly, those with public coverage (25%)were

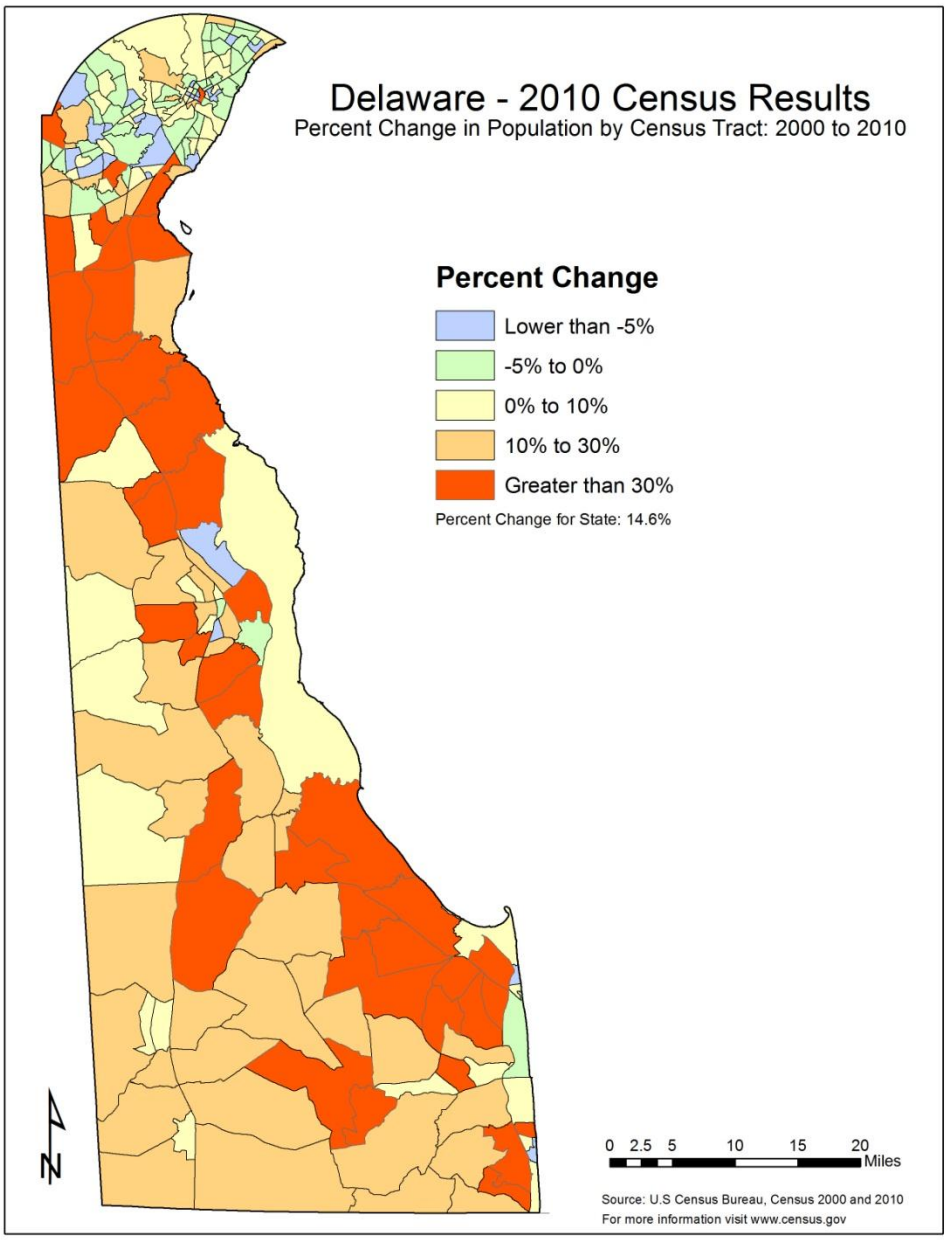
more likely than those individuals with private coverage (7%) to be told that a provider was not taking the type of insurance that they had.

Conclusion

One thing to keep in mind is that although provider reimbursement rates will be reimbursed by the federal government during 2013 and 2014 under the ACA, by January 1, 2015, the reimbursement rate by the federal government will decrease and the states will either have to maintain the physician payment rate or make cuts. Lower provider reimbursement for public programs became an issue with regards to health care access in Massachusetts. The 2009 Physician Workforce Study determined that one possible reason for access to care differences was lower provider reimbursement rates under insurance provided through public programs. Individuals with public insurance also had access to a limited set of providers under only four health plans.

With the inception of the ACA, there is the possibility that there will not be enough primary care providers and nurses for the newly insured individuals. The Massachusetts Physician Workforce Study found that there was no change in pre-reform levels in emergency department use for non-emergency conditions between the fall of 2006 and the fall of 2008. Approximately 15% of all adults and 22% of low income adults sought care in the emergency room for non-emergency conditions. The number one reason given by 55.8% of the adults going to the emergency center for non-emergencies was because they were unable to get an appointment with a doctor as soon as one was needed.

Figure 5.1 Delaware Population Change 2000 – 2010 By Census Tract



Source: Center for Applied Demography & Survey Research

ACA: Current Health Insurance Marketplace in Delaware

Health care options in Delaware include private insurance and publically sponsored programs. Private insurance in Delaware includes: Group Plans through the National Association of Health Underwriters (independent agents, brokers and consultants representing different health insurance companies and health plans), COBRA (continuing health care coverage as a result of a qualified health care event), Employer Sponsored Insurance, insurance for small businesses through their County Chamber of Commerce and insurance purchased on the individual market. Publically sponsored health insurance programs in the State of Delaware include: Medicaid, Medicare, Medicare Prescription Drug Program, Elder Info and the Delaware Pre Existing Insurance Plan established with the ACA (limited access).

Another public program that provides health care coverage includes Children and Families First. This program provides health care through four programs including:

1. Special Medical Foster Program
    a. specialized training for foster parents for medical fragile children
2. Treatment Foster Care Program
    a. intensive treatment for children with mental health or behavioral issues
3. Resource Mother Program
    a. helps at-risk pregnant mothers to receive appropriate prenatal and pediatric care
4. Adolescent Resource Center
    a. confidential counseling about sexual health and medical services for teens

Delaware Healthy Children Program is another state health care program that provides well-baby and well-child checkups, speech/hearing therapy, immunizations, physical therapy, etc.

Delaware Screening for Life provides for office visits, however there are age requirements for both men and women. Depending on the age requirement, individuals have the option of obtaining office visits, clinical breast exams, pelvic exams and pap tests. Finally, there is another program for Trade Dislocated Workers who are at least 55 years old. The Health Coverage Tax Credit program provides for inpatient and outpatient care, doctor's visits and major medical care.

Small Businesses

To date there have not been many decisions made with regards to how states plan on structuring small business health options (SHOP) within health benefit exchanges. We canvased California, Connecticut and Washington to get an idea of how they are handling Chambers of Commerce and business associations with regards to the Patient Protection and Affordable Care Act (ACA) and found that decisions have not yet been made with regards to this topic.

A Benefits Connection for small groups is operated in Delaware. The Allen Insurance Group, Benefits Connection, is an association program and a small group provider and similar to the setup of the Patient Protection and Affordable Care Act (ACA), Small Business Health Options (SHOP). SHOPS are designed to be state-run exchanges that will specialize in providing smaller employers insurance options for themselves and their employees. SHOPS can be made available for one - 50 employees up until January 2016 if states so choose, however, after that time they are limited to small groups with one -100 employees. The majority of groups who sign up for insurance through Allen Insurance Group, Benefits Connection include 50 or less individuals although this number does vary. This company has found that while the average rate increase for small group premiums is 12% to 15 %, this particular insurance group has average premium increases of 7% per year over eleven years. All members get the same rate change and there is no pre-existing condition exclusion for members with continuous coverage.

A number of different organizations in Delaware operate within the Benefits Connection including: the New Castle County Chamber of Commerce (NCCCC), Bethany Fenwick Chamber of Commerce, Central Delaware Chamber of Commerce, Middletown Chamber of Commerce, Chamber of Commerce for Greater Milford, Greater Millsboro Chamber of Commerce, Health Organization Management Enterprise, New Castle County Board of Realtors, Delaware Association of Non Profit Agencies, Home Builders Association of Delaware and Delaware Automotive Professionals Association. The benefits that are offered through the Benefits Connection include health insurance with either Blue Cross Blue Shield of Delware, AmeriHealth of Delaware, dental insurance through United Concordia, Dominion or Delta Dental, Group Life insurance, Group Disability, Blood Bank of Delmarva, supplemental insurance through Aflac, and workers compensation. The Benefits Connection insurance is provided to members and their dependents.

A company has to first become a member of an affiliated organization prior to signing up for the Benefits Connection. After becoming a member of a partner organization, the company can request a quote for their employees from the Allen Insurance Group, Benefits Connection. Insurance is based on age group, and employees cannot be excluded due to pre-existing conditions. Additionally, dependents can also become members of the primary group-holders' health insurance policy. The Benefits Connection is set up similar to a corporate health benefit structure with one individual serving as a point of contact for individuals who sign up for insurance. This individual works as an intermediary for "employees" between the affiliated organization and the insurance providers.

Health Insurance Licensing In Delaware

In the State of Delaware, there are numerous insurance companies licensed to provide insurance. The type of licensing varies depending on how the companies formed their health insurance business. This section focuses on six types of companies that are licensed to provide some form of health insurance in the state and best capture the health insurance marketplace in Delaware.

The Delaware Insurance Department categorizes the health related insurance companies into the following types; DOMLH (Domestic Life/Health – companies incorporated in Delaware and licensed to provide insurance in this state), FORLH (Foreign, Life/Health – companies incorporated in another state but licensed to provide health insurance in Delaware), HMO (Health Maintenance Organizations, HSC (Health Service Corporation), MPDP (Medicare Prescription Drug Plan), and DPO (Dental Plan Organization). Based on publically available data from the Delaware Insurance Department there are approximately 479 companies licensed to provide health or health related insurance in Delaware.

While there is a significant number of companies authorized to provide insurance in Delaware, just because they are listed in the Insurance Department database that does not mean that those companies are actually providing insurance to residents in the State of Delaware. Each of the companies authorized in Delaware has a unique NAIC (National Association of Insurance Commissioners) number. In some cases, the company is authorized to provide health or health related insurance in Delaware, but they might not be conducting any business that generates income or provides services. For example, while one company had $0 in direct premiums written in 2010, Blue Cross Blue Shield of Delaware (BCBSD) had direct premiums written in the amount of $498,775,482 in 2010.

Pre-Existing Condition Insurance Plan

When structuring the ACA, the federal government formed a pre-existing condition insurance plan. This insurance plan is currently available in every state including Delaware. The purpose of this insurance plan is to extend health insurance access to individuals who have been denied insurance coverage due to a pre-existing condition. While this new health insurance plan is a huge benefit, it is only available to individuals who have been without health insurance coverage for at least six months. This requirement significantly limits access to individuals who are in the market for health insurance. As of June 30, 2011, only 73 people were enrolled with coverage in the pre-existing condition insurance plan in Delaware.

Medicare Advantage Plan

With the implementation of the ACA, CMS began using a star rating system to rate Medicare Advantage Plan Contracts based on quality. The rating scale is from a 1 to 4 and Delaware's contract rating is 2.5. A study done by the Kaiser Family Foundation found that the average quality rating for the Medicare Advantage Plan in Delaware is among the lowest in the nation. There are only two other states that have ratings this low including Alaska and Vermont. While the contract rating for Medicare Advantage Plans in Delaware is 2.5, a study done by Avalere Health, a consulting firm, found that only 30% of the Medicare Advantage Plans are rated. Some plans are not rated because they are too new and too small.

Protections in Health Care Reform

Protections were built into the ACA to prevent problems as a result of the expected large number of additional people who will apply for health insurance in 2014. Due to the fact that insurers do not have data on the cost of health care spending for the uninsured, insurance companies are at risk for either understating or overstating premiums. If an insurer understates premiums, it is likely to risk the viability of the plan itself. If an insurer overstates premiums that

could result in large profits for the insurer, it could potentially reduce consumer participation in the health plan due to the prohibitive cost. Additionally, once the uninsured gain access to health insurance there is the likelihood that spending in the area of health care will potentially increase among this group.

Because of these potential risks, the ACA includes three areas in the law designed to mitigate risk including: risk adjustment, reinsurance, and risk corridors. According to the American Academy of Actuaries: risk adjustment is used to adjust payments to health plans based on the relative risk of plan participants: reinsurance is used to reimburse insurers for the cost of individuals who have unusually high claims: and risk corridors are used to mitigate the pricing risks that insurers face when they lack data on the health spending of potential enrollees. Risk corridors will operate from 2014 to 2016, and will provide a government subsidy if the losses of the insurer exceed a specific threshold and limit an insurer's gains by requiring them to pay the government if the gains exceeds a certain threshold. The idea is that risk corridors will be put in place because there is less expenditure data available, and as more data becomes available it will be easier for insurers to accurately set premiums. The goal of risk adjustment is to make payments to competing plans equal and reduce the incentive of plans to avoid insuring individuals who have high health care costs. The risk adjustment provision designed in the ACA will allow for the flow of payments from health care plans that enroll larger proportions of low risk individuals to plans that enroll larger proportions of high risk individuals.

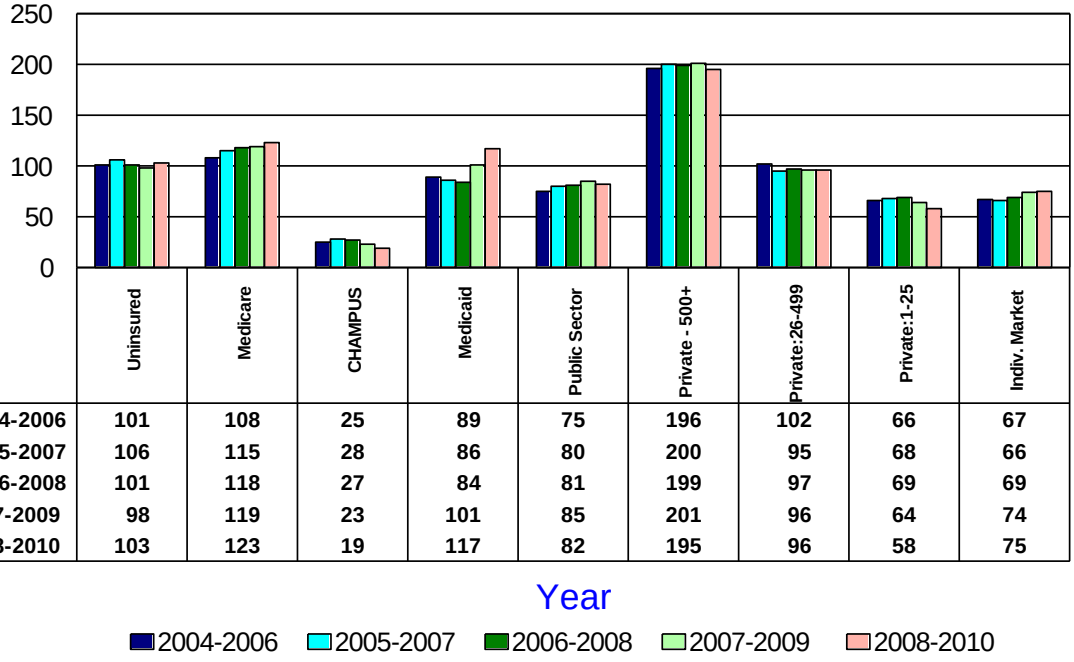
Strain on the Provider Market

The likely impact of the ACA on the provider market in Delaware is there will end up being a strain on access to health care services and health care providers unless additional measures are put in place to accommodate the increasing number of insured seeking access to care. Earlier in this report we highlighted the shortage of providers and nurses in the State of Delaware. This shortage is expected to worsen in 2014 due to the expected increasing numbers of people seeking care.

Although there will be shortages in the number of providers, the ACA does have controls in place to help mitigate the risk. These controls will ensure that the health insurance marketplace will not be stressed beyond capacity to accommodate a large number of both sick and healthy people who will seek access to health insurance. Risk adjustment, reinsurance and risk corridors were built into the ACA to ensure that the insurance marketplace will be able to accommodate the expected influx of people that will potentially have a greater need for health care services than relatively healthy individuals. The federal government is continuing to provide guidance on various areas of the ACA that will determine how regulations will be implemented in the provider marketplace.

The overall complexion of the demand for insurance currently is illustrated by Figure 6.0. If the law is fully implemented the number of uninsured will should precipitously. This is dependent on the willingness of the uninsured to purchase insurance either independently, through their employer, or from the exchange rather than pay the penalty if ever implemented.

Figure 6.0 Delaware, Number of Persons by Source of Insurance



	Uninsured	Medicare	CHAMPUS	Medicaid	Public Sector	Private - 500+	Private:26-499	Private:1-25	Indiv. Market
2004-2006	101	108	25	89	75	196	102	66	67
2005-2007	106	115	28	86	80	200	95	68	66
2006-2008	101	118	27	84	81	199	97	69	69
2007-2009	98	119	23	101	85	201	96	64	74
2008-2010	103	123	19	117	82	195	96	58	75

Source: Center for Applied Demography & Survey Research, University of Delaware
Current Population Survey 2004-1010, US Bureau of Census

More importantly, in Delaware at least, only a small portion of the population has conventional insurance. Major employers primarily are self insured and their contracts with

insurers are for administrative services only (ASO). Small employers and individuals purchasing insurance on their own are 15% of the population. State and local governments also tend to be self insured working with an ASO insurer. The federal government programs are also outside of the private insurance market place although they do affect the pricing of services throughout the nation.

State and local governments will grow slowly if at all given the budget constraints at this level. Medicaid is growing by about 8,000 people per year in Delaware and is likely to continue at this rate in the future. Medicare technically does not impact the state directly (except for the Medicaid/Medicare duals) but the increasing population of elderly as it doubles over the next 30 years will severely impact facilities, providers, and prices.

For those familiar with the Medicaid enrollment figures, the graph significantly understates the actual enrollment. The reasons for this are many but the Census Bureau has improved their techniques considerably and this is a national issue. The actual Delaware enrollment for 2009 was 177,000. The 1-year CPS estimate for 2009 was 129,793 which is still far from the actual number but is moving rapidly in the right direction. The American Community Survey for Delaware in 2009 measured 147,987 persons enrolled in Medicaid and recorded 28,000 fewer people without health insurance. For many years, it has been clear that the number of uninsured have been inflated in Delaware since nearly 30,000 were reported as being without health insurance but were eligible for Medicaid or CHIP based on poverty status.

Table 6.1 also provides estimates for those that currently work part-time or not at all and are without health insurance. They comprise 37.6% of the uninsured and are likely to be candidates for the subsidies provided by the exchange or will forego the insurance and pay the penalty.

Table 6.0 Characteristics of the Uninsured and Program Eligibility 2008-2010

Characteristics	Estimate	Medicaid	CHIP	Employer	Employer+	Unknown
0-18, Foster Child	501	X				
0-18, 0-100% poverty	6883	X				
0-18, 100-200% poverty	6055		X			
0-18, 200%+ poverty	6515					X
19-34,0-100% poverty, not full-time	6178	X				
19-34,0-100% poverty, works full-time	2227	X				
19-34,100-200% poverty, not full-time	5258					X
19-34,100-200%+ poverty, works full-	4807				X	
19-34,200%+ poverty, not full-time	9158					X
19-34,200%+ poverty, works full-time	9641			X		
35-49,0-100% poverty, not full-time	3769	X				
35-49,0-100% poverty, works full-time	1700	X				
35-49,100-200% poverty, not full-time	3467					X
35-49,100-200% poverty, works full-time	3661				X	
35-49, 200%+ poverty, not full-time	5075					X
35-49, 200%+ poverty, works full-time	9180			X		
50-64,0-100% poverty, not full-time	2584	X				
50-64,0-100% poverty, works full-time	531	X				
50-64,100-200% poverty, not full-time	2635					X
50-64,100-200% poverty, works full-time	894				X	
50-64,200%+ poverty, not full-time	5941					X
50-64, 200%+ poverty, works full-time	4603			X		
Total	101266	24374	6055	23425	9362	38050
	100.0%	24.1%	6.0%	23.1%	9.2%	37.6%
65+ uninsured	1406					
All uninsured	102672					

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