

# Maine Health Exchange Advisory Committee

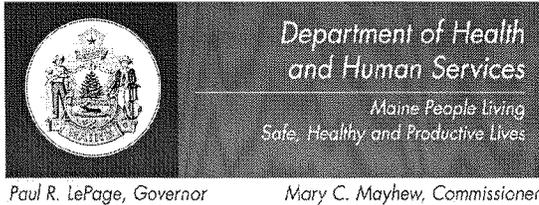
**Monday October 21, 2013  
10am to 4pm  
Appropriations Committee Room 228**

## Draft Agenda

- 10:00 to 10:15      Welcome and introduction from chairs
- 10:15 to 11:00      Information Requests/Updates from State Agencies
- 11:00 to 11:30      Federal Update –conference call  
*Christie Hager, Region One Director,  
U.S. Department of Health and Human Services*
- 11:30 to 12:30      Consumer Outreach and Enrollment---What are experiences of  
consumers?  
*Vanessa Santarelli & Caroline Zimmerman, Maine Primary Care  
Association (FQHC activities)  
Emily Brostek, Consumers for Affordable Health Care  
Ann Woloson, Maine Equal Justice Partners*
- 12:30 to 1:15      Lunch
- 1:15 to 2:00      Dental Plans on the Marketplace  
*Brian Staples, Northeast Delta Dental  
Invited, Anthem*
- 2:00 to 2:30      Small Business Experience  
*David Clough, National Federation of Independent Business-  
Maine Chapter*
- 2:30 to 3:00      Website Demonstration--- healthcare.gov; enroll207.com
- 3:00 to 4:00      Committee Discussion---What can Advisory Committee do to  
make marketplace work well for Mainers? Issues/Information for  
Next Meeting?

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Department of Health and Human Services  
Commissioner's Office  
RCVD OCT 21 '13  
11 State Street  
11 State House Station  
Augusta, Maine 04333-0011  
Tel.: (207) 287-3707; Fax (207) 287-3005  
TTY Users: Dial 711 (Maine Relay)

October 18, 2013

RCVD OCT 21 '13

To: Senator Margaret M. Craven, Senate Chair, Maine Health Exchange Advisory Committee  
Representative Sharon Anglin Treat, House Chair, Maine Health Exchange Advisory Committee  
Members of the Maine Health Exchange Advisory Committee

From: Mary C. Mayhew, Commissioner, Department of Health and Human Services

Re: Maine Health Exchange Advisory Committee  
Questions for the Department of Health and Human Services to be provided in writing for  
October 21, 2013 meeting

1. How many people are currently applying for Medicaid each month? How many are approved and how many people are denied each month by Medicaid category?

**Response:** The Department is currently gathering and verifying this data and will forward it when it is available.

2. Are there measures in place to assess the readiness of DHHS for the marketplace's open enrollment period and taking/making referrals between the marketplace and Medicaid program? How is the Department assessing its readiness?

**Response:**

Our current process between the Federally Facilitated Marketplace (FFM) and the State of Maine is an implementation of contingency plans, both at the State and Federal levels. There is a process which the Center for Medicare and Medicaid Services (CMS) refers to as Account Transfer (AT) which is not yet in production at the Federal or State levels.

Currently Maine citizens that apply at the Federally Facilitated Marketplace (FFM) are assessed for potential eligibility for MaineCare. If the assessment indicates that the applicant is not MaineCare eligible they can continue on and shop for a Qualified Health Plan (QHP) and subsidies at the FFM. If the assessment indicates that the applicant is potentially eligible for MaineCare they are notified and their contact information is entered into a file. That file is then made available to the State of Maine on a weekly basis which we are able to download for the purpose of obtaining a sense of the volume we can expect. There is limited applicant information within the file and is insufficient to process against our eligibility rules. Our first file made available to download was scheduled to be on 10/8/2013, but was not made available by CMS until 10/17/2013. The file contained 107 records of applicants applying at the FFM and were assessed as potentially MaineCare eligible.

If a Maine citizen applies for MainCare within the State of Maine we process the application against our current eligibility rules and if they are eligible they are enrolled. If they are deemed

ineligible we hold the application to run against the new Modified Adjusted Gross Income (MAGI) rules which we plan to have available by 10/28/2013. If they are identified as eligible for MaineCare after processing against the MAGI rules, we will pend that applicant to become enrolled in MaineCare on 1/1/2014. If they are determined to be ineligible after processing against our current and MAGI rules, they will be notified and we will hold that application until 11/15/2013 when we will have out Account Transfer process from the State of Maine to the FFM implemented and they will be able to shop for a Qualified Health Plan (QHP) and potential subsidies.

When the designed production technical AT process is in place (11/15/2013) the State of Maine will receive all 'full' applications received at the FFM from 10/1/2013 to current date. Once received by the State we will process against our current eligibility rules and if determined eligible they will be enrolled in MaineCare. If they are determined ineligible we will hold until we can process the application against our Modified Adjusted Gross Income (MAGI) rules (10/28/2013) to make a final eligibility determination. If determined eligible they are notified and placed in pend status for MaineCare enrollment on 1/1/2014. If determined ineligible they are notified and their 'account' will be transferred back to the FFM to shop for a Qualified Health Plan (QHP) and potential subsidies.

The State of Maine processes and technologies in place and those planned for the 10/28/2013 and 11/15/2013 deployments have and are currently going through rigorous user acceptance, integration and regression testing internally and with CMS.

3. What systems are in place to ensure a seamless application process regardless of what door (Marketplace v. DHHS) people apply?

**Response:**

There are multiple ways for a Maine citizen to apply for MaineCare through DHHS. We have an online application known as My Maine Connection (MMC) which guides the applicant through a series of questions and collects all applicant data required to determine eligibility for our current rules. We collect MAGI supplemental data that will be made available to our frontline eligibility specialists by 10/28/2013. Consumers can also apply over the phone, fax, mail and 'walk-in'. If the consumer walks in they have the option of utilizing a kiosk to apply online via MMC or apply face to face with an eligibility specialist. Those that choose to apply manually (non MMC application) will have all of the data collected necessary to process against the new MAGI rules when implemented on 10/28/2013. We also have an application verification process, approved by CMS, which could require the applicant to produce income verification documents.

If the applicant is determined to be ineligible for MaineCare they will receive notification and then would follow the process outlined in question 2 response.

4. How will people be transferred from DHHS to the Marketplace and/or Navigators, certified application counselors?

**Response:**

See above process in question 2 response. The Navigators are currently assisting with State of Maine consumers with the FFM application process only. Our frontline eligibility specialists have all contact information for the Navigators and all groups identified as resources for State of Maine consumers that request assistance with the FFM application process.

5. What data, if any, is DHHS collecting related to its obligation to refer people to the Marketplace?

**Response:** DHHS is collecting required data that includes, tax filing status, annual income, tax dependency, minimal essential health coverage, etc. Please see attached supplemental data sheet (Attachment A).

6. Will DHHS track whether people are churning on and off of Medicaid and the Marketplace? How will you track this data?

**Response:** DHHS has data that can track the number of individuals who come onto MaineCare and who go off. We will also be able to track the number of accounts sent to the FFM as a result of ineligibility for MaineCare.

7. Given existing infrastructure, what would be needed in order to deliver real-time processing of eligibility information and facilitate entry to the Marketplace immediately if a person is deemed ineligible for MaineCare?

**Response:** The State of Maine is currently in the process of planning 'phase 2' of the Business Process and IT Modernization project which will include real-time processing of a consumer's application and notification. If the consumer is determined to be ineligible for MaineCare then the account transfer process to FFM will occur as described above. The changes required will include tighter dynamic integration between MMC and our systematic eligibility rules process. There will also be an emphasis placed on consumer self-service which will drive more technology application processing which will allow for real-time decisions and notification.

8. What lessons have been learned through DHHS experience with the Private Insurance Purchase Program (PIP) and its implications for the Marketplace and/or possibility of a Basic Health Plan? What's been the retention rate of members on the PIP? How have average costs to DHHS per PIP member [premium plus any medical wrap expenses] compared to the average MaineCare costs per member [not including long term care or other non-medical costs].

**Response:** There are 1,345 members on PHIP.

	371.15	(PMPM wo/TPL)
-	<u>169.73</u>	(PMPM w/TPL)
=	201.42	(cost savings)
X	<u>1,345</u>	(# of MaineCare members)
=	\$270,909.90	
-	<u>\$157,000.00</u>	(average monthly cost of premiums)
=	\$113,909.90	(cost savings per month)

9. For those who are due to lose coverage given the Medicaid eligibility reductions, what has been their utilization of medical services as measured by physician services, hospital services, ED utilization, pharmacy, total medical costs, etc. This information could be helpful in examining the richness and sufficiency of the benchmark plan in existence for QHPs.

**Response:** See Attachment B

10. What considerations, if any, have been given to the application of SIM work to Marketplace (Exchange) infrastructure, the benchmark plan, and QHPs in general?

**Response:** SIM work has not focused on the Marketplace infrastructure but more on the delivery of quality healthcare services and payment.

<b>TAX INFORMATION, NAME OF PERSON #1 WHO LIVES WITH YOU:</b>			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
<b>DEDUCTIONS, PERSON #1 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY</b>			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
<b>TAX INFORMATION, NAME OF PERSON #2 WHO LIVES WITH YOU:</b>			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
<b>DEDUCTIONS, PERSON #2 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY</b>			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
<b>TAX INFORMATION, NAME OF PERSON #3 WHO LIVES WITH YOU:</b>			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
<b>DEDUCTIONS, PERSON #3 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY</b>			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
<b>TAX INFORMATION, NAME OF PERSON #4 WHO LIVES WITH YOU:</b>			
A. Will he/she file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will he/she file jointly with spouse:	Name of spouse:		
C. Will he/she claim dependents on your tax return:	Name of dependent 1:		
Name of dependent 2:	Name of dependent 3:		
D. Will he/she be claimed as a dependent on someone's tax return:	Name of filer:		
Total Income (list next year's total income for this person):			
<b>DEDUCTIONS, PERSON #4 WHO LIVES WITH YOU - ENTER AMOUNTS FOR ALL THAT APPLY</b>			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	

v. 10/01/2013

<b>MEDICAID APPLICATION SUPPLEMENT</b>			
<b>COMPLETE THIS SUPPLEMENT FOR YOURSELF, YOUR SPOUSE/PARTNER AND CHILDREN WHO LIVE WITH YOU AND/OR ANYONE ON YOUR SAME FEDERAL INCOME TAX RETURN IF YOU FILE ONE. IF YOU DON'T FILE A TAX RETURN, REMEMBER TO STILL ADD FAMILY MEMBERS WHO LIVE WITH YOU.</b>			
<b>APP LAST NAME:</b>	<b>APP FIRST NAME:</b>	<b>MI:</b>	
<b>FEDERALLY RECOGNIZED TRIBE MEMBERS</b>			
Names of those with Indian Health Service Coverage:			
Does Not Receive Indian Health Service Coverage, but is eligible:			
<b>OTHER MEDICAL INSURANCE</b> <small>(IF APPLICABLE, LIST THE HOUSEHOLD MEMBERS THAT CURRENTLY RECEIVE HEALTH COVERAGE)</small>			
Name:		Company:	
Policy:		Type:	
<b>EMPLOYER INSURANCE</b> <small>HOUSEHOLD MEMBERS RECEIVING, OR ELIGIBLE FOR, EMPLOYER SPONSORED HEALTH INSURANCE (NOW OR IN THE NEXT THREE MONTHS)</small>			
Name:		SSN:	Minimal essential coverage?
Date when eligible to enroll:		Coverage plan premium:	
Employer Name:		Employer EIN:	
Employer Address:			
Employer Phone:		Employer Email:	
Employer Insurance Name:		Employee Contact Info:	
<b>TAX INFORMATION, APPLICANT</b> <small>(YOU CAN STILL BE ELIGIBLE FOR PROGRAMS EVEN IF YOU DON'T FILE FEDERAL INCOME TAX)</small>			
A. Will you file Income Tax Next Year (if yes, please answer questions A-C; if no, skip to question D):			
B. Will you file jointly with spouse:		Name of spouse:	
C. Will you claim dependents on your tax return:		Name of dependent 1:	
Name of dependent 2:		Name of dependent 3:	
D. Will you be claimed as a dependent on someone's tax return:		Name of filer:	
<b>DEDUCTIONS, APPLICANT</b> <small>ENTER AMOUNTS FOR ALL THAT APPLY</small>			
Alimony paid:	How often?	Student loan interest:	How often?
Other deductions:	How often?	Type:	
<b>SIGNATURE</b>			
<b>I'M SIGNING THIS APPLICATION UNDER PENALTY OF PERJURY WHICH MEANS I'VE PROVIDED TRUE ANSWERS TO ALL THE QUESTIONS ON THIS FORM TO THE BEST OF MY KNOWLEDGE. I KNOW THAT I MAY BE SUBJECT TO PENALTIES UNDER FEDERAL LAW IF I PROVIDE FALSE AND OR UNTRUE INFORMATION.</b>			
Signature of applicant:			
Date:			

**COMBINED TOTAL - 101% TO 133% OF FPL PLUS CHILDLESS ADULT WAIVER**

<b>SERVICE CATEGORY</b>	<b>PATIENTS</b>	<b>VISITS</b>	<b>DOLLARS</b>
1010 Facility Inpatient Non Acute	3	8	\$12,124.84
1020 Facility Inpatient Long Term Care	19	29	\$98,279.92
1030 Facility Inpatient Maternity	1,294	1,874	\$3,931,588.49
1050 Facility Inpatient Medical	10,005	32,533	\$37,109,333.19
1210 Facility Outpatient Surgery	4,387	5,815	\$7,815,238.22
1220 Facility Outpatient ER	10,244	18,744	\$5,009,075.48
1230 Facility Outpatient Diagnostic Services	3,536	5,228	\$899,450.90
1231 Facility Outpatient Dialysis	16	137	\$59,895.67
1232 Facility Outpatient DME	23	26	\$496.25
1233 Facility Outpatient Home Health	87	296	\$61,594.47
1234 Facility Outpatient Pharmacy	5,960	9,250	\$568,950.99
1235 Facility Outpatient PT, OT, Speech Therapy	1,817	3,942	\$255,128.31
1236 Facility Outpatient Specialty Drugs	367	1,005	\$1,253,808.94
1237 Facility Outpatient Supplies and Devices	1,144	1,863	\$83,679.46
1238 Facility Outpatient Transportation	152	196	\$71,364.97
1299 Facility Outpatient Other	27,119	100,584	\$8,634,295.36
2010 Physician Specialty Inpatient	12	21	\$2,750.06
2020 Physician Non-Specialty Inpatient	3,837	10,091	\$2,371,722.90
2115 Physician Specialty Outpatient Surgery	108	140	\$31,195.25
2120 Physician Specialty ER	13	14	\$302.64
2125 Physician Specialty Office Visits	1,043	1,787	\$79,441.91
2139 Physician Specialty Outpatient Other	389	673	\$47,579.35
2155 Physician Non-Specialty Outpatient Surgery	4,711	6,132	\$1,875,198.55
2160 Physician Non-Specialty ER	14,879	26,744	\$1,111,416.92
2165 Physician Non-Specialty Office Visits	22,414	70,782	\$3,189,411.23
2199 Physician Non-Specialty Outpatient Other	9,144	18,171	\$766,544.00
2225 Professional Office Visits	12,388	25,850	\$1,174,037.84
2227 Professional Chiropractic Services	1,675	7,796	\$157,679.13
2230 Professional Diagnostic Services	6,886	12,034	\$567,780.87
2231 Professional Dialysis	20	125	\$7,570.35
2232 Professional DME	897	2,752	\$450,598.97
2233 Professional Home Health	32	298	\$130,629.61
2235 Professional PT, OT, Speech Therapy	2,235	8,183	\$256,878.70
2236 Professional Specialty Drugs	144	455	\$196,809.11
2237 Professional Supplies and Devices	2,601	5,925	\$647,248.76
2238 Professional Transportation	4,440	41,692	\$3,098,740.44
2240 Professional Injections	2,846	5,813	\$698,035.08
2299 Professional Services Other	11,351	17,944	\$1,316,073.36
3010 Mental Health Inpatient	1,048	2,395	\$1,631,903.24
3025 Mental Health Office Visits	4,605	9,371	\$468,357.90
3030 Mental Health Other Outpatient	11,557	87,765	\$10,789,235.58
3050 Substance Abuse Inpatient	734	3,281	\$2,957,530.93
3065 Substance Abuse Office Visits	878	3,903	\$227,389.76

**COMBINED TOTAL - 101% TO 133% OF FPL PLUS CHILDLESS ADULT WAIVER**

<b>SERVICE CATEGORY</b>	<b>PATIENTS</b>	<b>VISITS</b>	<b>DOLLARS</b>
3070 Substance Abuse Other Outpatient	4,042	60,662	\$6,696,400.79
4051 Laboratory Outpatient Chemistry Tests	15,425	31,795	\$1,320,269.23
4055 Laboratory Outpatient Pathology	9,310	12,106	\$401,534.79
4099 Laboratory Outpatient Other	19,776	46,175	\$935,604.96
4561 Radiology Outpatient CT Scans	3,206	3,898	\$579,627.81
4562 Radiology Outpatient Mammograms	4,711	6,235	\$231,293.54
4563 Radiology Outpatient MRIs	4,545	5,490	\$1,116,154.48
4564 Radiology Outpatient Nuclear Medicine	1,119	1,222	\$217,136.83
4566 Radiology Outpatient Therapeutic Radiology	85	317	\$282,086.50
4567 Radiology Outpatient Ultrasounds	8,072	13,475	\$1,080,009.91
4568 Radiology Outpatient X-Rays	11,950	18,841	\$514,338.73
4599 Radiology Outpatient Other	1,474	1,679	\$76,763.68
5070 Prescription Specialty Drugs	424	1,635	\$2,935,453.10
5075 Prescription Drugs Retail	34,611	382,690	\$22,567,249.96
8090 Dental	4,081	7,262	\$1,722,962.05
<b>GRAND TOTAL</b>	<b>309,891</b>	<b>1,145,149</b>	<b>\$140,793,254.26</b>

**NOTE: The PATIENTS column is an unduplicated count of persons who utilized a particular service - it is NOT a count of members.**



STATE OF MAINE  
 DEPARTMENT OF PROFESSIONAL  
 AND FINANCIAL REGULATION  
 BUREAU OF INSURANCE  
 34 STATE HOUSE STATION  
 AUGUSTA, MAINE  
 04333-0034

*Maine Health Exchange  
 Advisory Committee*

RECEIVED OCT 17 2013

Paul R. LePage  
 GOVERNOR

Eric A. Cioppa  
 Superintendent

October 16, 2013

Senator Margaret Craven, Chair  
 Representative Sharon Anglin Treat, Chair  
 Maine Health Exchange Advisory Committee  
 100 State House Station  
 Augusta, ME 04333

RE: Questions from the Maine Health Exchange Advisory Committee

Although I will be unable to attend the Advisory committee's meeting on Marketplace issues on October 21, I wanted to respond to the Committee's specific questions posed to the Bureau of Insurance regarding the operation of the federal health insurance marketplace for Maine and the Bureau's continuing role in health insurance regulation.

These responses can be supplemented as necessary with information that is currently available on the Bureau's website. We hope this information is helpful to consumers and others regarding health insurance choices offered by the Marketplace.

If the Committee has any additional questions that result from its discussion on the 21st, please let me know and I will make sure responses are forwarded as soon as possible.

Sincerely,

Eric Cioppa



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OFFICES LOCATED AT 76 NORTHERN AVENUE, GARDINER, MAINE 04345

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TTY: Please call Maine Relay 711

Customer Complaint: 1-800-300-5000

Fax (207)624-8599



Please find below the Bureau of Insurance responses to the three questions you have posed:

1. How will consumer complaints be addressed for health plans on the marketplace or about the functions of the marketplace ---subsidy and eligibility determinations? What is the Bureau's role in resolving complaints? What is the marketplace's role?

The Bureau has engaged in a dialogue with the federal Center for Consumer Information and Insurance Oversight (CCIIO) concerning the role of the respective agencies with respect to complaint handling. The Bureau's role remains much as it has been traditionally been. Pursuant to its role in administering and enforcing the provisions of the Maine Insurance Code, the Bureau will continue to receive and process consumer complaints regarding activities of health insurers and producers irrespective of whether they relate to coverage sought or procured in or out of the insurance marketplace (exchange). Examples of areas where the Bureau might receive complaints include:

- Claims processing, Denials, Appeals
- Insurer Customer Service
- Coordination of Benefits
- Marketing/Sales Complaints related to insurers or producers
- Privacy Violations related to insurers or producers

CCIIO anticipates handling complaints focused on the operation of the marketplace including eligibility/enrollment issues. Examples of complaints to be handled by CCIIO are as follows:

- Marketplace Eligibility/Enrollment Issues
- Identity Verification
- Problems receiving Eligibility Determination
- Medicaid/CHIP Decision (only when concern relates to FFM-generated assessment/determination)
- Advance Premium Tax Credit and Cost Sharing Reductions
- CMS/Call Center/Web-site Performance
- Other Federal Agency Performance
- Certified Application Counselors

Two other federal agencies, the U.S. Department of Labor and the Internal Revenue Service also have oversight responsibilities with respect to some aspects of the areas above. CCIIO will engage those agencies or refer cases to them as appropriate.



Provisions of both State and Federal law apply to navigators. Accordingly, both the Bureau and CCIIO may have some involvement in complaints involving navigators depending on the nature of the complaint. Given that navigators operate pursuant to federal contract, however, the Bureau's expectation is that most complaints involving navigators would be primarily handled by CCIIO.

This response is not intended to address any questions relating to the interaction of the Maine Department of Health and Human Services with CCIIO or any other federal agency. Representatives of DHHS can provide information regarding those matters.

2. Please describe the plan management functions that the Bureau of Insurance has over health plans operating on the exchange and provide copies of any MOUs or other agreements with the FFM or federal Department of Health and Human Services.

Neither the Bureau nor CCIIO has a Memorandum of Understanding (MOU) regarding plan management functions undertaken by the Bureau. There is a letter dated March 18, 2013 from Superintendent of Insurance Eric Cioppa to Gary Cohen, Deputy Director and Administrator of CCIIO, which discusses functions the Bureau was open to exploring. These functions are essentially those set forth in Section 4.0 of the Federal Exchange Blueprint. The attachment to the March 18 letter compares these functions to very similar functions which the Bureau already performs under State law. Mr. Cohen responded to Superintendent Cioppa's letter on March 29, 2013. Subsequent discussions were conducted via telephone. Copies of the March 18 and March 29 letters are attached.

3. Please provide an update on the rulemaking for certification of navigators pursuant to 24-A MRSA Section 2188. *[I have the recent bulletin that you issued—the Advisory Committee is interested in a draft of the rule if it will be available or, if not, an outline of the proposed rule to the extent possible.]*

A rulemaking hearing on proposed Maine Insurance Rule Chapter 950, Navigator Certification and Training for Health Benefit Exchanges, has been scheduled for Monday, October 28, 2013 at 9:00 a.m. in the Central Conference Room of the Department of Professional and Financial Regulation Building at 76 Northern Avenue, Gardiner. A copy of the proposed rule is attached.





Paul R. LePage  
GOVERNOR

STATE OF MAINE  
DEPARTMENT OF PROFESSIONAL  
AND FINANCIAL REGULATION  
BUREAU OF INSURANCE  
34 STATE HOUSE STATION  
AUGUSTA, MAINE  
04333-0034

Eric A. Cioppa  
Superintendent

March 18, 2013

Gary Cohen, Deputy Administrator and Director  
Center for Consumer Information and Insurance Oversight  
Centers for Medicare and Medicaid Services  
200 Independence Ave, SW  
Washington, DC 20201

Re: Functions of the Federally Facilitated Exchange in Maine

Dear Director Cohen:

On February 15th, 2013 the Center for Consumer Information and Insurance Oversight (CCIIO)/HHS, proposed to the State of Maine Bureau of Insurance ("the Bureau") a new Health Insurance Exchange coordination model. Under this model the Bureau would have continued responsibility for health insurance oversight activities for plans offered within the Federal Exchange, as the Bureau performs in connection with regulation of plans in the individual and small group market generally.

The purpose of this letter is to advise that the State of Maine is open to exploring options for coordination as described in your proposal. We understand that the Maine Bureau of Insurance would administer certain activities, as described below, in connection with the certification and oversight of Qualified Health Plans (QHPs). These are activities that the Bureau performs in the statewide health insurance market in order to protect Maine consumers and reduce administrative costs for Maine carriers. However, this partnership would involve our taking on responsibilities the Exchange would otherwise have to perform. Given our current fiscal situation, we can only proceed if our State is reimbursed for performing this work.



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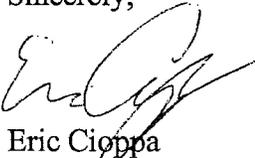
At the outset, please be advised that 24-A M.R.S.A. § 4309-A and various other statutes enacted by P.L. 2011 Ch. 364 require carriers to comply with all applicable requirements of the Affordable Care Act and allow the Superintendent to enforce these requirements through all powers provided under Title 24 and Title 24-A.<sup>1</sup>

As described in the attached chart, Bureau responsibilities for plans outside the Exchange (and the responsibilities the Bureau might assume by coordinating with the Federal Exchange) include:

- Licensing carriers and verifying compliance with Exchange eligibility requirements
- Conducting market conduct examinations
- Conducting financial and solvency examinations
- Reviewing plan documents for compliance with state law mandates and essential health benefits, which are essentially the same as QHP certification requirements
- Reviewing rates
- Investigating and resolving consumer complaints
- Ensuring compliance with appeal and external review requirements
- Providing technical assistance to carriers
- Monitoring compliance with access requirements.

We look forward to working with you to clarify how best to fulfill our respective responsibilities to the citizens of Maine.

Sincerely,



Eric Cioppa  
Superintendent of Insurance

cc: Paul R. LePage, Governor

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<sup>1</sup> §4309-A. Compliance with the Affordable Care Act

**1. Carriers.** A carrier shall comply with all applicable requirements of the federal Affordable Care Act.

**2. Superintendent.** The superintendent may enforce and administer this section through all powers provided under this Title and Title 24. The superintendent may adopt and amend rules, establish standards and enforce federal statutes and regulations in order to carry out the purposes of the federal Affordable Care Act. Rules or amendments adopted pursuant to this subsection, including amendments to major substantive rules, are routine technical rules as defined in Title 5, chapter 375, subchapter 2-A.



Attachment: CCIIO's Proposed Coordination Model for FFE states:

<i>Federal Exchange Plan Management Activities (Section 4.0 of the Blueprint for Approval of State-Based and State Partnership Insurance Exchanges)</i>		<i>Bureau of Insurance comparable responsibilities in the current individual and small group market</i>
4.1	Authority to certify and oversee carriers, consistent with Federal regulations.	licensing carriers, performing examinations, conducting audits
4.2	Certify carriers according to Federal certification requirements.	licensing carriers
4.2a	Certify plans in advance of the annual open enrollment period.	reviewing forms
4.2b	Ensure plans comply with Federal certification standards including, but not limited to: licensure, solvency, service area, network adequacy, essential community providers, marketing and discriminatory benefit design, accreditation, and consideration of rate increases.	licensing carriers (including solvency, service area, network adequacy, essential community providers), reviewing quality, reviewing forms, reviewing rates
4.2c	Collect, analyze, and if required, submit to the Federal government plan variations for cost-sharing reductions, advance payment estimates for such reductions, and any supporting documentation needed to ensure compliance with applicable regulations and accuracy of the cost-sharing reduction advance payments.	Review of rates and forms including plan schedules of benefits
4.2d	Ensure that plans meet actuarial value and essential health benefit standards.	reviewing forms, reviewing rates
4.2e	Ensure plans' compliance with market reform rules.	reviewing rates
4.3	Have processes that support the collection of carrier and plan data; facilitate the plan certification process; manage carriers and plans; and integrate with other Exchange business areas, including the Exchange	licensing carriers, performing examinations, conducting audits



<i>Federal Exchange Plan Management Activities (Section 4.0 of the Blueprint for Approval of State- Based and State Partnership Insurance Exchanges)</i>		<i>Bureau of Insurance comparable responsibilities in the current individual and small group market</i>
	Internet Web site, call center, quality, eligibility and enrollment, and premium processing.	
4.3a	Collect and analyze information on plan rates, covered benefits, and cost-sharing requirements.	reviewing rates
4.3b	Use plan rate data and rules for purposes such as generating consumer-facing premiums and determining the second-lowest cost silver plan for premium tax credit calculations.	rate review, data collection and availability
4.4	Ensure plans' ongoing compliance with certification requirements, including a process for monitoring performance and collecting, analyzing, and resolving enrollee complaints.	performing examinations, conducting audits, investigating complaints
4.4a	Ensure plans' ongoing compliance with Federal certification requirements and Exchange operational requirements.	ensuring compliance with certification requirements: reviewing forms
4.4b	Has a process to monitor plan performance and to collect, analyze, and resolve enrollee complaints in conjunction with any applicable State entities (e.g., consumer assistance programs, ombudsmen).	performing examinations, conducting audits, investigating complaints
4.5	Has the capacity to support carriers and provide technical assistance to ensure ongoing compliance with Federal standards.	providing technical assistance to carriers
4.6	Has a process for carrier recertification, decertification, and appeal of decertification determinations.	licensing carriers (including annual registration of PPOs), revoking licenses, completing appeals in possible revocations



<p><i>Federal Exchange Plan Management Activities (Section 4.0 of the Blueprint for Approval of State-Based and State Partnership Insurance Exchanges)</i></p>		<p><i>Bureau of Insurance comparable responsibilities in the current individual and small group market</i></p>
4.6a	<p>Has a process for recertification of carriers and plans including the annual receipt and review of rates, benefits, and cost sharing information.</p>	<p>licensing carriers (including annual registration of PPOs), reviewing rates, reviewing forms</p>
4.6b	<p>Has a process for decertification of plans and carriers and a process for transitioning enrollees into new plans.</p>	<p>working with carriers and plans seeking to leave the market</p>
4.6c	<p>Has a process for the appeal of a decertification of a plan and any necessary appeal of certification determinations.</p>	<p>completing appeals in possible revocations</p>
4.7	<p>Has a timeline for carrier accreditation, and systems and procedures to ensure carriers meet accreditation requirements as part of certification.</p>	<p>performing quality reviews that incorporate NCQA accreditation reviews</p>
4.8	<p>Ensure that carriers meet the minimum certification requirements pertaining to quality reporting and provide relevant information to the Exchange and HHS.</p>	<p>performing quality reviews that incorporate NCQA accreditation reviews</p> <p>No related activities for providing information to the Exchange and HHS</p>





March 29, 2013

Eric Cioppa  
Superintendent of Insurance  
State of Maine  
Department of Professional and Financial Regulation  
Bureau of Insurance  
34 State House Station  
Augusta, ME 04333-0334

Dear Superintendent Cioppa:

Thank you for your letter sharing your intent to explore options relating to the certification of the Qualified Health Plans (QHPs) that will be available to consumers beginning on October 1, 2013. Specifically, you have attested that Maine has the legal authority and operational capacity to conduct the plan management activities required to support certification of QHPs, as described in 45 CFR 155.1010(a). Additionally, Maine will perform all plan management activities listed in Section 4.0 of the Blueprint in time for the 2013 QHP selection process.

I understand that the Maine can only proceed with these activities if the State is reimbursed for performing this work.

Please be advised that States may apply for funds to assist them in actively working with the Federal government in the establishment of certain aspects of the Federally-Facilitated Marketplace (until the last funding opportunity in 2014). An example of such assistance includes States making recommendations concerning the certification of Qualified Health Plans in the Federally-Facilitated Marketplace. States may also provide education, information and support to consumers within the States. Please see appendix B of the current Funding Opportunity Announcement regarding allowable costs. Please see appendix B of the current Funding Opportunity Announcement regarding allowable costs. Funding Opportunity Number: IE-HBE-12-001, available at:

<http://www.grants.gov/search/search.do;jsessionid=Vcg0RQPpfQOBsTPVJCnykYmL2ZVQTrKL1vfzVTGP9hvCgVL8ygzy!-488397891?oppId=180734&mode=VIEW>

Please note that all Exchange Cooperative Agreements are subject to the requirements set forth in 2 CFR Part 225, Cost Principles for State, Local, and Indian Tribal Governments (previously OMB Circular A-87). Please also note that §1311(a)(4)(B) provides that no §1311 grants may be awarded after December 31, 2014; however, this should not prevent Maine from continuing to maintain its role in overseeing health insurance coverage offered within the State consistent with the traditional role of States in regulating the health insurance market.



I would like to thank you for ensuring that Maine will participate in a discussion with the Centers for Medicare & Medicaid Services (CMS) to determine Maine's operational plans and capacity to perform these functions. Based on what we learn during this one-day discussion, CMS will initiate a process that will enable us to rely on Maine's recommended determinations that health plans meet QHP certification requirements.

Assuming Maine continues to act in accordance with your attestations, CMS will continue to rely on Maine's recommendations in certifying QHPs. CMS, however, will maintain its legal responsibility for ensuring that QHPs meet all QHP certification standards.

Sincerely,



Gary Cohen, Director

Center for Consumer Information and Insurance Oversight

cc: Paul LePage, Governor



**Section 1. Authority and Purpose**

This Rule is adopted pursuant to 24-A M.R.S.A. §§ 212 and 2188, to establish standards and procedures for the certification of navigators to perform the activities and duties identified in 24-A M.R.S.A. §2188 and Subsection 1311(i) of the federal Affordable Care Act.

**Section 2. Applicability and Scope**

This Rule applies to navigators providing services in Maine for a Health Benefit Exchange established pursuant to Section 1311 of the federal Affordable Care Act (“the Exchange”).

**Section 3. Certification of navigators**

- A. *Certification required.* An individual may not serve as a navigator or perform navigator duties on behalf of a navigator organization or business entity as described in 24-A M.R.S.A. §2188 unless certified in accordance with this section. An organization or business entity that serves as a navigator may not employ, contract with, or allow an individual to perform navigator duties on its behalf unless the individual is certified in accordance with this section.
- B. *Examination.* An individual applying for navigator certification must pass a navigator examination administered or approved by the Superintendent and satisfy any applicable qualification standards established by the Exchange or otherwise required by the Affordable Care Act and the regulations thereunder. If the Exchange requires navigators to pass an examination administered by the Exchange, the Superintendent may determine that this examination satisfies the requirement of this subsection, or may require an additional examination limited to matters that are not fully addressed in the examination administered by the Exchange.
- C. *Application process.* The Superintendent shall make available an application and disclosure form for certification. Certification will be issued upon the Superintendent’s determination that the applicant has met the requirements specified in 24-A M.R.S.A. §2188 and this Rule.



- D. *Initial Fee.* Each applicant for certification shall pay a \$15 fee, payable to Treasurer, State of Maine upon submission of the application. The Superintendent may establish a different fee from time to time in any reasonable amount.
- E. *Duration.* Each certification continues in force continuously, unless suspended, revoked, or otherwise terminated. In addition to the grounds specified in 24-A M.R.S.A. § 2188(6), a navigator's certification shall be suspended or revoked if the Exchange denies, suspends, or terminates his or her certification for cause.
- F. *Training requirement.* As a condition of obtaining and maintaining certification, an individual must comply with applicable training standards established by the Superintendent. The Superintendent may determine that the training standards established by the Exchange or otherwise required by the Affordable Care Act and the regulations thereunder satisfy the requirement of this subsection, or may require additional training limited to matters that are not fully addressed in the training administered by the Exchange.
- G. *Verification of compliance.* If the Superintendent determines that the Exchange does not have effective procedures for transmitting information to identify individuals who have successfully completed the Exchange's examination and training requirements, the Superintendent shall require certified navigators and applicants for certification to provide satisfactory proof of compliance.

**Section 4. Severability**

If any section, term, or provision of this Rule shall be deemed invalid for any reason, any remaining section, provision, or definition shall remain in full force and effect.

**Section 5. Effective Date**

This Rule is effective \_\_\_\_\_.

*[DRAFTING NOTE: The Rule is proposed to take effect five days after filing with the Secretary of State pursuant to 5 M.R.S.A. § 8056(1)(B).]*





STATE OF MAINE  
**DIRIGO HEALTH AGENCY**  
53 STATE HOUSE STATION AUGUSTA, MAINE 04333-0053

PAUL R. LePAGE  
GOVERNOR

KARYNLEE HARRINGTON  
EXECUTIVE DIRECTOR

**DATE:** October 21, 2013

**TO:** Senator Craven, Representative Treat and Members of the Maine Health Exchange Advisory Committee

**FROM:** Karynlee Harrington, Executive Director, Dirigo Health Agency/Maine Quality Forum

**CC:** Colleen McCarthyReid, Legislative Analyst  
Joe Bruno, Chair Dirigo Health Agency Board of Trustees

**RE:** Committee Questions

- 
1. How does the current coverage in Dirigo compare with the new plans available through the marketplace?

**Attached are two documents which I provided the Dirigo Board of Trustees at the September Board meeting. The information in the first document comes from the BOI's (Bureau of Insurance) website. The information is an overview of the bronze plans that are available to an individual in Maine on the Exchange (basic coverage and rating factors). The second document provides similar information for the DirigoChoice plans.**

2. What sort of "transfer" assistance, information or guidance are Dirigo members receiving from DHA?

**As part of the Agency's transition planning - we started notifying our individual, sole proprietor and small group employers in November of 2012 by inserting information in the renewal package about the closure of the DirigoChoice program along with basic information (what was available at the time) regarding the health insurance exchange. In addition we sent reminder notices of the transition to our individual and sole prop members the months of May, July, September and October of 2013. Beginning in the month of April 2013 we started making outbound calls to our individual and sole prop members. In September we started a second round of outbound calls to the same population. As more information has become available about the Exchange and plans participating on the Exchange we have revised both our written and verbal communications. In fact at the end of last week we were notified of a new resource available on HealthCare.gov which now provides contact information for local resources to assist members in enrolling in coverage through the Exchange- link is:  
[LocalHelp.HealthCare.gov](http://LocalHelp.HealthCare.gov)**

Please let me know if you have additional questions. Karynlee



**Dirigo Non-group Benefit plans and factors**

Dirigo Benefit plans	Plan 2B	Plan 2C	Plan 2D	Plan 2E	Plan 2F	Plan 3B	Plan 3C	Plan 3D	Plan 3E	Plan 3F
Deductible	\$750	\$1,050	\$1,375	\$1,700	\$2,000	\$750	\$1,250	\$1,750	\$2,250	\$2,750
OOP	\$1,850	\$2,850	\$3,850	\$4,850	\$5,850	\$950	\$1,650	\$2,350	\$3,050	\$3,750
Coinsurance	30%	30%	30%	30%	30%	30%	30%	30%	30%	30%
ER co pay	ded & coins									
Office visit	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Outpatient	ded & coins									
Sp office visit	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25	\$25
Urgent Care	ded & coins									
PT/OT/ST	ded & coins									
Rx tier 1	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10	\$10
Rx tier 2	\$30	\$30	\$30	\$30	\$30	\$30	\$30	\$30	\$30	\$30
Rx tier 3	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50	\$50
Pediatric dental	n/a									

Plan rates (base*plan rate)	Plan 2B	Plan 2C	Plan 2D	Plan 2E	Plan 2F	Plan 3B	Plan 3C	Plan 3D	Plan 3E	Plan 3F
Q3 13 effective dates	\$722.96	\$685.87	\$638.20	\$603.17	\$573.00	\$758.26	\$709.26	\$652.72	\$612.89	\$579.66

Area Factors	County	Factors
	Cumberland	0.900
	York	0.900
	Kennebec	0.925
	Knox	0.950
	Sagadahoc	0.950
	Androscoggin	0.965
	Lincoln	0.975
	Oxford	0.975
	Franklin	1.025
	Waldo	1.050
	Aroostook	1.150
	Hancock	1.150
	Penobscot	1.150
	Piscataquis	1.150
	Somerset	1.150
	Washington	1.150

Age factors	Band	AgeFactors
	<30	0.51
	30-39	0.712
	40-44	0.857
	45-49	1.086
	50-54	1.234
	55-59*	1.35
	60-64*	1.35
	65+*	1.35

\* reflects impact of banding

Contract type factors	Type	Rate Ratio
	Individual	1.000
	Couple	2.000
	Parent/Child(ren)	1.800
	Family	3.000
	Child Only*	0.408

\*for child only use age factor of 1.0

Subscriber rate = plan rate \* age factor\* area factor \* contract type factor



Individual On-Exchange Bronze Plan and Factors

Bronze Plan Benefits	MCHO PPO-0030001	Anthem HMO - 710004	Anthem POS - 720004
Deductible	\$5,000	\$5,750	\$6,000
QOP	\$6,350		
Coinsurance	50%	10%	0%
ER Co-pay	\$825	\$200 + Ded/Co	\$200 + Ded
Office Visit	\$45	\$40/2 + Ded/Co	\$40/2 + Ded
Outpatient	\$45	Ded/Co	Deductible
Sp Office visit	\$140	Ded/Co	Deductible
Urgent Care	\$140	\$50+ Ded/Co	\$50 + Deductible
Hearing/Physical	Ded/Co		Deductible
Rx Tier 1	\$30	Ded/Co	Deductible
Rx Tier 2	Ded/Co		Deductible
Rx Tier 3	Ded/Co		Deductible
Rx Tier 4	Ded/Co		Deductible
Pediatric Dental	No	No	No

Age Factors

0-20	0.635
21-24	1.000
25	1.004
26	1.024
27	1.048
28	1.087
29	1.119
30	1.135
31	1.159
32	1.183
33	1.198
34	1.214
35	1.222
36	1.230
37	1.238
38	1.246

Base Rate * Plan Rate		Tobacco Factors	
Anthem HMO	\$199.43	Anthem	1.3
Anthem PPO	\$266.51	MCHO	None
MCHO	\$213.96		

Area Factors	Anthem HMO	Anthem PPO	MCHO
1	0.9206	0	0.9
2	1.1077	0	0.975
3	1.1287	0.9487	1.05
4	0	1.0317	1.2

Area	Counties					
1	Cumberland	Sagadahoc	York			
2	Knox	Kennebec	Lincoln	Oxford		
3	Androscoggin	Waldo	Franklin	Penobscot	Somerset	Piscataquis
4	Hancock	Aroostook	Washington			

39	1.262
40	1.278
41	1.302
42	1.325
43	1.357
44	1.397
45	1.444
46	1.500
47	1.563
48	1.635
49	1.706

Monthly Premium =( Base Rate\* Plan Rate\*Area Factor\*Age Factor\*Tobacco Factor)

50	1.786
51	1.865
52	1.952
53	2.040
54	2.135
55	2.230
56	2.333
57	2.437
58	2.548
59	2.603
60	2.714
61	2.810
62	2.873
63	2.952
64 +	3.000



**The New York Times**

October 12, 2013

# From the Start, Signs of Trouble at Health Portal

By ROBERT PEAR, SHARON LaFRANIERE and IAN AUSTEN

WASHINGTON — In March, Henry Chao, the chief digital architect for the Obama administration's new online insurance marketplace, told industry executives that he was deeply worried about the Web site's debut. "Let's just make sure it's not a third-world experience," he told them.

Two weeks after the rollout, few would say his hopes were realized.

For the past 12 days, a system costing more than \$400 million and billed as a one-stop click-and-go hub for citizens seeking health insurance has thwarted the efforts of millions to simply log in. The growing national outcry has deeply embarrassed the White House, which has refused to say how many people have enrolled through the federal exchange.

Even some supporters of the Affordable Care Act worry that the flaws in the system, if not quickly fixed, could threaten the fiscal health of the insurance initiative, which depends on throngs of customers to spread the risk and keep prices low.

"These are not glitches," said an insurance executive who has participated in many conference calls on the federal exchange. Like many people interviewed for this article, the executive spoke on the condition of anonymity, saying he did not wish to alienate the federal officials with whom he works. "The extent of the problems is pretty enormous. At the end of our calls, people say, 'It's awful, just awful.'"

Interviews with two dozen contractors, current and former government officials, insurance executives and consumer advocates, as well as an examination of confidential administration documents, point to a series of missteps — financial, technical and managerial — that led to the troubles.

Politics made things worse. To avoid giving ammunition to Republicans opposed to the project, the administration put off issuing several major rules until after last November's elections. The Republican-controlled House blocked funds. More than 30 states refused to set up their own exchanges, requiring the federal government to vastly expand its project in unexpected ways.

The stakes rose even higher when Congressional opponents forced a government shutdown in the latest fight over the health care law, which will require most Americans to have health insurance. Administration officials dug in their heels, repeatedly insisting that the project was on track despite evidence to the contrary.

Dr. Donald M. Berwick, the administrator of the federal Centers for Medicare and Medicaid Services in 2010 and 2011, said the time and budgetary pressures were a constant worry. "The staff was heroic and dedicated, but we did not have enough money, and we all knew that," he said in an interview on Friday.

Administration officials have said there is plenty of time to resolve the problems before the mid-December deadline to sign up for coverage that begins Jan. 1 and the March 31 deadline for coverage that starts later. A round-the-clock effort is under way, with the government leaning more heavily on the major contractors, including the United States subsidiary of the Montreal-based CGI Group and Booz Allen Hamilton.

One person familiar with the system's development said that the project was now roughly 70 percent of the way toward operating properly, but that predictions varied on when the remaining 30 percent would be done. "I've heard as little as two weeks or as much as a couple of months," that person said. Others warned that the fixes themselves were creating new problems, and said that the full extent of the problems might not be known because so many consumers had been stymied at the first step in the application process.

Confidential progress reports from the Health and Human Services Department show that senior officials repeatedly expressed doubts that the computer systems for the federal exchange would be ready on time, blaming delayed regulations, a lack of resources and other factors.

Deadline after deadline was missed. The biggest contractor, CGI Federal, was awarded its \$94 million contract in December 2011. But the government was so slow in issuing specifications that the firm did not start writing software code until this spring, according to people familiar with the process. As late as the last week of September, officials were still changing features of the Web site, HealthCare.gov, and debating whether consumers should be required to register and create password-protected accounts before they could shop for health plans.

One highly unusual decision, reached early in the project, proved critical: the Medicare and Medicaid agency assumed the role of project quarterback, responsible for making sure each separately designed database and piece of software worked with the others, instead of assigning that task to a lead contractor.

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Some people intimately involved in the project seriously doubted that the agency had the in-house capability to handle such a mammoth technical task of software engineering while simultaneously supervising 55 contractors. An internal government progress report in September 2011 identified a lack of employees “to manage the multiple activities and contractors happening concurrently” as a “major risk” to the whole project.

While some branches of the military have large software engineering departments capable of acting as the so-called system integrator, often on medium-size weapons projects, the rest of the federal government typically does not, said Stan Soloway, the president and chief executive of the Professional Services Council, which represents 350 government contractors. CGI officials have publicly said that while their company created the system’s overall software framework, the Medicare and Medicaid agency was responsible for integrating and testing all the combined components.

By early this year, people inside and outside the federal bureaucracy were raising red flags. “We foresee a train wreck,” an insurance executive working on information technology said in a February interview. “We don’t have the I.T. specifications. The level of angst in health plans is growing by leaps and bounds. The political people in the administration do not understand how far behind they are.”

The Government Accountability Office, an investigative arm of Congress, warned in June that many challenges had to be overcome before the Oct. 1 rollout.

“So much testing of the new system was so far behind schedule, I was not confident it would work well,” Richard S. Foster, who retired in January as chief actuary of the Medicare program, said in an interview last week.

But Mr. Chao’s superiors at the Department of Health and Human Services told him, in effect, that failure was not an option, according to people who have spoken with him. Nor was rolling out the system in stages or on a smaller scale, as companies like Google typically do so that problems can more easily and quietly be fixed. Former government officials say the White House, which was calling the shots, feared that any backtracking would further embolden Republican critics who were trying to repeal the health care law.

Marilyn B. Tavenner, the administrator of the Centers for Medicare and Medicaid Services, and Kathleen Sebelius, the secretary of health and human services, both insisted in July that the project was not in trouble. Last month, Gary M. Cohen, the federal official in charge of health insurance exchanges, promised federal legislators that on Oct. 1, “consumers will be able to go online, they’ll be able to get a determination of what tax subsidies they are eligible for, they’ll be able to see the premium net of subsidy,” and they will be able to sign up.

But just a trickle of the 14.6 million people who have visited the federal exchange so far have managed to enroll in insurance plans, according to executives of major insurance companies who receive enrollment files from the government. And some of those enrollments are marred by mistakes. Insurance executives said the government had sent some enrollment files to the wrong insurer, confusing companies that have similar names but are in different states. Other files were unusable because crucial information was missing, they said.

Many users of the federal exchange were stuck at square one. A New York Times researcher, for instance, managed to register at 6 a.m. on Oct. 1. But despite more than 40 attempts over the next 11 days, she was never able to log in. Her last attempts led her to a blank screen.

Neither Ms. Tavenner nor other agency officials would answer questions about the exchange or its performance last week.

Worried about their reputations, contractors are now publicly distancing themselves from the troubled parts of the federally run project. Eric Gundersen, the president of Development Seed, emphasized that his company had built the home page of HealthCare.gov but had nothing to do with what happened after a user hit the “Apply Now” button.

Senior executives at Oracle, a subcontractor based in California that provided identity management software used in the registration process that has frustrated so many users, defended the company’s work. “Our software is running properly,” said Deborah Hellinger, Oracle’s vice president for corporate communications. The identical software has been widely used in complex systems, she said.

The serious technical problems threaten to obscure what some see as a nationwide demonstration of a desire for more affordable health insurance. The government has been heavily promoting the HealthCare.gov site as the best source of information on health insurance. An August government e-mail said: “35 days to open enrollment.” A September e-mail followed: “5 days to open enrollment. Don’t wait another minute.”

The response was huge. Insurance companies report much higher traffic on their Web sites and many more callers to their phone lines than predicted.

That made the flawed opening all the more disappointing to supporters of the health plan, including Timothy S. Jost, a law professor and a consumer representative to the National Association of Insurance Commissioners.

“Even if a fix happens quickly, I remain very disappointed that the Department of Health and Human Services was not better prepared for the rollout,” he said.

*Robert Pear reported from Washington, Sharon LaFraniere from New York and Ian Austen from Ottawa. Quentin Hardy contributed reporting from San Francisco, and Kitty Bennett contributed research.*





Published: October 12, 2013

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# How the Federal Exchange Is Supposed to Work, and How It Didn't

Since the new health insurance exchanges run by the federal government opened on Oct. 1, millions of consumers have encountered technical problems when using them. [Related Article »](#)

### PROBLEM

Consumers had difficulty creating online accounts and were unable to compare plans.

### Application

Consumers provide basic information to set up accounts, which allows them to compare costs and benefits of health plans. They can apply for a plan as well as for financial assistance, which can be in the form of tax credits or government assistance programs.

### State-run exchanges

### PROBLEM

Some state-run exchanges, like those in Rhode Island, Minnesota and Nevada, had problems using the federal verification hub to confirm applicants' identities.

### Verification

The application is sent through a data services hub, which checks the identity of the consumer through information from various federal agencies.

**Social Security Administration** to verify Social Security Number, citizenship and other information.

**Department of Homeland Security** to make sure the applicant is a citizen or legal resident.

**Internal Revenue Service** and a government contractor to verify applicants' incomes if they are seeking financial assistance.

**Veterans Health Administration, Defense Department, Office of Personnel Management, Medicare, Peace Corps** and the applicant's state Medicaid agency to check that they are not already enrolled in other health insurance programs.

### Comparing options, picking a plan

The Web site shows applicants their options, which can include private insurance plans and coverage through government programs. The site also tells them if they qualify for tax credits or a discount on out-of-pocket costs. Applicants choose a plan.

### PROBLEM

Insurers have received few enrollment files from the federal exchange, and many files are incomplete, missing

### Confirmation of enrollment

The exchange sends the applicants' information to the insurance company. The insurance company sends confirmation to the federal exchange.

crucial information on  
consumers who  
signed up.

**Covered**  
Coverage can begin as early as Jan. 1, 2014.

Sources: Centers for Medicare & Medicaid Services, Department of Health and Human Services

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## Tracking the Progress of the Health Exchanges

The Affordable Care Act's insurance marketplaces opened on Oct. 1. Technological problems prevented some people from creating accounts, comparing plans or learning whether they qualify for a federal subsidy to help pay for coverage. Sixteen states and the District of Columbia have created their own exchanges, and the federal government is managing a marketplace in 34 states. [Related Article »](#)

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**Exchanges managed by the federal government**

Failure of a major software component in the federal exchange Web site have caused problems for people trying to enroll in plans. By Friday, the exchange reported 8.6 million unique visitors to its Web site.

**California**

The exchange had more than 514,000 unique visitors on its Web site, and 7,700 applications were started on opening day.

**Colorado**

The exchange saw 8,400 accounts created during the first two days, and its Web site is averaging about 50,000 unique visitors a day.

---

**Connecticut**

The exchange had 109,861 visitors and had processed 1,426 applications as of Tuesday. The most expensive tier of plans is not currently being offered.

**District of Columbia**

By Monday, more than 6,000 people had shopped for plans and more than 1,000 applications had been submitted online. While people can apply for subsidies, the exact amount will be e-mailed to them in early November.

**Hawaii**

The Web site had nearly 20,000 unique visits on the first day. But users cannot yet compare prices of the 95 plans being offered, or get their exact subsidy amount.

---

**Idaho**

**Kentucky**

**Maryland**

Though the exchange is run by the state, all applications will be routed through the federal system for the next year or two.

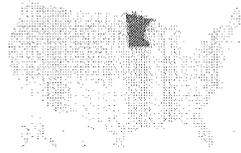
More than 8,000 individuals or families have enrolled for coverage, and more than 17,000 have completed applications.

The Web site was disconnected several times on Tuesday. Enrollment counselors said they had to resort to paper applications during the first days because the site remained slow. As of Monday, more than 13,500 people had created accounts.



**Massachusetts**

More than 6,000 applications had been started and nearly 1,200 completed by Monday. But the exchange is currently unable to provide subsidy or Medicaid information. That feature will be made available within the month.



**Minnesota**

Some users had trouble signing up, but by Tuesday, 6,800 Minnesotans had created accounts.



**Nevada**

As of 5 p.m. on Monday, 19,931 accounts had been created through the exchange.



**New Mexico**

New Mexico runs the exchange for employers but uses the federal exchange for individuals and families. By Friday afternoon, 428 employers had signed up.



**New York**

The exchange doubled its server capacity after a surge of traffic overwhelmed its Web site on opening day. Nearly 65,500 people had actively shopped for plans as of Friday, and on Tuesday, the exchange reported that more than 40,000 had completed applications.



**Oregon**

The exchange cannot yet accept applications, but its Web site had 230,000 unique visitors during the first week.



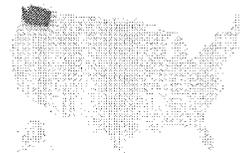
**Rhode Island**

A surge of traffic caused the Web site to crash briefly on Tuesday. By Friday, 580 applications had been processed and 2,929 accounts created.



**Vermont**

By Tuesday afternoon, the exchange had more than 46,000 unique visitors to its Web site, and more than 3,600 accounts had been established.



**Washington**

The Web site was taken offline for much of the first day, but it was running more smoothly by Thursday. More than 39,000 people have created accounts, and nearly 9,500 have enrolled in plans.

*New Mexico and Idaho are state-based exchanges but for now, are using the federal exchange infrastructure for the first year.*

By KEITH COLLINS, JOSHUA KATZ and HAEYOUN PARK

Sources: State exchanges; Centers for Medicare and Medicaid Services; Kaiser Family Foundation

10

October 2013 | Issue Brief

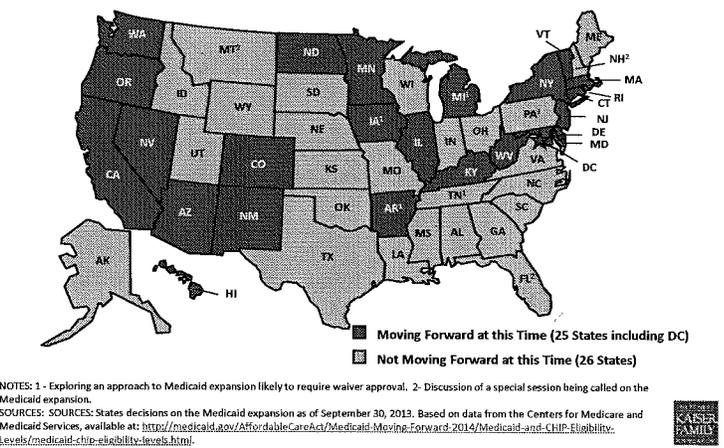
## The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid

The expansion of Medicaid eligibility to nearly all low-income adults is a core component of the coverage provisions in the 2010 Affordable Care Act (ACA). The ACA Medicaid expansion provides a link between new private coverage options available through either Health Insurance Marketplaces or employers and the existing Medicaid program, which previously had many gaps in coverage for adults. Historically, Medicaid eligibility generally was restricted to low income individuals in a specified category, such as children, their parents, the aged, or individuals with disabilities. In most states, adults without dependent children were not eligible for Medicaid. Further, eligibility levels for parents were generally set very low and varied greatly across states. As a result, only 30% of poor nonelderly adults had Medicaid coverage in 2012, compared to 70% of poor children, and uninsured rates for poor adults (42%) were well over twice the national average (18%).<sup>1</sup>

The expansion of Medicaid, effective in January 2014, fills in historical gaps in Medicaid eligibility for low-income adults and has the potential to extend health coverage to millions of currently uninsured individuals. This expansion essentially sets a national Medicaid income eligibility level of 138% of poverty (about \$27,000 for a family of three<sup>2</sup>) for adults. The expansion was intended to be national and to be the vehicle for covering low-income individuals, with premium tax credits for Marketplace coverage serving as the vehicle for covering people with higher incomes. However, the June 2012 Supreme Court ruling made the expansion of Medicaid optional for states, and as of September 2013, 26 states did not plan to implement the expansion (Figure 1).

Figure 1

### Status of State Medicaid Expansion Decisions, as of September 30, 2013

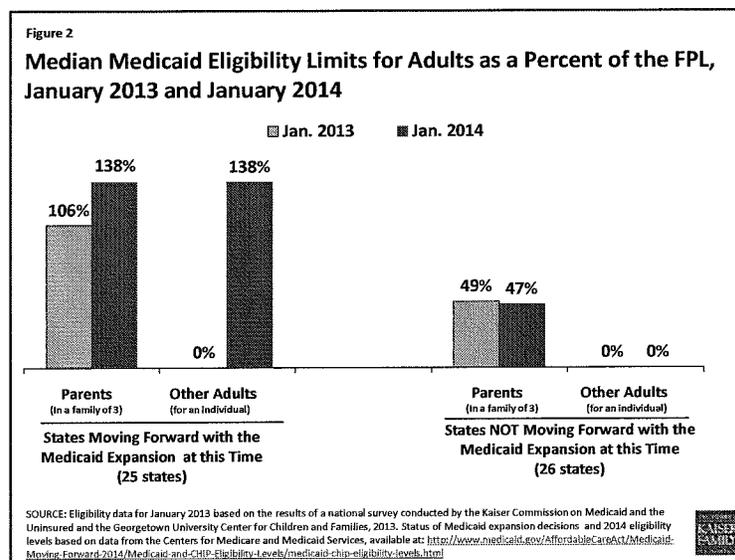


In states that do not expand Medicaid, over five million poor uninsured adults have incomes above Medicaid eligibility levels but below poverty and may fall into a “coverage gap” of earning too much to qualify for Medicaid but not enough to qualify for Marketplace premium tax credits. Most of these people have very limited coverage options and are likely to remain uninsured. This brief describes the coverage gap and presents estimates of the population that falls into this situation. An overview of the methodology underlying the analysis can be found in the Methods box at the end of the report, and more detail is available in the accompanying Technical Appendices.

## THE ACA MEDICAID EXPANSION & THE COVERAGE GAP

Effective January 2014, the ACA establishes a new minimum Medicaid eligibility level of 138% of poverty for non-disabled adults who were not previously eligible for the program. As with current Medicaid, legal immigrants who have been in the country for five years or less and immigrants who are not lawfully present are not eligible for this coverage. The federal government will finance the full cost of the Medicaid expansion for the first three years (2014-2016); after that, the federal government's share of costs will phase down, reaching 90% in 2020. Nationally, 17 million currently uninsured nonelderly adults may meet the income and citizenship criteria to be eligible for Medicaid after the expansion.<sup>3</sup> The number of eligible individuals varies by state, reflecting the income and age distribution in the state as well as the current scope of insurance coverage.

Many of the 25 states moving forward with the Medicaid expansion already offer coverage for parents up to poverty, but adults without dependent children are generally ineligible (see Figure 2). In these states, the expansion extends Medicaid eligibility to all parents and other adults up to the new Medicaid limit. For people with incomes above that limit, other provisions of the ACA—particularly the availability of premium tax credits to purchase individual coverage through the Health Insurance Marketplaces—will facilitate access to affordable coverage.



In most states that do not expand Medicaid, however, many people will be left without an affordable coverage option. Medicaid eligibility for adults in states not moving forward with the ACA Medicaid expansion is limited. As of January 2014, the median eligibility level for parents in states not moving forward will be just 47% of poverty, or about \$9,400 a year for a family of three (Figure 2). Only four states not expanding Medicaid (Alaska, Maine, Tennessee, and Wisconsin) cover parents up to at least poverty (see Table 1), and eligibility limits in some states are less than 20% of the poverty level (16% in Alabama, 19% in Texas). Of the states not moving forward with the expansion, only Wisconsin provides Medicaid coverage to adults without dependent children.<sup>4</sup>

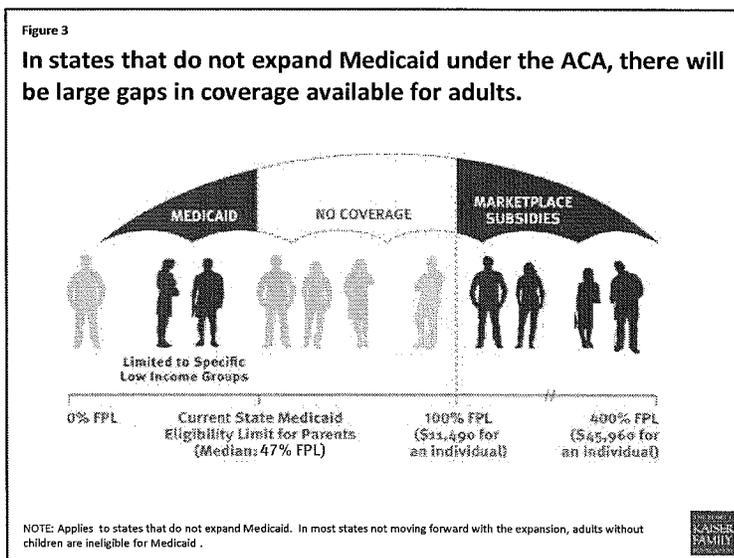
**Table 1: Medicaid Adult Income Eligibility Limits as a Percent of the Federal Poverty Level in States Not Moving Forward with the ACA Medicaid Expansion, January 2014**

	Parents of Dependent Children (in a family of three)		Other Adults (Non- Disabled) (for an individual)	
	As a share of poverty	As an annual income limit	As a share of poverty	As an annual income limit
<b>Median</b>	<b>47%</b>	<b>\$ 9,245</b>	<b>0%</b>	<b>0%</b>
Alabama	16%	\$ 3,221	0%	\$ 0
Alaska	128%	\$ 31,245	0%	\$ 0
Florida	35%	\$ 6,809	0%	\$ 0
Georgia	39%	\$ 7,589	0%	\$ 0
Idaho <sup>5</sup>	27%	\$ 5,357	0%	\$ 0
Indiana <sup>5</sup>	24%	\$ 4,697	0%	\$ 0
Kansas	38%	\$ 7,421	0%	\$ 0
Louisiana <sup>5</sup>	24%	\$ 4,685	0%	\$ 0
Maine <sup>5</sup>	105%	\$ 20,513	0%	\$ 0
Mississippi	29%	\$ 5,669	0%	\$ 0
Missouri <sup>5</sup>	24%	\$ 4,661	0%	\$ 0
Montana <sup>5</sup>	52%	\$ 10,109	0%	\$ 0
Nebraska	55%	\$ 10,817	0%	\$ 0
New Hampshire	75%	\$ 14,645	0%	\$ 0
North Carolina	45%	\$ 8,861	0%	\$ 0
Ohio <sup>5</sup>	95%	\$ 18,557	0%	\$ 0
Oklahoma <sup>5</sup>	48%	\$ 9,377	0%	\$ 0
Pennsylvania	38%	\$ 7,421	0%	\$ 0
South Carolina	67%	\$ 13,085	0%	\$ 0
South Dakota	54%	\$ 10,529	0%	\$ 0
Tennessee	111%	\$ 21,677	0%	\$ 0
Texas	19%	\$ 3,737	0%	\$ 0
Utah <sup>5</sup>	47%	\$ 9,113	0%	\$ 0
Virginia	52%	\$ 10,121	0%	\$ 0
Wisconsin <sup>5</sup>	100%	\$ 19,529	100%	\$ 11,490
Wyoming	59%	\$ 11,453	0%	\$ 0

NOTE: Reflects eligibility levels for MAGI groups, including 5 percentage point income disregard. For more detail on who is included in MAGI groups, see: Kaiser Commission on Medicaid and the Uninsured. *Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule*. December 2012, available at:

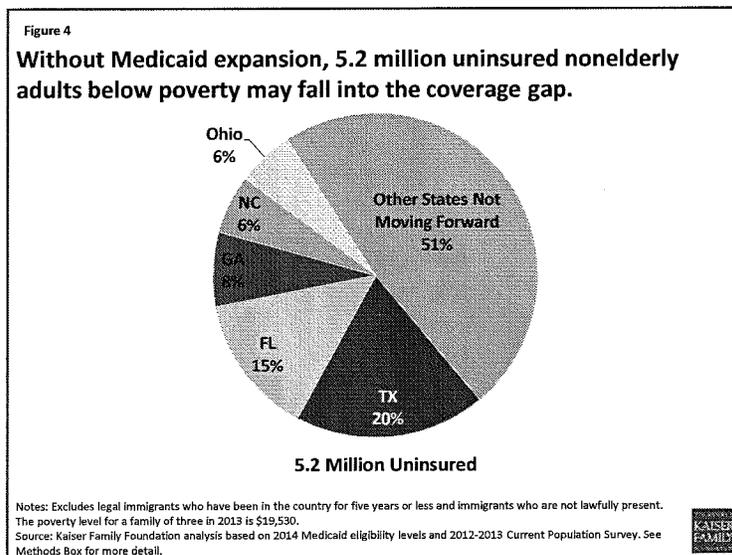
<http://www.kff.org/medicaid/issue-brief/medicaid-eligibility-enrollment-simplification-and-coordination-under-the-affordable-care-act-a-summary-of-cmss-march-23-2012-final-rule/> SOURCE: Status of Medicaid expansion decisions and 2014 eligibility levels based on data from the Centers for Medicare and Medicaid Services, available at: <http://medicaid.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Medicaid-and-CHIP-Eligibility-Levels/medicaid-chip-eligibility-levels.html>.

The ACA envisioned people below 138% of poverty receiving Medicaid and thus does not provide premium tax credits for the lowest income. As a result, individuals below poverty are not eligible for Marketplace tax credits, even if Medicaid coverage is not available to them. Individuals with incomes above 100% of poverty in states that do not expand may be eligible to purchase subsidized coverage through the Marketplaces; however, only about a third of uninsured adults (3.2 million people) who could have been eligible for Medicaid if their state expanded fall into this income range. Thus, there will be a large gap in coverage for adults in states that do not expand Medicaid (Figure 3).



## ESTIMATES OF PEOPLE IN THE COVERAGE GAP

Nationally, over five million poor uninsured adults will fall into the “coverage gap” that results from state decisions not to expand Medicaid (Figure 4 and Table 2), meaning their income is above current Medicaid eligibility but below the lower limit for Marketplace premium tax credits. These individuals would have been newly-eligible for Medicaid had their state chosen to expand coverage. A fifth of people in the coverage gap reside in Texas, which has both a large uninsured population and very limited Medicaid eligibility (Figure 4). Fifteen percent live in Florida, eight percent in Georgia, six percent live in North Carolina, and another six percent live in Ohio.



The population in the coverage gap represents over a quarter (27%) of the uninsured adult population in states that are not expanding Medicaid (Table 2). This share ranges across states, from a low of 18% in Alaska to a high of 37% in Mississippi. This variation reflects not only variation in Medicaid eligibility but also variation in the income distribution of the uninsured by state. There are no uninsured adults in the coverage gap in Wisconsin because the state will provide Medicaid eligibility to adults up to the poverty level in 2014. Looking only at uninsured adults below 139% of poverty in non-expansion states—the income range originally targeted for the Medicaid expansion— about half fall into the coverage gap. The remaining share either may be eligible for Medicaid under non-expansion rules or could receive tax credits to purchase coverage in the Marketplace. The share of the Medicaid-target population that falls into the coverage gap varies by state, from 40% in Alaska (again, 0% in Wisconsin) to 65% in Oklahoma.

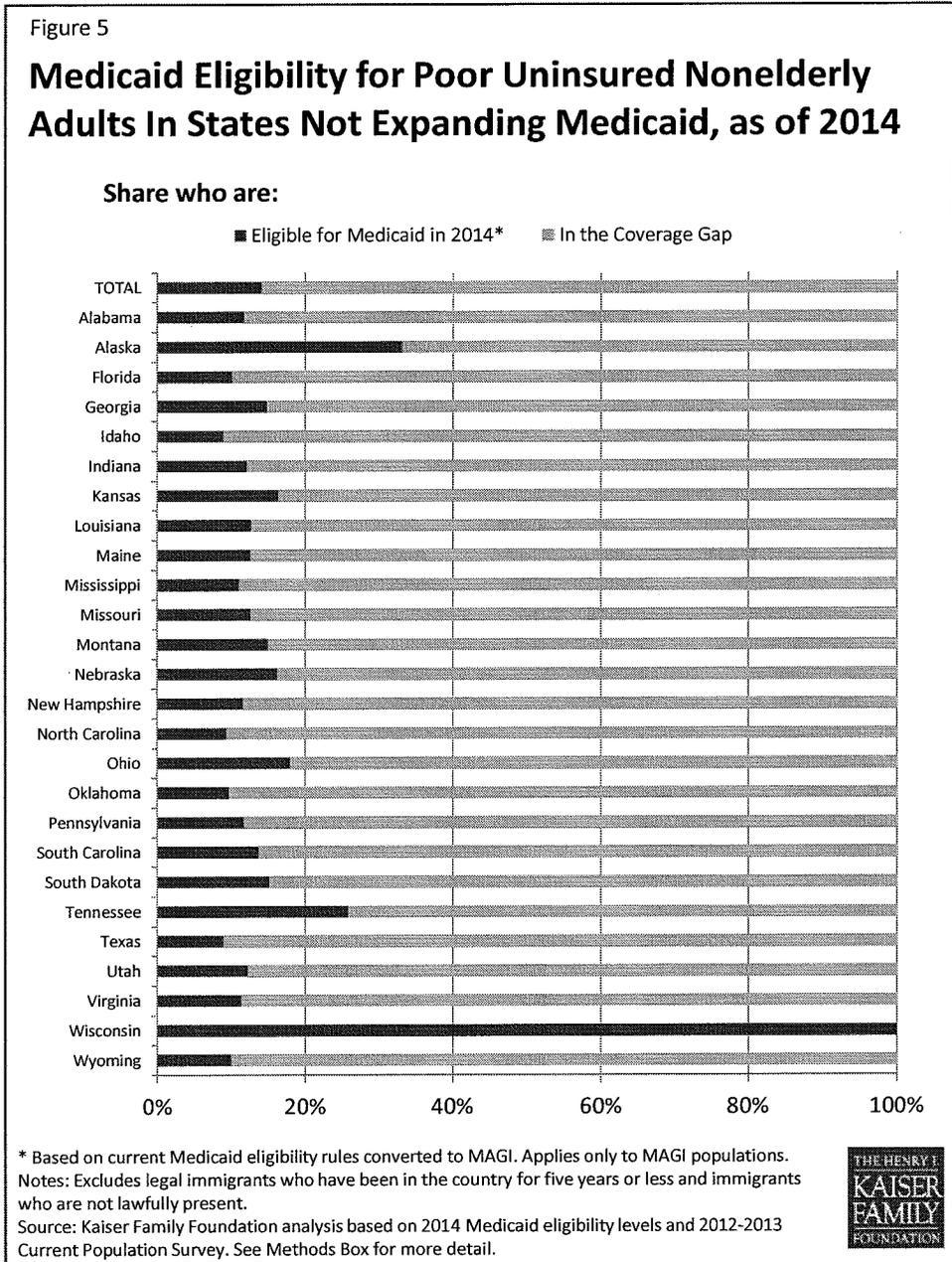
**Table 2: Number of Poor Uninsured Nonelderly Adults in the ACA Coverage Gap, by State**

State	Number in Coverage Gap	As a Share of All Uninsured Nonelderly Adults in State	As a Share of Low-Income (<139% FPL) Uninsured Nonelderly Adults in State	As a Share of Poor (<100% FPL) Uninsured Nonelderly Adults in State
<b>Total in states not moving forward with Medicaid expansion</b>	<b>5,161,820</b>	<b>27%</b>	<b>56%</b>	<b>86%</b>
Alabama	191,320	36%	63%	88%
Alaska	17,290	18%	40%	67%
Florida	763,890	27%	58%	90%
Georgia	409,350	31%	60%	85%
Idaho	54,780	30%	60%	91%
Indiana	181,930	28%	56%	88%
Kansas	77,920	29%	55%	84%
Louisiana	242,150	34%	60%	87%
Maine	24,390	22%	57%	87%
Mississippi	137,800	37%	61%	89%
Missouri	193,420	30%	61%	87%
Montana	40,140	27%	56%	85%
Nebraska	32,570	20%	52%	84%
New Hampshire	26,190	20%	54%	88%
North Carolina	318,710	28%	58%	91%
Ohio	330,240	28%	55%	82%
Oklahoma	144,480	28%	65%	90%
Pennsylvania	281,290	25%	56%	88%
South Carolina	194,330	33%	59%	86%
South Dakota	25,480	29%	56%	85%
Tennessee	161,650	24%	47%	74%
Texas	1,046,430	27%	56%	91%
Utah	57,850	21%	55%	88%
Virginia	190,840	25%	55%	89%
Wisconsin	-	-	-	-
Wyoming	17,390	23%	59%	69%

Note: Excludes undocumented immigrants and legal immigrants who have been in the US for < 5 years.

Source: KFF analysis of March 2012 and 2013 CPS and Medicaid MAGI eligibility levels. See Methods Box for more detail.

Among poor uninsured adults, the share that falls into the coverage gap varies across states, reflecting both Medicaid eligibility levels and the income distribution of adults below poverty (Table 1 and Figure 5). Nationally, 86% of poor uninsured adults in states not expanding are ineligible for Medicaid. The share of poor uninsured adults in the gap ranges from a high of 91% in Idaho, North Carolina and Texas to 67% in Alaska. However, in most states not moving forward with the ACA Medicaid expansion, the vast majority of poor adults will remain ineligible for Medicaid coverage. Some of those who are eligible for Medicaid but not currently enrolled may take up coverage as a result of new outreach under the ACA; however, many are likely to remain uninsured.



## CONCLUSION

The ACA was passed with the goal of filling in gaps in the availability of affordable health coverage in the United States. Given particularly high uninsured rates for adults living below poverty, the expansion of Medicaid to all adults up to 138% of poverty is a key component of this effort. In states that expand their Medicaid programs, millions of adults will gain Medicaid coverage under the law. However, with many states opting not to implement the Medicaid expansion, millions of adults will remain outside the reach of the ACA and continue to have limited, if any, option for health coverage: most do not have access to employer-based coverage through a job, few can afford coverage on their own, and most are currently ineligible for public coverage in their state. While a small share may be eligible to purchase subsidized coverage through the new Health Insurance Marketplaces, most have incomes below the poverty level and thus will be ineligible for these premium tax credits. It is unlikely that people who fall into the coverage gap will be able to afford Marketplace coverage: The national average premium for a 40-year-old individual purchasing coverage through the Marketplace is \$270 per month for a silver plan and \$224 per month for a bronze plan,<sup>6</sup> which equates to about half of income for those at the lower income range of people in the gap and about a quarter of income for those at the higher income range of people in the gap. Further, people in the coverage gap are ineligible for cost-sharing subsidies for Marketplace plans and may face additional out-of-pocket costs up to \$6,350 a year if they were to purchase Marketplace coverage. Given the limited budgets of people in the coverage gap, these costs are likely prohibitively expensive.

People in the coverage gap are likely to face barriers to needed health services or, if they do require medical care, potentially serious financial consequences. Further, the safety net of clinics and hospitals that has traditionally served the uninsured population will continue to be stretched in these states. Notably, there is no deadline for state decisions about implementing the Medicaid expansion. Millions will be helped by the insurance provisions in the law; however, more than five million poor adults in states not expanding Medicaid coverage will be ineligible for assistance, while millions more who earn more than they do will receive tax credits to help them pay for coverage in the new insurance Marketplaces. The number and distribution of this population by state will be the subject of a forthcoming Kaiser Family Foundation report.

## Methods

This analysis uses pooled data from the 2012 and 2013 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC). The CPS ASEC provides socioeconomic and demographic information for the United States population and specific subpopulations. Importantly, the CPS ASEC provides detailed data on families and households, which we use to determine income for ACA eligibility purposes (see below for more detail). We merge two years of data in order to increase the precision of our estimates.

Medicaid and Marketplaces have different rules about household composition and income for eligibility. For this analysis, we calculate household membership and income for both Medicaid and Marketplace premium tax credits for each person individually, using the rules for each program. For more detail on how we construct Medicaid and Marketplace households and count income, see the detailed technical Appendix A available at [here](#).

Immigrants who are not lawfully present are ineligible for Medicaid and Marketplace coverage. Since CPS data do not directly indicate whether an immigrant is lawfully present, we impute documentation status for each person in the sample. To do so, we draw on the methodology in the State Health Access Data Assistance Center (SHADAC) paper, “State Estimates of the Low-Income Uninsured Not Eligible for the ACA Medicaid Expansion.”<sup>7</sup> This approach uses the Survey of Income and Program Participation (SIPP) to develop a model that predicts immigration status; it then applies the model to CPS, controlling to state-level estimates of total undocumented population from Department of Homeland Security. For more detail on the immigration imputation used in this analysis, see the technical Appendix B available at [here](#).

As of January 2014, Medicaid financial eligibility for most nonelderly adults will be based on modified adjusted gross income (MAGI). To determine whether each individual is eligible for Medicaid, we use each state’s MAGI eligibility level that will be effective as of 2014.<sup>8</sup> Some nonelderly adults with incomes above MAGI levels may be eligible for Medicaid through other pathways; however, we only assess eligibility through the MAGI pathway.<sup>9</sup>

An individual’s income is likely to fluctuate throughout the year, impacting his or her eligibility for Medicaid. Our estimates are based on annual income and thus represent a snapshot of the number of people in the coverage gap at a given point in time. Over the course of the year, a larger number of people are likely to move and out of the coverage gap as their income fluctuates.

<sup>1</sup> Urban Institute and Kaiser Commission on Medicaid and the Uninsured analysis based on the Census Bureau’s March 2013 Current Population Survey (CPS: Annual Social and Economic Supplements).

<sup>2</sup> The 2013 federal poverty guideline for a family of three was \$19,530. See: <http://aspe.hhs.gov/poverty/13poverty.cfm>

<sup>3</sup> Kaiser Family Foundation analysis of March 2013 Current Population Survey. See Methods Box for more detail.

<sup>4</sup> Some of these states currently provide more limited benefits than Medicaid to childless adults under Section 1115 Medicaid waiver demonstration authority. Wisconsin extends Medicaid to childless adults with incomes up to 100% FPL.

<sup>5</sup> January 2014 eligibility limits in Idaho, Indiana, Louisiana, Maine, Missouri, Montana, Ohio, Oklahoma, Utah, and Wisconsin reflect coverage under the Medicaid state plan. These states have additional coverage for parents or other adults above state plan limits through a section 1115 demonstration or a pending demonstration proposal. The demonstrations include limits on eligibility and/or benefits, do not offer coverage to all residents of the state, and/or include an enrollment cap.

<sup>6</sup> The methods for arriving at this estimate can be found on the Kaiser Family Foundation Subsidy Calculator, (available here: <http://www.kff.org/interactive/subsidy-calculator/>). The calculator is based on Congressional Budget Office (CBO) projections from July 2012 (Available here: <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>)

<sup>7</sup> State Health Access Data Assistance Center. 2013. “State Estimates of the Low-income Uninsured Not Eligible for the ACA Medicaid Expansion.” Issue Brief #35. Minneapolis, MN: University of Minnesota. Available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf404825](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf404825).

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<sup>8</sup> Kaiser Commission on Medicaid and the Uninsured. *Fact Sheet: Medicaid Eligibility for Adults as of January 1, 2014*. (Washington, DC: Kaiser Family Foundation), October 1, 2014. Available at: <http://www.kff.org/medicaid/fact-sheet/medicaid-eligibility-for-adults-as-of-january-1-2014/>.

<sup>9</sup> Non- MAGI pathways for nonelderly adults include disability-related pathways, such as SSI beneficiary; Qualified Severely Impaired Individuals; Working Disabled; and Medically Needy. We are unable to assess disability status in the CPS sufficiently to model eligibility under these pathways. However, previous research indicates high current participation rates among individuals with disabilities (largely due to the automatic link between SSI and Medicaid in most states, see Kenney GM, V Lynch, J Haley, and M Huntress. "Variation in Medicaid Eligibility and Participation among Adults: Implications for the Affordable Care Act." *Inquiry*. 49:231-53 (Fall 2012)), indicating that there may be a small number of eligible uninsured individuals in this group. Further, many of these pathways (with the exception of SSI, which automatically links an individual to Medicaid in most states) are optional for states, and eligibility in states not implementing the ACA expansion is limited. For example, the median income eligibility level for coverage through the Medically Needy pathway is 15% of poverty in states that are not expanding Medicaid, and most states not expanding Medicaid do not provide coverage above SSI levels for individuals with disabilities. (See: O'Mally-Watts, M and K Young. *The Medicaid Medically Needy Program: Spending and Enrollment Update*. (Washington, DC: Kaiser Family Foundation), December 2012. Available at: <http://www.kff.org/medicaid/issue-brief/the-medicaid-medically-needy-program-spending-and/>. And Kaiser Commission on Medicaid and the Uninsured, "Medicaid Financial Eligibility: Primary Pathways for the Elderly and People with Disabilities," February 2010. Available at: <http://www.kff.org/medicaid/issue-brief/medicaid-financial-eligibility-primary-pathways-for-the-elderly-and-people-with-disabilities/>.



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Laurie Kane-Lewis  
10/21/13

## Report says neediest health centers to get least ACA funding for patients

Community health centers in states that have rejected Medicaid expansion under the Affordable Care Act will forgo more than half a billion dollars in new revenue in 2014, according to a new report from the George Washington University School of Public Health and Health Services.

By CHRISTINE VESTAL

Stateline.org

WASHINGTON — Community health centers in states that have rejected Medicaid expansion under the Affordable Care Act will forgo more than half a billion dollars in new revenue in 2014, according to a new report from the George Washington University School of Public Health and Health Services. New Hampshire legislators are still working to decide how to proceed with Medicaid expansion.

The study for the first time quantifies the "spillover" effect of states' failure to expand Medicaid. In 2014, the study estimates, community health centers in the 25 states that have chosen to expand Medicaid will gain an estimated \$2 billion in Medicaid money from newly eligible patients. By contrast, the 25 states that have opted out will miss out on an estimated \$555 million.

"Health centers in opt-out states can be expected to struggle, falling further behind their expansion state counterparts in terms of service capacity, number of patients served (both insured and uninsured), and in their ability to invest in initiatives that improve the quality and efficiency of health care," the report states.

The nation's 1,128 federally funded community health centers operate in more than 8,000 locations, and provided care to an estimated 20.2 million patients in 2011. Another 100 so-called "look alike" centers that receive state and local funding served another 1 million patients. Nationally, 72 percent of all patients who receive care at health centers have family incomes below the federal poverty level, and 36 percent of them are uninsured.

Previous research has shown that when patients who frequent a health center become insured, the center's revenues increase. The new money may allow the center to serve more patients, add new services such as dental and mental health care, or expand to additional locations.

Without the new money, the study concludes, health centers in the non-expansion states will continue to struggle.

"It's a huge loss for the whole community, not just for the patients who are uninsured," said Sara Rosenbaum, a lead author of the study. "The health centers doors are open to everyone."

The mostly Southern states that have opted out of the Medicaid expansion have the nation's highest uninsured rates, lowest median incomes and poorest overall health. Overburdened community health centers in those states serve the highest percentage of patients with incomes at or below the federal poverty level, which is \$11,490 for an individual.

"The immediate spillover is revenue loss for the community, which translates into services and jobs," Rosenbaum said. "But in the long term, in a whole swath of the country, these are the health centers that are going to be held back in their ability to improve and expand."

Neighbors Maryland and Virginia illustrate the point: In Maryland, which is expanding Medicaid, more than 39,000 health-center patients will gain Medicaid coverage, generating an estimated \$33 million in revenue in 2014. In Virginia, which has opted not to expand Medicaid, health centers will forgo an estimated \$17 million in revenues from 35,000 uninsured patients who would have qualified for expanded Medicaid.



**Geiger Gibson /  
RCHN Community Health Foundation Research Collaborative**

**Policy Research Brief # 33**

**Assessing the Potential Impact of the Affordable Care Act on  
Uninsured Community Health Center Patients:  
A Nationwide and State-by-State Analysis**

**Peter Shin, PhD, MPH  
Jessica Sharac, MSc, MPH  
Sara Rosenbaum, JD**

The George Washington University  
School of Public Health and Health Services  
Department of Health Policy

**October 16, 2013**

## **About the Geiger Gibson / RCHN Community Health Foundation Research Collaborative**

The Geiger Gibson Program in Community Health Policy, established in 2003 and named after human rights and health center pioneers Drs. H. Jack Geiger and Count Gibson, is part of the School of Public Health and Health Services at The George Washington University. It focuses on the history and contributions of health centers and the major policy issues that affect health centers, their communities, and the patients that they serve.

The RCHN Community Health Foundation, founded in October 2005, is a not-for-profit foundation whose mission is to support community health centers through strategic investment, outreach, education, and cutting-edge health policy research. The only foundation in the country dedicated to community health centers, the Foundation builds on health centers' 40-year commitment to the provision of accessible, high quality, community-based healthcare services for underserved and medically vulnerable populations. The Foundation's gift to the Geiger Gibson program supports health center research and scholarship.

Additional information about the Research Collaborative can be found online at <http://sphhs.gwu.edu/projects/geiger-gibson-program> or at [rchnfoundation.org](http://rchnfoundation.org).

## **Executive Summary**

In this brief, we estimate the number of uninsured community health center (CHC) patients who would gain coverage under the Affordable Care Act using data from the 2009 HRSA Survey of CHC patients and 2011 Uniform Data System. We find that were all states to implement the Affordable Care Act Medicaid expansion, an estimated 5 million uninsured health center patients – or two-thirds of all uninsured patients served by CHCs nationally – would be eligible for coverage. However, over one million uninsured patients – 72% of whom live in southern states -- who would have been eligible for coverage will remain uninsured because of states' decisions to opt out of the expansion. The spillover effects of the decision to opt out of the Medicaid expansion are likely to be significant. Health centers in opt-out states can be expected to struggle, falling further behind their expansion state counterparts in terms of service capacity, number of patients served (both insured and uninsured), and in their ability to invest in initiatives that improve the quality and efficiency of health care.

## Introduction

The Affordable Care Act (ACA) can be expected to provide access to affordable health insurance coverage to most low income Americans. The Act achieves this aim through a combination of two approaches. The Act expands Medicaid to cover all nonelderly adults with incomes up to 138% of the federal poverty level (FPL). The Act also creates new Health Insurance Marketplaces that make subsidized private insurance coverage through Qualified Health Plans (QHPs) available for people with family incomes between 100 and 400% of the FPL. The most significant level of assistance is available to people with family incomes up to 200% FPL, who are eligible for subsidies that reduce the cost of coverage under a reasonably comprehensive insurance plan to 5% of family income or below. For example, a family of 4 with \$40,000 in income in 2014 would qualify for a \$6,325 subsidy toward a health plan purchased in the Marketplace, which otherwise would cost \$8,290 – a discount of more than two-thirds.<sup>1</sup>

Health Insurance Marketplace subsidies were designed to work in tandem with Medicaid. With the exception of certain recently-arrived legal U.S. residents who qualify for subsidies even with poverty-level incomes, eligibility for Marketplace subsidies does not begin until family income exceeds 100% FPL. In states that expand Medicaid to cover all low income adults, Medicaid coverage will extend to 138% FPL and Marketplace subsidies will begin only above this point. In any state that opts out of the Medicaid expansion,<sup>2</sup> the poorest uninsured adults – those with incomes below 100% FPL – will remain completely uninsured unless they can qualify for coverage under the state's traditional program. Traditional Medicaid eligibility rules for nonelderly adults are far more restrictive, however. Eligibility is limited to adults who are pregnant, persons with disabilities, or parents; furthermore, financial eligibility standards for low-income parents average well below 138% FPL.<sup>3</sup> As a result, in a state that opts out, a poor adult who does not fall into a traditional category cannot qualify for Medicaid coverage at any income level, while parents may be unable to qualify unless their incomes are extremely low. As of September 30, 2013, 26 states had elected to opt out of the Medicaid expansion.<sup>4</sup> On October 10th, 2013, Ohio received federal approval for its Medicaid expansion, and final state action is expected by the end of October.<sup>5</sup>

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<sup>1</sup> Kaiser Family Foundation, subsidy calculator, Available at: <http://kff.org/interactive/subsidy-calculator/#state=&zip=&income-type=dollars&income=40%2C000&employer-coverage=0&people=4&adult-count=2&adults%5B0%5D%5Bage%5D=21&adults%5B0%5D%5Btobacco%5D=0&adults%5B1%5D%5Bage%5D=21&adults%5B1%5D%5Btobacco%5D=0&child-count=2&child-tobacco=0> (Accessed online October 8, 2013).

<sup>2</sup> This option was not part of the original law but was instead created by the United States Supreme Court's decision in *NFIB v Sebelius*, which held that states could not be compelled to expand their existing programs to encompass all non-elderly low income adults.

<sup>3</sup> Kaiser Family Foundation State Health Facts. (October 1, 2013). Medicaid Income Eligibility Limits for Adults at Application, Effective January 1, 2014. Available at: <http://kff.org/medicaid/state-indicator/medicaid-income-eligibility-limits-for-adults-at-application-effective-january-1-2014/>

<sup>4</sup> Centers for Medicare and Medicaid Services (CMS). (September 30, 2013). State Medicaid and CHIP Income Eligibility Standards Effective January 1, 2014. Available at: <http://www.medicare.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/Downloads/Medicaid-and-CHIP-Eligibility-Levels-Table.pdf>

<sup>5</sup> Higgs, R. (October 11, 2013). Ohio gains federal approval to expand its Medicaid program to cover state's working poor. [http://www.cleveland.com/open/index.ssf/2013/10/ohio\\_gains\\_federal\\_approval\\_to.html](http://www.cleveland.com/open/index.ssf/2013/10/ohio_gains_federal_approval_to.html)

In 2011, the nation's 1,128 community health centers (CHC) operating at more than eight thousand medically underserved urban and rural sites provided health care to over 20.2 million patients.<sup>6</sup> An additional 100 "look alike" health centers served another 1 million patients that year. Health center patients are extremely poor. As a result, health center patients are extremely sensitive to state Medicaid eligibility decisions. Nationally, 72% percent of all patients who receive care at health centers have family incomes below 100% of the federal poverty level (\$19,530 for a family of 3 in 2013), while 92% have family incomes below twice the FPL (\$58,590 for a family of 3 in 2013). In 2011, 36% of all patients (7.4 million people) were uninsured.

As their uninsured patients gain coverage, health centers in turn can be expected to realize significant growth in financial resources, a crucial consideration in light of the fact that health centers by law serve all community residents, regardless of their insurance status. Despite the insurance expansions resulting from the ACA, health centers can be expected to continue to see large numbers of patients who remain uninsured on either a short-term or long-term basis. They will also serve as a source of care for patients who are covered but unable to afford the deductibles and coinsurance that are part of qualified health plans sold in the Marketplace, even at the reduced levels made possible through the cost-sharing assistance also available under the ACA. The added revenues realized from the coverage expansions, however, will enable health centers to expand into new communities, to increase the number of patients served, to add badly needed services such as adult dental and mental health care, and to increase clinical staffing levels.

Previous research has documented the favorable spillover effects on health centers of expanding insurance coverage to the poor. Studies have demonstrated the link between higher levels of insurance coverage among adult patients and improved health center capacity as measured by the level and scope of health care, the number of patients served, the number of service locations, clinical staffing levels, and health care quality.<sup>7</sup> Other research, which focused on the unique experience of Massachusetts's health centers, shows how comprehensive health reform affects health center capacity for both insured and uninsured patients.<sup>8</sup> Massachusetts's 2006 health reform law helped fuel a significant expansion in health centers' service capacity; at the same time, while the overall proportion of uninsured patients served by health centers declined significantly in the years following health reform, the proportion of CHC patients without health insurance stood at 21.3% in 2011, more than 6 times

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<sup>6</sup> Bureau of Primary Health Care. (2012). *Uniform Data System (UDS) Report 2011*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: [http://bphc.hrsa.gov/uds/doc/2011/National\\_Universal.pdf](http://bphc.hrsa.gov/uds/doc/2011/National_Universal.pdf)

<sup>7</sup> Kaiser Family Foundation. (2012) *Medicaid and community health centers: The relationship between coverage for adults and primary care capacity in medically underserved communities*. Available at: <http://kff.org/health-reform/issue-brief/medicaid-and-community-health-centers-the-relationship/>

<sup>8</sup> Ku, L., Jones, E., Shin, P., Byrne, F.R., and Long, S.K. (2011) Safety-net providers after health reform: Lessons from Massachusetts. *Arch Intern Med*, 171(15): 1379-84.

the statewide average of 3.4%.<sup>9</sup> Furthermore, while the overall proportion of uninsured patients fell, the actual number of uninsured residents receiving care at Massachusetts health centers increased by 6% between 2007 and 2011.<sup>10</sup> In sum, the ACA insurance expansions can be expected to strengthen health centers' overall operations, while also growing their capacity to treat the remaining uninsured residents.

## Estimated Impact

Because of the ACA's income eligibility rules for Medicaid and for substantial premium subsidies and cost sharing assistance, three distinct income ranges become important in estimating the potential effects of state coverage choices on health centers and patients. The first is the number of patients with incomes at or below 138% FPL, the Medicaid eligibility upper income limit in states that expand. The second key income range is the number of patients with incomes at or below 100% FPL, the population that will remain ineligible for Marketplace premium subsidies and cost-sharing assistance in states that opt out of the Medicaid expansion. The third pertinent income range is the number of health center patients with incomes between the Marketplace threshold (either 100% or 138% FPL) and 200% FPL, where premium subsidies and cost-sharing assistance are sufficiently generous to make a significant difference in patients' ability to afford care.

Using data from the 2009 Health Center User Survey and the 2011 Uniform Data System (UDS), we estimated the potential impact of the ACA on uninsured CHC patients both nationally and by state. We present results in Tables 2 and 3, which display estimates for states that expand Medicaid as well as for those that opt out of the expansion. The 2009 survey, which was administered by the Health Resources and Services Administration (HRSA), represents the most current patient-level information available on CHC patients nationally.<sup>11</sup> Because the proportion of low income non-elderly adults nationally who are uninsured appears to have changed little (0.2% increase) from 2007-2011,<sup>12</sup> the survey

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<sup>9</sup> Bureau of Primary Health Care. (2012). *Uniform Data System (UDS) Massachusetts Rollup Report 2011*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: [http://bphc.hrsa.gov/uds/doc/2011/UDS\\_2011\\_Rollups\\_MA\\_Universal.pdf](http://bphc.hrsa.gov/uds/doc/2011/UDS_2011_Rollups_MA_Universal.pdf); US Census Bureau. (2012). Current Population Survey, Annual Social and Economic Supplement. <http://www.census.gov/cps/data/cpstalecreator.html>

<sup>10</sup> Number of uninsured in MA increased from 123,388 in 2007 to 131,141 in 2011. Bureau of Primary Health Care. (2008). *Uniform Data System (UDS) Massachusetts Rollup Report 2007*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: [http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/2007/MA/07rollup\\_statema\\_08jul2008.pdf](http://bphc.hrsa.gov/healthcenterdatastatistics/statedata/2007/MA/07rollup_statema_08jul2008.pdf); Bureau of Primary Health Care. (2012). *Uniform Data System (UDS) Massachusetts Rollup Report 2011*. Washington, DC: Health Resources and Services Administration, US Department of Health and Human Services. Available at: [http://bphc.hrsa.gov/uds/doc/2011/UDS\\_2011\\_Rollups\\_MA\\_Universal.pdf](http://bphc.hrsa.gov/uds/doc/2011/UDS_2011_Rollups_MA_Universal.pdf)

<sup>11</sup> The CHC survey estimates are based on 4,562 CHC patients that represent a weighted total of over 16.5 million CHC patients. The survey included questions on family income and family size that were combined with 2009 poverty guidelines to categorize federal poverty levels.

<sup>12</sup> Kaiser Commission on Medicaid and the Uninsured. (2013). *Reversing the Trend? Understanding the Recent Increase in Health Insurance Coverage among the Nonelderly Population*. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/04/8264-02.pdf>

continues to be a source of reliable information in estimating the impact of the ACA on uninsured CHC patients. The 2011 UDS data consist of organizational, financial, patient mix, and utilization summaries submitted to HRSA by each federally-funded health center.

Table 1 shows the income distribution of uninsured CHC patients by various eligibility levels. For states expanding Medicaid, the key ranges consist of Medicaid assistance up to 138% FPL coupled with Marketplace premium assistance between 138% and 200% FPL. (Because of Medicaid's 5-year waiting period, legal residents generally would receive help through Marketplace premium assistance regardless of income). For states that opt out of the Medicaid expansion, the critical ranges are incomes up to 100% FPL and 100%-200% FPL. Table 1 shows, not surprisingly, that the majority of CHC patients who are uninsured are poor and are most likely to qualify for Medicaid.

**Table 1. Uninsured health center patients by federal poverty level**

<b>Income range</b>	<b>Distribution of uninsured CHC patients (2009), by income</b>	<b>Estimated number of uninsured health center patients (2011)*</b>
≤100% FPL	53%	3,903,005
101-200% FPL	31%	2,282,890
201-400% FPL	13%	957,341
>400% FPL	3%	220,925
≤138% FPL	70%	5,154,913
139-400% FPL	27%	1,988,323
≤400% FPL	97%	7,143,236

\*Calculated by multiplying 2<sup>nd</sup> column percentages by the 7,364,161 uninsured reported in the 2011 UDS

Source: 2009 CHC User Survey, HRSA and the 2011 UDS, HRSA

**Tables 2 and 3** present state-level data on the overall size of the health center patient population and the number of health center patients who are uninsured. In order to illustrate the impact of states' Medicaid expansion decisions on health center revenues, we also estimate, separately for non-expansion/opt-out and expansion states, the potential state-specific revenue gains and losses under a full Medicaid expansion scenario as compared with a non-expansion scenario.<sup>13</sup> This was calculated by multiplying the number of uninsured health center patients who were expected to gain coverage by the average per capita Medicaid revenue received by health centers in 2011.

Because the 2011 UDS does not report on uninsured patients by income, we applied the Urban Institute's estimated share of uninsured residents who are expected to gain

<sup>13</sup> Eligibility levels in effect as of January 1, 2014 based on information current as of September 30, 2013, provided to CMS by states either for purposes of FFM programming of state-specific Medicaid/CHIP rules, through state plan amendments, or by direct request from CMS. These levels are subject to change.

coverage in opt-out and opt-in states (see Table A2 in Appendix).<sup>14</sup> Using the Urban Institute formula, we find that approximately 5 million CHC patients nationwide could be expected to gain coverage were all states to expand Medicaid.

### Health centers in the opt-out states

Table 2 shows that health centers in the 25 non-expansion states serve approximately 3.1 million uninsured patients. Based on the Urban Institute statewide projections, we estimate that about 1.2 million CHC patients in these opt-out states can be expected to become eligible for coverage. This means that an estimated one million patients in the opt-out states who would have gained coverage will remain uninsured. Approximately 72% of health center patients who would have gained coverage but will remain uninsured live in southern states<sup>15</sup> (AL, FL, GA, LA, MS, NC, OK, SC, TN, TX, VA).

Some patients might be expected to qualify for Medicaid under traditional eligibility rules (i.e., pregnancy, disability, or status as parents of minor children), but since eligibility levels for parents average below 50% FPL in the opt-out states, the number who qualify on traditional eligibility criteria will be relatively low. At the same time however, the number of eligible health center patients who fail to gain insurance coverage as a result of living in non-expansion states represent approximately half the expected number who would have gained coverage had these states expanded Medicaid. The actual share of health center patients who remain uninsured may be higher than the overall share of the state low income population that remains uninsured in the opt-out states, given the fact that health centers are by law located in the poorest communities with higher concentration of potentially Medicaid-eligible residents.<sup>16</sup>

Opting out of the Medicaid expansion can be expected to have significant spillover effects on health center operations. Had expansion occurred in the opt-out states, health centers would have been expected to generate approximately \$1.2 billion in 2014, adjusted for inflation. Under an opt-out scenario, health centers in these states are expected to receive approximately half that amount, shown on Table 2.

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<sup>14</sup> Buettgens, M., Kenney, G.M., Recht, H., & Lynch, V. (2013). *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States*. Robert Wood Johnson Foundation. Available at: [http://www.rwjf.org/content/dam/farm/reports/issue\\_briefs/2013/rwjf408158](http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf408158)

<sup>15</sup> Based on the U.S.Census Bureau regions.

<sup>16</sup> Kaiser Family Foundation (2013) *Community Health Centers in an Era of Health Reform: An Overview and Key Challenges to Health Center Growth*. Available at: <http://kaiserfamilyfoundation.files.wordpress.com/2013/03/8098-03.pdf>; Rosenbaum, S., Jones, E., Shin, P. and Ku, L.(2009) *National Health Reform: How Will Underserved Communities Fare?* Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Available at: <http://www.rchnfoundation.org/?p=864>; Ku, L., Shin, P., and Rosenbaum, S. (2009) *Estimating the Effects of Health Reform on Health Centers' Capacity to Expand to New Medically Underserved Communities and Populations*. Geiger Gibson/RCHN Community Health Foundation Research Collaborative. Available at: <http://www.rchnfoundation.org/?p=866>

**Table 2. Estimated Impact on Uninsured Patients and Health Center Revenues in States that Opt Out of the ACA Medicaid Expansion**

State	Number of CHCs (2011)	Total CHC patients (2011)	Uninsured CHC patients (2011)	Uninsured eligible with Medicaid expansion	Uninsured eligible without Medicaid expansion	Potential revenue gained in 2014 under Medicaid expansion	Potential revenue gained in 2014 without Medicaid expansion
Alabama	14	320,044	152,414	121,931	57,917	\$55,006,620	\$26,128,144
Alaska	25	91,020	32,216	24,162	13,853	\$29,452,818	\$16,886,283
Florida	44	1,080,695	504,432	343,014	186,640	\$188,666,714	\$102,656,888
Georgia	27	317,299	162,305	113,614	56,807	\$41,472,145	\$20,736,072
Idaho	11	126,354	65,318	48,989	27,434	\$41,565,975	\$23,276,946
Indiana	19	273,536	102,076	79,619	43,893	\$42,721,645	\$23,551,676
Kansas	13	147,489	75,668	54,481	31,024	\$29,088,881	\$16,564,502
Louisiana	24	223,095	86,976	66,102	33,921	\$33,426,925	\$17,153,290
Maine	18	181,171	26,385	20,844	13,984	\$14,806,379	\$9,933,393
Mississippi	21	324,046	134,212	106,027	48,316	\$34,849,947	\$15,880,989
Missouri	21	420,130	145,288	114,778	61,021	\$79,115,667	\$42,061,494
Montana	15	101,406	50,835	41,176	23,892	\$23,444,078	\$13,603,354
Nebraska	6	63,532	33,674	24,245	13,806	\$11,406,865	\$6,495,576
New Hampshire	10	65,466	19,267	14,643	9,441	\$9,590,343	\$6,183,248
North Carolina	28	411,015	214,217	147,810	81,402	\$73,440,392	\$40,445,433
Oklahoma	17	135,272	54,478	39,224	22,336	\$29,228,346	\$16,643,919
Pennsylvania	35	637,928	164,857	126,940	70,889	\$66,923,667	\$37,372,957
South Carolina	20	326,829	129,838	98,677	50,637	\$50,887,002	\$26,113,067
South Dakota	6	58,003	21,328	17,062	8,531	\$9,223,857	\$4,611,928
Tennessee	23	372,360	150,413	114,314	61,669	\$49,637,726	\$26,778,247
Texas	64	975,509	501,327	315,836	170,451	\$180,192,888	\$97,246,956
Utah	11	112,794	62,782	42,692	25,113	\$35,245,488	\$20,732,640
Virginia	25	285,359	108,328	74,746	40,081	\$36,786,082	\$19,725,870
Wisconsin	16	281,591	67,793	51,523	29,151	\$42,776,643	\$24,202,574
Wyoming	5	18,022	7,512	5,334	3,305	\$2,421,402	\$1,500,587
<b>Total</b>	<b>518</b>	<b>7,349,965</b>	<b>3,073,939</b>	<b>2,207,782</b>	<b>1,185,514</b>	<b>\$1,211,378,495</b>	<b>\$656,486,033</b>

## Health centers in the expansion states

Table 3 shows that health centers in expansion states will potentially see 2.8 million patients gain coverage and, as a result, will generate a potential revenue increase of over \$2 billion. Again, the number of CHC patients eligible for new coverage is likely underestimated given the higher prevalence of poverty among CHC patients than the general population.

**Table 3. Estimated Impact on Patients and Health Center Revenues in States that Implement the ACA Medicaid Expansion**

State	Number of CHCs (2011)	Total CHC patients (2011)	Uninsured CHC patients (2011)	Uninsured eligible with Medicaid expansion	Uninsured eligible without Medicaid expansion	Potential revenue gained in 2014 with Medicaid expansion	Potential revenue gained in 2014 without Medicaid expansion
Arizona	16	408,737	118,255	73,318	40,207	\$65,195,104	\$35,752,154
Arkansas	12	156,159	65,858	49,394	26,343	\$23,070,616	\$12,304,329
California	121	3,104,183	1,287,447	823,966	450,606	\$637,033,588	\$348,377,743
Colorado	15	474,241	191,596	126,453	72,806	\$88,070,409	\$50,707,205
Connecticut	13	315,992	73,956	48,071	28,103	\$39,839,839	\$23,290,983
Delaware	3	38,861	15,074	10,401	6,331	\$5,132,612	\$3,124,199
D.C.	4	122,891	20,124	13,282	6,238	\$7,329,804	\$3,442,786
Hawaii	14	137,266	33,911	26,111	11,869	\$21,340,024	\$9,700,011
Illinois	37	1,098,483	339,834	224,290	115,544	\$108,105,419	\$55,690,671
Iowa	13	179,120	61,935	47,071	26,013	\$27,540,900	\$15,219,971
Kentucky	19	278,242	105,406	85,379	43,216	\$56,382,656	\$28,539,369
Maryland	16	282,831	61,633	39,445	21,572	\$33,264,557	\$18,191,554
Massachusetts	36	615,708	131,141	85,242	85,242	\$59,550,775	\$59,550,775
Michigan	29	546,245	178,903	144,911	73,350	\$96,842,052	\$49,018,816
Minnesota	15	165,474	65,113	46,881	27,999	\$28,909,207	\$17,265,221
Nevada	2	57,987	27,730	17,747	9,706	\$7,423,394	\$4,059,669
New Jersey	20	454,243	196,515	115,944	68,780	\$61,669,906	\$36,583,842
New Mexico	15	285,700	111,181	76,715	38,913	\$49,372,208	\$25,043,874
New York	52	1,489,141	373,617	246,587	141,974	\$204,705,824	\$117,860,929
North Dakota	4	32,404	8,975	7,090	4,308	\$3,502,831	\$2,128,302
Ohio <sup>17</sup>	33	484,631	162,444	131,580	68,226	\$60,346,341	\$31,290,695
Oregon	25	289,731	110,401	80,593	46,368	\$93,573,777	\$53,836,967
Rhode Island	8	123,095	39,004	26,133	15,602	\$17,796,267	\$10,624,637
Vermont	8	121,682	12,362	9,272	6,305	\$7,024,584	\$4,776,717
Washington	25	794,485	278,369	194,858	111,348	\$198,253,434	\$113,287,677
West Virginia	27	379,702	91,295	73,949	38,344	\$44,822,471	\$23,241,281
<b>Total</b>	<b>582</b>	<b>12,437,234</b>	<b>4,162,079</b>	<b>2,824,683</b>	<b>1,585,313</b>	<b>\$2,046,098,599</b>	<b>\$1,152,910,377</b>

<sup>17</sup> Ohio was added to the expansion group based on Governor Kasich's recent submission of a federally approved expansion plan to his state budget control board for final approval. Approximately 63,354 eligible patients would have remained uninsured had Ohio not expanded Medicaid.

## Discussion

These estimates illustrate the potential impact of the Affordable Care Act on uninsured health center patients and health center capacity. In the states that expand Medicaid, the number of patients expected to be eligible for coverage through Medicaid and premium assistance is approximately 2.8 million. In these states, health centers can expect to gain approximately \$2 billion (adjusted to 2014 dollars) in additional revenues from Medicaid and payments by qualified health plans. Because patient cost-sharing under qualified health plans will be higher, even with cost-sharing assistance, total revenues received may be slightly lower than estimated here, but since more than 90% of health center patients have incomes below twice the FPL, health centers can nonetheless be expected to realize significant revenues from insurance reform, similar to the experience of Massachusetts health centers.

By contrast, the 518 health centers in states that do not couple Marketplace premium subsidies with Medicaid expansions—nearly half (46%) of all grantees in 2011—can be expected to struggle. Over one million uninsured patients in these states who would have been eligible for coverage are likely to remain uninsured, and health centers in these states stand to lose nearly \$555 million in revenues in 2014 dollars. Health centers in the opt-out states will be able to qualify some of their patients under traditional Medicaid eligibility rules, but we anticipate that this number will be modest, since most of those previously eligible would have been identified and enrolled because of health centers' outreach and enrollment assistance efforts that predate health reform. With the opt-out states representing the nation's highest proportions of uninsured poor,<sup>18</sup> the Medicaid expansion becomes especially vital. It is the residents of these states who, research shows, bear the greatest burden of illness and poor health and stand to gain the most from the health care access improvements that Medicaid produces.<sup>19</sup>

Because of the close association between high concentrations of uninsured poor populations and medical underservice – the key indicator of need used to determine where health centers will be located – health centers in these opt-out states already face especially deep challenges. Health centers in opt-out states can be expected to fall further behind over time compared to those in expansion states in terms of number of patients served (both insured and uninsured), expanded service capacity, recruitment and retention of clinical staff, expansion of service sites, and the introduction of further improvements in clinical quality.

In the coming years, more states may expand Medicaid. But in the near-term, health centers in non-expansion states can be expected to confront more significant growth challenges, more limited service capacity, and more limited ability to invest in the types of system reforms that improve quality and efficiency. Assessing the Affordable Care Act's impact on health centers and their communities thus emerges as a principal means of enabling policymakers to understand how health insurance reform ultimately enables the types of community health system transformations that extend beyond the immediate receipt of care at an individual patient level and affect health and health care on a community-wide basis.

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<sup>18</sup> Tavernise, S. & Gebeloff, R. (October 2, 2013). Millions of Poor Are Left Uncovered by Health Law. *The New York Times*. Available at: <http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html>

<sup>19</sup> Commonwealth Fund, Health Care in the Two Americas  
[http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Sep/1700\\_Schoen\\_low\\_income\\_score\\_card\\_FULL\\_REPORT\\_FINAL\\_v4.pdf](http://www.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2013/Sep/1700_Schoen_low_income_score_card_FULL_REPORT_FINAL_v4.pdf) (Accessed online October 12, 2013)

## Appendix

Table A1 shows the breakdown of health centers by income status and the proportion of each income group of patients who are uninsured. Approximately 97% of all CHC patients have incomes below and at 400% of FPL. In general, the majority of CHC patients have incomes less than 100% (and 138%) of FPL.

A1. Income Profile of CHC Patients

Income range	Proportion of all CHC patients	Proportion of patients within income level who are uninsured
≤100% FPL	54%	35%
101-200% FPL	32%	36%
201-400% FPL	11%	42%
>400% FPL	3%	38%
≤138% FPL	73%	35%
139-400% FPL	24%	41%
≤400% FPL	97%	36%

Source: 2009 CHC User Survey, HRSA.

Table A2 is derived from the Urban Institute’s report which examined how many uninsured would be eligible for Medicaid, the Children’s Health Insurance Program and subsidized private insurance.

A2. Uninsured Eligible for Coverage, By State

State	With Expansion	Without Expansion	State	With Expansion	Without Expansion
Alabama	80%	38%	Montana	81%	47%
Alaska	75%	43%	Nebraska	72%	41%
Arizona	62%	34%	Nevada	64%	35%
Arkansas	75%	40%	New Hampshire	76%	49%
California	64%	35%	New Jersey	59%	35%
Colorado	66%	38%	New Mexico	69%	35%
Connecticut	65%	38%	New York	66%	38%
Delaware	69%	42%	North Carolina	69%	38%
District of Columbia	66%	31%	North Dakota	79%	48%
Florida	68%	37%	Ohio	81%	42%
Georgia	70%	35%	Oklahoma	72%	41%
Hawaii	77%	35%	Oregon	73%	42%
Idaho	75%	42%	Pennsylvania	77%	43%
Illinois	66%	34%	Rhode Island	67%	40%
Indiana	78%	43%	South Carolina	76%	39%
Iowa	76%	42%	South Dakota	80%	40%
Kansas	72%	41%	Tennessee	76%	41%
Kentucky	81%	41%	Texas	63%	34%
Louisiana	76%	39%	Utah	68%	40%
Maine	79%	53%	Vermont	75%	51%
Maryland	64%	35%	Virginia	69%	37%
Massachusetts	65%	65%	Washington	70%	40%
Michigan	81%	41%	West Virginia	81%	42%
Minnesota	72%	43%	Wisconsin	76%	43%
Mississippi	79%	36%	Wyoming	71%	44%
Missouri	79%	42%			

Source: Buettgens, M., Kenney, G.M., Recht, H., & Lynch, V. (2013). *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States*. Robert Wood Johnson Foundation.

The following tables (A3-A4) show the distribution of CHC patients by income less than or equal to 100% FPL. The source for all estimates is the 2011 UDS data.

**A3. CHC Patients with  
Incomes Less than 100% FPL in Non-Expansion States**

<b>State</b>	<b>Total CHC patients</b>	<b>Reported number of CHC patients ≤ 100% FPL</b>	<b>No. of CHC patients ≤ 100% FPL*</b>	<b>Pct. Of CHC patients ≤ 100% FPL</b>
Alabama	320,044	202,237	226,027	70.6%
Alaska	91,020	21,394	47,243	51.9%
Florida	1,080,695	626,933	759,554	70.3%
Georgia	317,299	173,229	225,899	71.2%
Idaho	126,354	64,985	80,624	63.8%
Indiana	273,536	156,147	216,140	79.0%
Kansas	147,489	83,014	103,433	70.1%
Louisiana	223,095	117,589	170,450	76.4%
Maine	181,171	57,810	81,418	44.9%
Mississippi	324,046	203,480	235,477	72.7%
Missouri	420,130	249,652	316,772	75.4%
Montana	101,406	49,861	63,649	62.8%
Nebraska	63,532	32,693	42,472	66.9%
New Hampshire	65,466	28,252	34,669	53.0%
North Carolina	411,015	237,794	312,153	75.9%
Oklahoma	135,272	68,709	94,105	69.6%
Pennsylvania	637,928	323,087	418,130	65.5%
South Carolina	326,829	192,874	253,390	77.5%
South Dakota	58,003	18,265	31,617	54.5%
Tennessee	372,360	214,404	306,960	82.4%
Texas	975,509	599,230	717,432	73.5%
Utah	112,794	65,950	84,586	75.0%
Virginia	285,359	100,609	165,968	58.2%
Wisconsin	281,591	135,608	181,516	64.5%
Wyoming	18,022	6,345	10,886	60.4%
<b>Total for non-expansion states</b>	<b>7,349,965</b>	<b>4,030,151</b>	<b>5,180,571</b>	<b>70.5%</b>

\*This was calculated by adding the reported number of patients ≤100% FPL in the UDS with the number of patients with unknown income multiplied by the percentage of those ≤100% FPL

**A4. CHC Patients with  
Incomes Less than 100% FPL in Expansion States**

<b>State</b>	<b>Total CHC patients</b>	<b>Reported number of CHC patients ≤ 100% FPL</b>	<b>No. of CHC patients ≤ 100% FPL*</b>	<b>Pct. reported ≤ 100% FPL</b>
Arizona	408,737	196,932	308,023	75.4%
Arkansas	156,159	70,551	103,068	66.0%
California	3,104,183	2,174,229	2,445,913	78.8%
Colorado	474,241	317,026	354,809	74.8%
Connecticut	315,992	179,452	207,332	65.6%
Delaware	38,861	18,933	22,844	58.8%
District of Columbia	122,891	73,068	93,523	76.1%
Hawaii	137,266	81,541	102,547	74.7%
Illinois	1,098,483	672,932	844,626	76.9%
Iowa	179,120	72,620	126,581	70.7%
Kentucky	278,242	124,003	164,941	59.3%
Maryland	282,831	120,125	177,555	62.8%
Massachusetts	615,708	296,337	403,895	65.6%
Michigan	546,245	269,346	363,935	66.6%
Minnesota	165,474	71,928	118,462	71.6%
Nevada	57,987	25,227	42,958	74.1%
New Jersey	454,243	303,646	358,172	78.9%
New Mexico	285,700	129,684	190,957	66.8%
New York	1,489,141	654,197	1,018,864	68.4%
North Dakota	32,404	10,487	21,344	65.9%
Ohio	484,631	199,882	342,416	70.7%
Oregon	289,731	182,700	221,493	76.4%
Rhode Island	123,095	43,681	83,527	67.9%
Vermont	121,682	15,842	37,483	30.8%
Washington	794,485	473,696	539,288	67.9%
West Virginia	379,702	125,167	194,120	51.1%
<b>Total for expansion states</b>	<b>12,437,234</b>	<b>6,903,232</b>	<b>8,888,674</b>	<b>71.5%</b>

\*This was calculated by adding the reported number of patients ≤100% FPL in the UDS with the number of patients with unknown income multiplied by the percentage of those ≤100% FPL





U.S. Small Business Administration

## AFFORDABLE CARE ACT: KEY SMALL BUSINESS PROVISIONS

The Affordable Care Act (ACA) will help small businesses by lowering premium cost growth and increasing access to quality, affordable health insurance. If you're a small employer, the following are some of the ACA provisions that may apply.

### Provisions Currently in Effect

#### **Small Business Tax Credits**

The small business tax credit helps small businesses afford the cost of health care coverage for their employees and is specifically targeted for those businesses with low- and moderate-income workers. The credit is designed to encourage small employers to offer health insurance coverage for the first time or maintain coverage they already have. Businesses that have fewer than 25 full-time equivalent employees, pay average annual wages below \$50,000, and contribute 50% or more toward employees' self-only health insurance premiums may qualify for a small business tax credit of up to 35% to help offset the costs of insurance. In 2014, this tax credit goes up to 50% and is available to qualified small businesses who participate in the Small Business Health Options Program (SHOP), described below. Eligible small employers can claim the current credit through 2013, and the enhanced credit can be claimed for a maximum of two consecutive taxable years beginning in 2014 through the SHOP.

#### **Summary of Benefits and Coverage (SBCs) Disclosure Rules**

Employers are required to provide employees with a standard Summary of Benefits and Coverage form explaining what their plan covers and what it costs. The purpose of the SBC form is to help employees better understand and evaluate their health insurance options. Penalties may be imposed for non-compliance. The Department of Labor has provided a sample completed SBC that employers may reference.

#### **Medical Loss Ratio Rebates**

Under ACA, insurance companies must spend at least 80% of premium dollars on medical care rather than administrative costs. Insurers who do not meet this ratio are required to provide rebates to their policyholders, which is typically an employer who provides a group health plan. Employers who receive these premium rebates must determine whether the rebates constitute plan assets. If treated as a plan asset, employers have discretion to determine a reasonable and fair allocation of the rebate. For more information on the federal tax treatment of Medical Loss Ratio rebates, refer to IRS's FAQs.

#### **W-2 Reporting of Aggregate Health Care Costs**

Beginning January 2013 (applicable to 2012 reporting), most employers must report the aggregate annual cost of employer-provided coverage for each employee on the Form W-2. The new W-2 reporting requirement is informational only and it does not require taxation on any health plan coverage. Reporting is required for most employer-sponsored health coverage, including group medical coverage. **Small Employer Exception:** For 2012 reporting and beyond until further guidance is issued, the W-2 reporting requirement does not apply to employers required to file fewer than 250 Form W-2s in the prior calendar year. To learn more about the requirements, as well as exclusions, visit IRS.gov.

#### **Limits on Flexible Spending Account Contributions**

Beginning January 2013, the maximum amount an employee may elect to contribute to health care flexible spending arrangements (FSAs) for any year will be capped at \$2500, subject to cost-of-living adjustments. Note that the limit only applies to elective employee contributions and does not extend to employer contributions. To learn more about FSA Contributions, as well as what is excluded from the cap, visit IRS.gov.

### **Additional Medicare Withholding on Wages**

Beginning January 1, 2013, ACA increases the employee portion of the Medicare Part A Hospital Insurance (HI) withholdings by .9% (from 1.45% to 2.35%) on employees with incomes of over \$200,000 for single filers and \$250,000 for married joint filers. It is the employer's obligation to withhold this additional tax, which applies only to wages in excess of these thresholds. The employer portion of the tax will remain unchanged at 1.45%.

### **New Medicare Assessment on Net Investment Income**

Beginning January 1, 2013, a 3.8% tax will be assessed on net investment income such as taxable capital gains, dividends, rents, royalties, and interest for taxpayers with Modified Adjusted Gross Income (MAGI) over \$200,000 for single filers and \$250,000 for married joint filers. Common types of income that are not investment income are wages, unemployment compensation, operating income from a non-passive business, Social Security Benefits, alimony, tax-exempt interest, and self-employment income.

### **Employer Notification of the New Health Insurance Marketplace**

Beginning January 1, 2014, consumers, self-employed, and small businesses will have access to affordable coverage through the new health insurance Marketplace (also commonly known as the Exchange). No later than October 1, 2013, employers covered by the Fair Labor Standards Act (generally, those firms that have at least one employee and at least \$500,000 in annual dollar volume of business), must provide notification to their employees about the new Marketplace. This notice must be given to all current employees by October 1st, and to each new employee beginning October 1st, regardless of plan enrollment status (if applicable) or of part-time or full-time status. The Department of Labor has provided employers with two sample notices they may use to comply with this rule, one for employers who do not offer a health plan and another for employers who offer a health plan for some or all employees. Refer to DOL's Technical Guidance for more information.

### **Upcoming Provisions in 2014**

#### **Small Business Health Options Program (SHOP) and Individual Marketplaces**

Coverage through the competitive health insurance marketplaces for individuals and small businesses will be in place January 1, 2014, with open enrollment beginning October 1, 2013. The Marketplaces will offer four levels of benefit packages that differ by the percentage of costs the health plan covers. Individuals and the self-employed may qualify for individual tax credits and subsidies on a sliding scale, based on income, through the Marketplaces.

Small businesses with generally 50 or fewer employees will have access to Marketplaces through the Small Business Health Options Program (SHOP). Currently, small businesses may pay on average 18% more than big businesses for health insurance. SHOP will offer small businesses increased purchasing power to obtain a better choice of high-quality coverage at a lower cost. SHOP will also pool risks for small groups and reduce administrative complexity, thereby reducing costs. In 2016, employers with up to 100 employees will be able to participate in SHOP. Businesses can enroll starting on October 1, 2013 through their brokers or directly through the SHOP. Stay connected to the latest information on the Marketplaces by going to signup.healthcare.gov.

#### **90-Day Maximum Waiting Period**

Beginning January 1, 2014, individuals who are eligible for health coverage will not have to wait more than 90 days to begin coverage. HHS, IRS, and the Department of Labor have issued proposed rules on how employers should apply the 90-day rule.

#### **Workplace Wellness Programs**

The Affordable Care Act creates new incentives to promote employer wellness programs and encourage employers to take more opportunities to support healthier workplaces. Health-contingent wellness programs generally require individuals to meet a specific standard related to their health to obtain a reward, such as programs that provide a reward to employees who don't use, or decrease their use of, tobacco, and programs that reward employees who achieve a specified level or lower cholesterol. Under final rules that take effect on January 1, 2014, the maximum reward to employers using a health-contingent wellness program will increase from 20 percent

to 30 percent of the cost of health coverage. Additionally, the maximum reward for programs designed to prevent or reduce tobacco use will be as much as 50 percent. The final rules also allow for flexibility in the types of wellness programs employers can offer. For more information and to view the final rules, visit <http://www.dol.gov/ebsa>.

## **Upcoming Provisions in 2015**

### **Employer Shared Responsibility Provisions**

Beginning in 2015, employers with 50 or more full-time (or full-time equivalent) employees that do not offer affordable health insurance that provides minimum value to their full-time employees (and dependents) may be required to pay an assessment if at least one of their full-time employees receives a premium tax credit to purchase coverage in the new individual Marketplace. A full-time employee is one who is employed an average of at least 30 hours per week. If a business meets the threshold level of 50 full-time or full-time equivalent employees, or is close to it, it's important to understand how these rules may apply and how the payment amounts could be calculated.

**Note:** On July 2, 2013, Treasury issued transitional relief to employers covered by these rules indicating that no shared responsibility payments will apply until 2015. Refer to this [Notice](#) from the IRS for the latest information on the Employer Shared Responsibility transitional relief for 2014.

Businesses with fewer than 50 employees are generally not affected by the Employer Shared Responsibility rules – that is nearly **96 percent of all firms** in the United States. These smaller employers do not have to pay an assessment if their full-time employees receive premium tax credits in the new Marketplace.

### **Health Insurance Coverage Reporting Requirements**

Also beginning in 2015, the Affordable Care Act provides for information reporting by employers subject to the employer shared responsibility provisions regarding the health coverage they offer to their full-time employees (known as Section 6056 rules). New information reporting by issuers, self-insuring employers, and other parties that provide health coverage also take effect in 2015 (Section 6055 rules). On September 5, 2013, Treasury issued Proposed Regulations that provide further guidance about these provisions and invites stakeholders to submit comments on these proposed rules through early November 2013. The public comments will be taken into account in developing final reporting rules. To read the proposed rules, click [here](#).

## **ADDITIONAL RESOURCES**

The U.S. Small Business Administration's health care web page, [www.sba.gov/healthcare](http://www.sba.gov/healthcare), is dedicated to educating small business owners about the Affordable Care Act.

Small business owners can also take advantage of a new, streamlined health care tool, housed at [Business USA](#), to help you find out exactly what you and your employees need to know about the Affordable Care Act. In a few quick steps, you'll understand the essentials of new insurance options and other health care changes.

[Healthcare.gov](http://Healthcare.gov), a web portal maintained by HHS, is the site of the new Health Insurance Marketplace. The [small business](#) tab includes information about the SHOP Marketplace for small employers, coverage options, and more. Businesses can stay connected to the latest information on the Marketplaces by signing up for text and email alerts at [signup.healthcare.gov](http://signup.healthcare.gov).

For more information about the SHOP Marketplace, small businesses can call [1-800-706-7893](tel:1-800-706-7893) (TTY users: 1-800-706-7915), Monday through Friday, 9 a.m. to 5 p.m. EST.



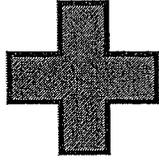
# Small Business Health Care Tax Credit



Business employs fewer than 25 full-time equivalent employees



Employees' average annual wages are less than \$50,000



Business pays for at least 50% of employees' self-only premium costs



Up to 35% Federal Tax Credit in 2013 and \*50% in 2014 if for-profit entity

*\*SHOP participants only*

## Small Business Health Care Tax Credit Scenarios

### Examples of Employers Receiving the Credit

#### Example 1: Auto Repair Shop with 10 Employees Gets \$24,500 Credit for 2010

**Main Street Mechanic:**

- **Employees:** 10
- **Wages:** \$250,000 total, or \$25,000 per worker
- **Employee Health Care Costs:** \$70,000

**2010 Tax Credit: \$24,500** (35% credit)

**2014 Tax Credit: \$35,000** (50% credit)

#### Example 2: Restaurant with 40 Part-Time Employees Gets \$28,000 Credit for 2010

**Downtown Diner:**

- **Employees:** 40 half-time employees (the equivalent of 20 full-time workers)
- **Wages:** \$500,000 total, or \$25,000 per full-time equivalent worker
- **Employee Health Care Costs:** \$240,000

**2010 Tax Credit: \$28,000** (35% credit with phase-out)

**2014 Tax Credit: \$40,000** (50% credit with phase-out)

#### Example 3: Foster Care Non-Profit with 9 Employees Gets \$18,000 Credit for 2010

**First Street Family Services.org:**

- **Employees:** 9
- **Wages:** \$198,000 total, or \$22,000 per worker
- **Employee Health Care Costs:** \$72,000

**2010 Tax Credit: \$18,000** (25% credit)

**2014 Tax Credit: \$25,200** (35% credit)



## Small Business Health Care Tax Credit Questions and Answers: Who Gets the Tax Credit

### Q. Who is eligible?

A. A small employer is eligible for the credit if it has fewer than 25 full-time employees or a combination of full-time and part-time (for example, two half-time employees equal one employee for purposes of the credit); the average annual wages of employees must be less than \$50,000 (adjusted for inflation beginning in 2014), and the employer must pay a uniform percentage for all employees that is equal to at least 50% of the premium cost of the insurance coverage. For tax years beginning in 2014 and forward, the employer must contribute toward premiums on behalf of each employee enrolled in a qualified health plan (QHP) offered by the eligible small employer through a Small Business Health Options Program (SHOP Exchange) established as part of the Affordable Care Act to qualify for the credit.

### Q. Can a tax-exempt organization be eligible?

A. Yes. A tax-exempt organization described in section 501(c) of the Internal Revenue Code (Code) and exempt from tax under section 501(a) of the Code that otherwise meets the definition of an eligible small employer may qualify for the credit. The credit is refundable for tax-exempt employers but is limited to the amount of the tax-exempt employer's payroll taxes withheld during the calendar year in which the taxable year begins. See the "What is the maximum credit for a tax-exempt qualified employer?" question on the [Calculating the Credit page](#).

### Q. How does the credit change in 2014?

A. There are a few important changes to the credit for tax years beginning in 2014 and forward.

- The credit amount increases to 50% of premiums paid for eligible small employers and to 35% of employer premiums paid for tax-exempt eligible small employers.
- An employer must contribute a uniform percentage of premiums (at least 50%) on behalf of each employee enrolled in a qualified health plan offered by the small employer through a SHOP Exchange.
- An employer may claim the credit for two-consecutive taxable years, beginning with the first taxable year in or after 2014 in which the eligible small employer attaches a Form 8941, Credit for Small Employer Health Insurance Premiums, to its income tax return, or in the case of a tax-exempt eligible small employer, attaches a Form 8941 to the Form 990-T, Exempt Organization Business Income Tax Return.
- Cost-of-living adjustments are made to the average annual wage phaseout amounts. (The credit is phased out gradually when average annual wages exceed certain amounts.)

### Q: What if an eligible small employer's 2014 health plan year is not the same as its 2014 taxable year? Can the employer still claim the credit for the entire 2014 taxable year?

A. Yes. For the 2014 taxable year, an eligible small employer does not need to switch plans mid-year to comply with the requirement that an employer offer coverage to its employees through a SHOP Exchange. An employer that has a plan year that begins after the start of its taxable year may count premiums paid for the entire 2014 taxable year if (1) the employer begins offering coverage through a SHOP Exchange on the first day of the 2014 health plan year; and (2) the employer offers coverage during the period before the first day of the 2014 health plan year that would have qualified the employer for the credit under the rules applicable to years before 2014.

**Example:** Employer is an eligible small employer and a calendar year taxpayer. Employer's health plan year runs from July 1, 2014 through June 30, 2015. Employer offers a QHP to its employees on the SHOP Exchange on July 1, 2014. If, from Jan. 1, 2014, through June 30, 2014, the employer has been offering coverage to its employees under the rules applicable to years before 2014, then employer may count premiums paid on behalf of each employee enrolled in coverage for the entire 2014 taxable year, even though employer did not offer coverage through a SHOP Exchange for the first six months of 2014.

For a detailed description of transition rule applicable to the SHOP Exchange, see §1.45R-3(i) of the proposed regulations.

### Q: What if an employer already claimed the credit for prior years? Can the employer still take advantage of the credit in 2014?

A. Yes, an eligible small employer may take the credit for tax years beginning in 2010 through 2013 without those years counting toward the two-consecutive taxable year period. Starting in 2014, an employer may claim the credit for two-consecutive taxable years, beginning with the first taxable year in or after 2014 in which the eligible small employer attaches a Form 8941 to its income tax return, or in the case of a tax-exempt eligible small employer, attaches a Form 8941 to the Form 990-T.

### Q. Is a household employer eligible for the credit, even if he or she has employees who are not performing services in a trade or business?

A. Yes, a household employer may be eligible for the credit.

**Q. How about an employer outside the U.S.?**

A. An employer located outside the United States (including a U.S. territory) may be an eligible small employer if the employer has income effectively connected with the conduct of a trade or business in the United States, and otherwise meets the requirements for claiming the credit.

**Q. How are employer contributions to a multiemployer plan treated for purposes of the credit?**

A. For taxable years 2010 through 2013, contributions by an employer to a multiemployer plan (but not self-insured health coverage offered through a multi-employer plan) are treated as premiums paid by the employer for purposes of the credit. However, 100 percent of the cost of coverage must be paid from employer contributions, not by employee contributions to satisfy the uniform percentage requirement for premiums paid on behalf of each employee covered by the multiemployer plan. See [Notice 2010-82](#) for more guidance. For tax years 2014 and forward, eligibility for the credit depends on employers contributing on behalf of employees enrolled in a QHP offered to employees by the employer through a SHOP Exchange.

**Q. Can a section 521 farmers cooperative be eligible?**

A. Yes. A section 521 farmers cooperative subject to tax under section 1381 may be eligible for the credit if it otherwise meets the definition of an eligible small employer. See the "Who is eligible?" question on this page.

**Related Items:**

- [Calculating the Credit](#)
- [Determining FTEs and Average Annual Wages](#)
- [How to Claim the Credit](#)
- [Transition Relief for Tax Years Beginning in 2010](#)

Return to [Small Business Health Care Tax Credit for Small Employers](#).

*Page Last Reviewed or Updated: 2013-08-23*





## Small Business Health Care Tax Credit Questions and Answers: Determining FTEs and Average Annual Wages

### **Q. What is an FTE?**

A. A full-time equivalent employee (FTE). See the "How is the number of FTEs determined?" question for more information on how to calculate the number of FTEs.

### **Q. Who is an employee for purposes of determining FTEs and average annual wages?**

A. In general, all employees of the eligible small employer are taken into account when determining FTEs and average annual FTE wages, including employees who terminated employment during the tax year, employees covered under a collective bargaining agreement, and employees who are not enrolled in health care coverage. The following individuals are not considered employees for purposes of the credit: owners of the small business, such as sole proprietors, partners, shareholders owning more than 2% of an S corporation or more than 5% of a C corporation; spouses of these owners; and family members of these owners, which include a child, grandchild, sibling or step-sibling, parent or ancestor of a parent, a step-parent, niece or nephew, aunt or uncle, son-in-law or daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law. A spouse of any of these family members should also not be counted as an employee.

### **Q. Can I be counted as an employee if I own my small business?**

A. No. See "Who is an employee for purposes of determining FTEs and average wages" for information on who may be counted in the FTE and average annual wage calculation.

### **Q. What about family members of the small business owner?**

A. Family members who work for the small employer are not counted as employees in calculating the credit. See "Who is an employee for purposes of determining FTEs and average wages" for information on who may be counted in the FTE and average annual wage calculation.

### **Q. Do seasonal workers count in FTEs and average annual wages?**

A. Generally, no. Seasonal workers are workers who perform labor or services on a seasonal basis, including retail workers employed exclusively during holiday seasons. Seasonal workers are not employees for purposes of the credit unless the seasonal worker provides services to the employer on more than 120 days during the taxable year, however, premiums paid on behalf of a seasonal worker are counted in determining the amount of the credit.

### **Q. Do part-time workers count in FTEs and average annual wages?**

A. Yes, part-time workers are counted in FTEs and average annual wages. If an employee works part-time throughout most of the year, he or she is not a seasonal worker and the employer must count the employee's hours of service during the year in its FTE and average annual wage calculation.

### **Q. Are leased employees counted in FTEs and average annual wages?**

A. Yes, leased employees (as defined in section 414(n)) are counted in the FTE and average annual wage calculation. A leased employee is a person who is not an employee of the service recipient and who provides services to the service recipient pursuant to an agreement with the leasing organization.

### **Q. Are ministers included in a church's FTE calculation?**

A. The answer depends on whether, under the common law test for determining worker status, the minister is considered an employee of the church or self-employed. If the minister is an employee, the minister is taken into account in determining an employer's FTEs, and premiums paid on behalf of the minister can be taken into account in computing the credit. If the minister is self-employed, the minister is not included in the employer's FTE calculation and premiums paid on behalf of the minister are not taken into account.

### **Q. Are ministers' compensation taken into account in the average annual wage calculation?**

A. No. Compensation paid to a minister performing services in the exercise of his or her ministry is not subject to FICA tax and is not wages as defined in section 3121(a). It is not taken into account in the average annual wage calculation.

### **Q. What are the permissible ways to count hours of service?**

A. An employee's hours of service for a year include hours for which the employee is paid, or entitled to payment, for the performance of duties for the employer during the employer's tax year. Hours of service also include hours for which the employee is paid for vacation, holiday, illness, incapacity

(including disability), layoff, jury duty, military duty, or leave of absence. Hours of service do not include the hours of seasonal employees who work for 120 or fewer days during the taxable year, nor do they include hours worked for a year in excess of 2,080 by a single employee.

There are three methods for calculating the total number of hours of service for a single employee for the taxable year: actual hours worked; days-worked equivalency; and weeks-worked equivalency. Employers do not need to use the same method for all employees and may apply different methods for different classifications of employees if the classifications are reasonable and consistently applied. For example, an employer may use the actual hours worked method for all hourly employees and the weeks-worked equivalency method for all salaried employees.

(1) **Actual Hours Worked:** An employer may determine actual hours of service from records of hours worked and hours for which payment is made or due, including hours for paid leave. For example, if payroll records indicate an employee worked 2,000 hours and was paid for an additional 80 hours on account of vacation, holiday and illness, the employee must be credited with 2,080 hours of service (2,000 hours worked + 80 hours for which payment was made or due).

(2) **Days-Worked Equivalency:** An employer may use a days-worked equivalency whereby the employee is credited with 8 hours of service for each day the employee would be required to be credited with at least one hour of service, including hours for paid leave. For example, if an employer uses the days-worked equivalency for an employee who works from 8:00a.m.–12:00p.m. every day for 200 days, the employee must be credited with 1,600 hours of service (8 hours for each day the employee would otherwise be credited with at least one hour of service x 200 days).

(3) **Weeks-Worked Equivalency:** An employer may use a weeks-worked equivalency whereby the employee is credited with 40 hours of service for each week for which payment is made or due including weeks of paid leave. For example, if an employee worked 49 weeks, took two weeks of vacation with pay, and took one week of leave without pay, the employee must be credited with 2,040 hours of service (51 weeks x 40 hours per week).

**Q. How is the number of FTEs determined?**

A. Add up the total hours of service for which the employer pays wages to employees during the year (but not more than 2,080 hours for any employee), and divide that amount by 2,080. If the result is not a whole number, round to the next lowest whole number. (If the result is less than one, round up to one FTE.) In some circumstances, an employer with 25 or more employees may qualify for the credit if some of its employees work less than full-time. For example, an employer with 48 employees that are each half-time has 24 FTEs and, therefore may qualify for the credit. See the "Who is an employee for purposes of determining FTEs and average annual wages?" and the "What are the permissible ways to count hours of service?" questions on this page for information on how to compute an employee's hours of service and determining which employees are counted.

**Example:** For the 2014 taxable year, an employer pays five employees wages for 2,080 hours each, three employees wages for 1,040 hours each, and one employee wages for 2,300 hours. The employer uses a method that counts hours actually worked. The employer's FTEs would be calculated as follows:

10,400 hours for the five employees paid for 2,080 hours (5 x 2,080)  
 3,120 hours for the three employees paid for 1,040 hours (3 x 1,040)  
 2,080 hours for the one employee paid for 2,300 hours (lesser of 2,300 and 2,080)

The total hours counted is 15,600 hours. The employer has seven FTEs (15,600 divided by 2,080 = 7.5, rounded to the next lowest whole number).

**Q. How is an employer's average annual wages determined?**

A. All wages paid to employees (including overtime pay) are taken into account in computing an eligible small employer's average annual wages. Add up the total wages paid by the employer during the taxable year to its employees (see the "Who is an Employee for Purposes of Determining FTEs and Average Annual Wages" question on this page), and divide that number by the number of FTEs for the year. The result is then rounded down to the nearest \$1,000 (if not otherwise a multiple of \$1,000). Include only wages paid for hours of service (see the "What are the Permissible Ways to Count Hours of Service?" question on this page). Use wages as defined for purposes of the Federal Insurance Contributions Act (FICA) (without regard to the social security wage base limitation).

**Example:** For the 2014 taxable year, an employer pays a total of \$224,000 in wages to employees and has 10 FTEs. The employer's average annual wages are \$22,000 (\$224,000 / 10 = \$22,400, rounded down to the nearest \$1,000).

**Q. How are average annual wages and FTEs calculated when the employer has a short taxable year?**

A. In accordance with general accounting principles, average annual wages and FTEs may be pro-rated or annualized in calculating the credit. For example, if a small employer has only been in business and paying premiums for 6 months during its first taxable year, it may pro-rate or annualize the employee hours worked and wages earned to reflect the 6 months the employer has been in operation.

**Q. How is the credit reduced if the number of FTEs exceeds 10 or average annual wages exceed \$25,000?**

A. The credit phases out for eligible small employers if the number of FTEs exceeds 10, or if the average annual wages for FTEs exceed \$25,000 (as adjusted for inflation beginning in 2014). If the number of FTEs exceeds 10, the reduction is determined by multiplying the otherwise applicable

credit amount by a fraction, the numerator of which is the number of FTEs in excess of 10, and the denominator of which is 15. If average annual FTE wages exceed \$25,000, the reduction is determined by multiplying the otherwise applicable credit amount by a fraction, the numerator of which is the amount by which average annual FTE wages exceed \$25,000 and the denominator of which is \$25,000. The credit will be reduced based on the sum of the two reductions. This may reduce the credit to zero for some employers with fewer than 25 FTEs and average annual FTE wages of \$50,000 (as adjusted for inflation).

**Example 1:** For the 2014 taxable year, Employer has 12 FTEs and average annual wages of \$30,000. Employer pays \$96,000 in employee premiums, which does not exceed the average premium for the small group market in the employer's rating area.

- (1) Credit determined before any reduction:  $(50 \text{ percent} \times \$96,000) = \$48,000$
- (2) Credit reduction for FTEs in excess of 10:  $(\$48,000 \times 2/15) = \$6,400$
- (3) Credit reduction for average annual wages in excess of \$25,000:  $(\$48,000 \times \$5,000/\$25,000) = \$9,600$
- (4) Total credit reduction:  $(\$6,400 + \$9,600) = \$16,000$
- (5) Total 2014 tax credit:  $(\$48,000 - \$16,000) = \$32,000$

**Example 2 (Tax-Exempt Eligible Small Employer):** Same facts as Example 1, but Employer is a tax-exempt eligible small employer and the total amount of Employer's payroll taxes equals \$30,000 for calendar year 2014.

- (1) Credit determined before any reduction:  $(35 \text{ percent} \times \$96,000) = \$33,600$
- (2) Credit reduction for FTEs in excess of 10:  $(\$33,600 \times 2/15) = \$4,480$
- (3) Credit reduction for average annual wages in excess of \$25,000:  $(\$33,600 \times \$5,000/\$25,000) = \$6,720$
- (4) Total credit reduction:  $(\$4,480 + \$6,720) = \$11,200$
- (5) Employer's payroll taxes: \$30,000
- (6) Total 2014 tax credit:  $(\$33,600 - \$11,200) = \$22,400$  (the lesser of \$22,400 and \$30,000).

**Q. How is eligibility for the credit determined if the employer is a member of a controlled group or an affiliated service group?**

A. Members of a controlled group (e.g., businesses with the same owners) or an affiliated service group (e.g., related businesses where one performs services for the other) are treated as a single employer for purposes of the credit. For example, all employees of the controlled group or affiliated service group, and all wages paid to employees by the controlled group or affiliated service group, are counted in determining whether any member of the controlled group or affiliated service group is a qualified employer. Rules for determining whether an employer is a member of a controlled group or an affiliated service group are provided under sections 414(b), (c), (m) and (o) of the Code.

**Example:** A taxpayer owns 100% of a sole proprietorship and files a Schedule C. The taxpayer also owns at least 80% of the voting power or value of the shares of an S Corporation. Even if the sole proprietorship and the S Corporation individually meet the requirements for the small business health care tax credit, section 414 of the Code and related regulations provide that there is common control under section 1563(a) of the code and when there is common control, the taxpayer must calculate their credit including the employees, their wages and premiums paid for all entities as one entity.

**Related Items:**

- [Who Gets the Tax Credit](#)
- [Calculating the Credit](#)
- [How to Claim the Credit](#)
- [Transition Relief for Tax Years Beginning in 2010](#)

Return to [Small Business Health Care Tax Credit for Small Employers](#).

*Page Last Reviewed or Updated: 23-ago-2013*







# In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

## Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance

October 16, 2013

Authors: Jon R. Gabel, Heidi Whitmore, Jeremy Pickreign, Jennifer L. Satorius, and Sam Stromberg

Journal: *Health Affairs* Web First, published online Oct. 16, 2013

Contact: Jon R. Gabel, M.A., Senior Fellow, NORC, University of Chicago, gabel-jon@norc.org, or Mary Mahon, Assistant Vice President, Public Information, The Commonwealth Fund, mm@cmwf.org

Access to full article: <http://content.healthaffairs.org/lookup/doi/10.1377/hlthaff.2013.0861>

### Synopsis

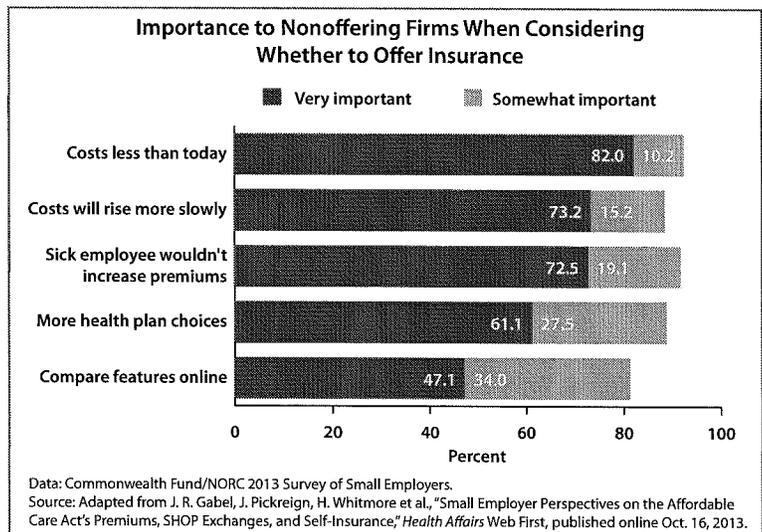
Employers are interested in features of the Small Business Health Options (SHOP) marketplaces, including the ability to compare health plans and get help administering them, but they are very sensitive to the cost of coverage. To increase the potential for success among SHOP marketplaces, it will be important to elicit buy-in from insurance brokers, who play a large role in managing benefits for small businesses, and to limit the number of small firms moving to self-insure.

### The Issue

Compared with midsize and large-group markets, the health insurance market for small groups (those with fewer than 50 members) has higher administrative costs, more volatile pricing, and lower-value products. The Affordable Care Act includes several provisions intended to strengthen this market, notably the establishment of the Small Business Health Options (SHOP) exchanges, or marketplaces. The state-based SHOP marketplaces will allow employers to compare and purchase plans and will perform administrative functions, such as billing and claims adjudication. The marketplaces opened for enrollment on October 1 for coverage beginning January 1, 2014. This Commonwealth Fund-supported study reports on the results of a survey that asked more than 600 small firms about whether they offer coverage, how they view SHOP features, and how the health reform law has affected them to date.

### Key Findings

- Sixty percent of the small firms offered employee health benefits in 2012, and 41 percent of employees were enrolled in their employer's plan.



- Among firms not offering coverage, 75 percent pointed to cost as the most important reason why they do not. When asked what monthly premium for single-employee coverage they could afford, firms reported prices considerably below the current market average of \$502.
- A majority (56%) of small-business owners who currently offer health benefits were interested in a key feature of the SHOP marketplaces: the ability to offer employees a choice of health plans while paying a fixed cost, with employees paying extra for choosing a more expensive plan.
- Other features of the SHOP marketplaces were also broadly appealing: 70 percent of respondents said they would be very interested in getting one bill and paying one check each month, and 68 percent would value the ability to compare plans' costs, benefits, and physician networks.
- Eighty percent of firms offering coverage use brokers to help with tasks such as selecting health plans and enrolling employees—functions the SHOP marketplaces can provide.

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### Addressing the Problem

Health insurance brokers act as de facto benefit managers for the vast majority of small firms, a business model that may be threatened by the SHOP marketplaces. The survey findings suggest marketplaces may need to elicit buy-in from brokers while demonstrating their value to employers. The survey also found that among firms using insurance brokers, one-quarter are considering self-insuring, or paying for health claims directly, and buying stop-loss coverage to protect against catastrophic costs. To avoid leaving fully insured markets (like the SHOP marketplaces) with greater risks and higher premiums, states or Congress could regulate or prohibit the sale of stop-loss coverage to small firms.

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### About the Study

Researchers at NORC at the University of Chicago interviewed CEOs, office managers, CFOs, and others at 604 randomly selected private firms with three to 50 employees. Among the 604 firms, 434 offered health benefits and 170 did not. For firms not offering coverage, the survey asked about their reasons, their experience in shopping for coverage, and factors that would make them likely to purchase it. Firms offering coverage were asked about their experiences in purchasing coverage, views of SHOP features, the effects of the health care law, and whether they had considered self-insurance.

**“One clear message from employers is that the cost of coverage is by far the most important factor in purchasing decisions.”**

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### The Bottom Line

Several features of the SHOP marketplaces have appeal for small businesses. Affordability will be a key consideration as small businesses decide whether to purchase coverage from the marketplaces.

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### Citation

J. R. Gabel, J. Pickreign, H. Whitmore et al., “Small Employer Perspectives on the Affordable Care Act's Premiums, SHOP Exchanges, and Self-Insurance,” *Health Affairs* Web First, published online Oct. 16, 2013.

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*This summary was prepared by Martha Hostetter.*

October 21, 2013

# Northeast Delta Dental's Marketplace Plans

Presentation for Maine Health Exchange Advisory Committee

Brian Staples  
Senior Sales Executive  
Northeast Delta Dental



## Northeast Delta Dental's Marketplace Plans

### **ACA provisions related to oral health :**

- Provides grants for school based dental sealant programs
- Includes 5 year public education campaign to promote oral health
- National grant program to demonstrate the effectiveness of research-based dental caries disease management
- Requires all plans to cover oral health services for children
- Allows stand alone dental benefit plans to be sold on the public exchanges



## Northeast Delta Dental's Marketplace Plans

### Essential Health Benefits:

- 10 categories of services that must be covered
- Applies to plans sold in individual and small group markets beginning in 2014
- Applies to plans sold on AND off exchange
- Does not apply to grandfathered, self-insured or large group medical plans or excepted benefit plans (dental, for example)



## Northeast Delta Dental's Marketplace Plans

### **Essential Health Benefits:**

- (1) ambulatory patient services
- (2) emergency services
- (3) Hospitalization
- (4) maternity and newborn care
- (5) mental health and substance use disorder services, including behavioral health treatment
- (6) prescription drugs
- (7) rehabilitative and habilitative services and devices
- (8) laboratory services
- (9) preventive and wellness services and chronic disease management, and
- (10) pediatric services, including oral and vision care.



## Northeast Delta Dental's Marketplace Plans

- Pediatric dental benefit (PDB) can be either
  - embedded in a medical plan or covered in a stand-alone dental benefit plan
- Medical plans do not have to offer the PDB if a stand-alone dental plan is available on the state's Exchange ("the dental carve out")



## Northeast Delta Dental's Marketplace Plans

### Benchmark plans:

- On Maine Marketplace, pediatric dental benefit must mirror the Federal Employee Dental and Vision Insurance Program (FEDVIP) plan's covered services
- Cost sharing terms of plans not considered in selection of benchmark (co-insurance, co-pays, deductible, etc.)
- "Pediatric" on FFM is up to age 19 for dental



## Northeast Delta Dental's Marketplace Plans

- Current norm: 99% of market currently is stand-alone dental plans
- ACA's pediatric dental plan requirements are not what consumers are familiar with currently; education needed
- ACA's pediatric dental benefit plan design requirements:
  - No plan maximum
  - An OOPM now
  - No cost-sharing on preventive services
  - Out of network expenses need not count to the OOPM
  - Actuarial Values of 70% or 85%



## Northeast Delta Dental's Marketplace Plans

- Market reforms only apply to PDB (as an EHB) so family plans can have different cost-sharing for kids and adults
- Adults do not have to purchase the PDB



## Northeast Delta Dental's Marketplace Plans

### **Delta Dental offering the following plans:**

- Family High
- Family Low
- Pediatric (only) High
- Pediatric (only) Low

All plans offered on Individual and SHOP Marketplaces.

No deductible on any preventive services.



## Northeast Delta Dental's Marketplace Plans

### Delta Dental's PEDIATRIC Dental Benefit Plan

#### Design on Exchange:

- Up to age 19
- 100/80/50/50 (85% AV) or 100/60/50/50 (70% AV)
- Medically necessary orthodontia
- OOPM \$700, \$1400 family maximum
- 100/100/100/100 after OOPM reached
- Office visit co-pay \$15/30; Deductible \$50/ \$150
- Delta Dental PPO network (national)



## Northeast Delta Dental's Marketplace Plans

### Delta Dental's ADULT Dental Benefit Plan Design on Exchange:

- 100/80/50 (AV doesn't apply) or 100/60/50 (AV doesn't apply)
- No orthodontia
- Plan Maximum \$1000
- Office visit co-pay \$15/30; Deductible \$50/ \$150
- Delta Dental PPO network







## Northeast Delta Dental's Marketplace Plans

### Consumer Considerations:

- Monthly Premium
- Provider Network
- Confirming which deductible and OOPM applies to the pediatric dental benefits (Med or SADB)
  - Key distinction between embedded and SADB?

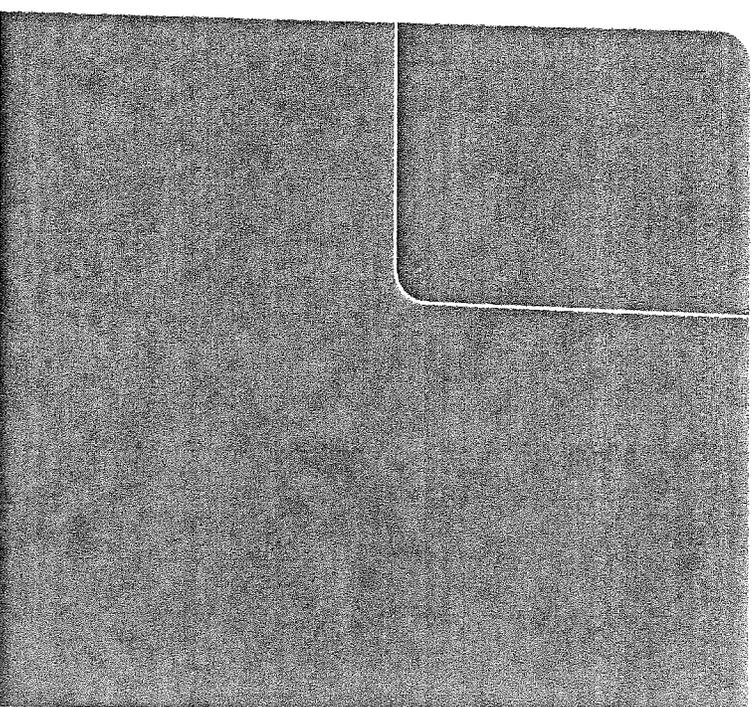


# **Anthem Exchange Offerings**

**Maine Health Exchange Advisory Committee**

**October 21, 2013**

**Eric Jermyn, Director of Sales**





# Maine – ON Exchange Embedded and Stand Alone Dental Products

Segment	ON Exchange
Individual	Individual – Dental Embedded in 1 Bronze & 1 Gold plan at the 70AV level.
Small Group	No Small Group Plans On exchange with embedded pediatric dental EHB
Stand Alone Dental Certified Products for ON - Exchange	<ul style="list-style-type: none"> <li>• Standalone Dental EHB products at 70/85 AV Levels</li> <li>• Standalone Dental Family products at H/Low levels; which includes the Dental EHB at 70/85 AV respectively.</li> </ul>



# Anthem Individual Exchange Product Offerings

Guided Access-HMO-South (Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Waldo, and York counties)

Metal Level	Bronze				Silver				Gold				Catastrophic	
Plan	Anthem Bronze Guided Access with HSA - cabo	Anthem Bronze Guided Access with HSA - caar	Anthem Bronze Guided Access - cabr	Anthem Bronze Guided Access - caaa	Anthem Silver Guided Access with HSA - cbdo	Anthem Silver Guided Access - cbbc	Anthem Gold Guided Access - ccab	Anthem Gold Child Dental - cddp	Anthem Gold Access with Child Dental -	Anthem Catastrophic Guided Access				
Deductible	\$4,000	\$6,300	\$4,300	\$7,100	\$2,500	\$3,000	\$750	\$750	\$750	\$6,350				
Coinsurance	20%	0%	20%	10%	10%	5%	0%	0%	0%	0%				
OOP Max	\$6,350	\$6,350	\$6,350	\$6,350	\$4,000	\$4,500	\$6,000	\$6,000	\$6,000	\$6,350				
Pediatric Dental					✓				✓					

Guided Access-POS-North (Aroostook, Hancock, Penobscot, Piscataquis, Somerset and Washington counties)

Metal Level	Bronze				Silver				Gold				Catastrophic	
Plan	Anthem Bronze Guided Access with HSA - caac	Anthem Bronze Guided Access with HSA - caav	Anthem Bronze Guided Access - cabk	Anthem Bronze Guided Access - caaq	Anthem Silver Guided Access with HSA - cbdk	Anthem Silver Guided Access - cbdk	Anthem Gold Guided Access - ccaj	Anthem Gold Child Dental - cdcx	Anthem Gold Access with Child Dental -	Anthem Catastrophic Guided Access				
Deductible	\$3,500	\$5,900	\$5,000	\$6,000	\$3,000	\$2,500	\$1,250	\$1,250	\$1,250	\$6,350				
Coinsurance	25%	0%	20%	0%	10%	10%	5%	5%	0%	0%				
OOP Max	\$6,350	\$6,350	\$6,000	\$6,350	\$3,950	\$6,000	\$3,500	\$3,500	\$3,500	\$6,350				
Pediatric Dental				✓					✓					





# Maine: On Exchange Approved Standalone Product

Benefit Categories	Anthem Dental Pediatric (70 AV) IN/OON	Anthem Dental Pediatric Enhanced (85 AV) IN/OON	Anthem Dental Family All Ages; 0-18 get Ped benefit, 19+ get Adult benefit (70 AV) IN/OON	Anthem Dental Family Enhanced All Ages; 0-18 get Ped benefit, 19+ get Adult benefit (85 AV) IN/OON
Diagnostic and preventive	90%/70%	100%/80%	90%/70%	100%/80%
Basic services	60%/50%	80%/60%	60%/50%	80%/60%
Endodontic/Periodontal/Oral Surgery	50%/50%	50%/50%	50%/50%	50%/50%
Major Services	50%/50%	50%/50%	50%/50%	50%/50%
Medically Necessary Ortho (12 month WP)	50%/50%	50%/50%	50%/50%	50%/50%
Medically Necessary Ortho LT Max for OON only	n/a/\$1,000	n/a/\$1,000	n/a/\$1,000	n/a/\$1,000
Cosmetic Ortho Lifetime Max *	not covered	not covered	not covered	\$1,000*
Deductible (applies to all services)	\$0 / \$0	\$0 / \$0	\$0 / \$0	\$0 / \$0
Annual Maximum	n/a / \$1,000	n/a / \$1,000	n/a / \$1,000	n/a / \$1,000
Annual Out of Pocket Maximum **	\$700 / n/a	\$700 / n/a	\$700 / n/a	\$700 / n/a

\* Cosmetic Ortho is covered for members through age 18 in the Family Enhanced Plan ONLY; at 50% / %50

\*\* Annual OOP Max: \$700 for one child / \$1,400 for 2+ children.





HealthCare.gov



P.O. Box 4629  
Portland, ME 04112-4629  
david.clough@nfib.org  
www.nfib.com/me



**SMALL BUSINESS**

# The SHOP Marketplace is Open for Business!

You can enroll in health coverage that works for you—and your employees.

Questions about SHOP? Call 1-800-706-7893 (TTY: 1-800-706-7915) Monday - Friday, 9 a.m. - 7 p.m. EST

Want to learn more first?

[Start here](#)

## THE SHOP MARKETPLACE MOST POPULAR

## MAY INTEREST YOU

How do I choose coverage that's right for my business?  
What is the SHOP Marketplace?

What if I'm self-employed?

Can I use an agent or broker?  
How do I apply for coverage?

What if my business has over 50 employees?

What is the Marketplace in my state?  
What does Marketplace insurance cover?  
What do I need to tell my employees?

Will my business get tax credits?  
How can I get ready for SHOP?  
Once I choose coverage, how do my employees sign up?



## Get ready for the Marketplace

**Answer a few quick questions and we'll provide the most relevant information for you before you apply for coverage in the Marketplace. We'll also tell you your next steps.**

This is not the application for Marketplace coverage. This tool helps you get ready to apply. No information you enter here will carry over to your application.

If you'd like to start your application for Marketplace coverage now instead of using this tool, [visit the main Marketplace page \(https://www.healthcare.gov/marketplace/individual\)](https://www.healthcare.gov/marketplace/individual).

### Which best describes you?

I'm looking for coverage for myself or my family

I'm looking for coverage for a small business I own or operate

[Why are we asking these questions? \(/why-are-we-asking-these-questions/\)](/why-are-we-asking-these-questions/)



3

## Get ready for the Marketplace

What state is your operation based in?

How many full-time equivalent employees do you have?

None. I'm self-employed

Under 25

Under 50

50+

Do you currently offer insurance to your employees?

Yes, and I plan to keep the coverage I have

Yes, and I want to explore my options

No

[Why are we asking these questions? \(why-are-we-asking-these-questions\)](#)



## Your Results

### YOU ANSWERED

#### Type

I'm looking for coverage for a small business I own or operate

#### State

Maine

#### Full-time Employees

Under 25

#### Currently Offer

Yes, and I want to explore my options

### Top Information for You

#### How can I get ready for SHOP?

If you own a small business, you can prepare to use SHOP now. You can explore your options, gather key information, and check in with an agent or broker.

**Learn more about [How can I get ready for SHOP? \(/how-can-i-get-ready-for-shop\)](#)**

#### How do I choose coverage that's right for my business?

There are 4 categories of plans in the SHOP Marketplace. They offer similar benefits, but differ based on how enrollees and the plan share the costs of care.

**Learn more about [How do I choose coverage that's right for my business? \(/how-do-i-choose-insurance-thats-right-for-my-business\)](#)**

#### What do small businesses need to know?

Businesses with 50 or fewer employees may get employee health coverage in the SHOP Marketplace. Employers of this size aren't required to offer health coverage.

**Learn more about [What do small businesses need to know? \(/what-do-small-businesses-need-to-know\)](#)**

#### What if I already insure my employees?

If you insure your employees now, you can keep the coverage you have. If you have 50 or fewer full-time employees, you may offer a plan via SHOP instead.

**Learn more about [What if I already insure my employees? \(/what-if-i-already-insure-my-employees\)](#)**

#### What is the SHOP Marketplace?

5

The Small Business Health Options Program (SHOP) is a new program that simplifies the process of buying health insurance for your small business.

Learn more about [What is the SHOP Marketplace? \(/what-is-the-shop-marketplace\)](#)

## Will I qualify for small business health care tax credits?

You may qualify for employer health care tax credits if you have fewer than 25 full-time equivalent employees making an average of about \$50,000 a year or less.

Learn more about [Will I qualify for small business health care tax credits? \(/will-i-qualify-for-small-business-health-care-tax-credits\)](#)

## Your Next Steps

### Take Action

If you live in Maine, **you'll use this website, HealthCare.gov**, to apply for coverage, compare plans, and enroll. Here's [what you need to know \(/get-covered-a-1-page-guide-to-the-health-insurance-marketplace/\)](#) before you apply. You can also see if you [qualify for lower costs \(/how-can-i-save-money-on-marketplace-coverage/\)](#) and [preview plans and prices \(/how-much-will-marketplace-insurance-cost/\)](#). You'll find out final costs and savings on Marketplace plans based on your specific situation [when you apply \(/how-do-i-apply-for-marketplace-coverage/\)](#).

### Print Your Checklist

Based on your answers, we've created a customized checklist to help you get ready.

### Find Local Help

Get personal help applying for health coverage...

Enter City and State or Zip Code (Example: "Austin, TX" or "33109")

## Marketplace Application Checklist *if you own or operate a small business and you:*

6

- Want to offer coverage to your employees using SHOP
- Have 50 or fewer full-time equivalent employees

The Small Business Health Options Program (SHOP) is a new program that simplifies the process of buying health insurance for your small business.

When you use SHOP, you'll need certain information about your business to fill out the application. Use the checklist below to help you get ready.

- Employer Identification Number
- Tax ID
- Number of employees
- Date of birth for all employees (and their dependents, if you plan to offer dependent coverage)

You can apply for 2014 coverage as soon as October 1, 2013.

Stay up-to-date about the Marketplace. Visit [HealthCare.gov/subscribe](http://HealthCare.gov/subscribe) to get email or text updates that will help you get ready to apply.



7

## How do I apply for Marketplace coverage?

You can apply for health coverage in the Marketplace 4 ways: with a paper application, online, by phone, or in person with an assister.

### Apply with a paper application

You can fill out a paper application and mail it in. You'll find out whether you're eligible for lower costs on private insurance, Medicaid, or the Children's Health Insurance Program (CHIP).

Once you get your eligibility notice, you can either go online to compare, choose, and enroll in a plan or contact our call center. A customer service representative will help you.

If you or someone on your application are eligible for Medicaid or CHIP, a representative will contact you to enroll.

To get a paper application, download the [application form](#)

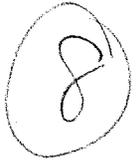
<http://marketplace.cms.gov/getofficialresources/publications-and-articles/marketplace-application-for-family.pdf> and [instructions](#)

<http://marketplace.cms.gov/getofficialresources/publications-and-articles/marketplace-application-for-family-instructions-.pdf>.

### Apply online in 4 steps

When you apply online, you'll follow a 4-step process:

1. **Set up an account.** Start by going to the [Marketplace \(/marketplace/individual\)](#) page. First you'll provide some basic information. Then choose a user name, password, and security questions for added protection.
2. **Fill out the online application.** You'll provide information about you and your family, like income, household members, current health coverage information, and more. This will help the Marketplace find options that meet your needs. **Important: If your household files more than one tax return, call the Marketplace Call Center at 1-800-318-2596 (TTY: 1-855-889-4325) before you start an application.** This is a very important step. Please don't skip it. Representatives can provide directions to make sure your application is processed correctly.
3. **Compare your options.** You'll be able to see all the options you qualify for, including private insurance plans and free and low-cost coverage through [Medicaid \(/do-i-qualify-for-medicaid\)](#) and the [Children's Health Insurance Program \(CHIP\) \(/are-my-children-eligible-for-chip\)](#). The Marketplace will tell you if you qualify for [lower costs on your monthly premiums \(/will-i-qualify-to-save-on-monthly-premiums\)](#) and [out-of-pocket costs \(/will-i-qualify-to-save-on-out-of-pocket-costs\)](#) on private insurance. You'll see details on costs and benefits to help you [choose a plan \(/how-do-i-choose-marketplace-insurance/\)](#) that's right for you.



4. **Enroll.** After you choose a plan, you can enroll online and decide how you pay your premiums to your insurance company. You must pay your premium by the date the insurer provides before your coverage can begin. Coverage can begin as soon as January 1, 2014. If you or a member of your family qualify for Medicaid or CHIP, a representative will contact you to enroll.

Learn [what you can do to get ready to enroll \(/how-can-i-get-ready-to-enroll-in-the-marketplace\)](#). If you run a small business, here's what you can do to [get ready to offer coverage for your employees in the SHOP Marketplace \(/how-can-i-get-ready-for-shop\)](#).

If you have any questions, there's plenty of [live and online help \(/how-do-i-get-help-enrolling-in-the-marketplace/\)](#) along the way.

### **Apply by phone or with an in-person assister**

- To apply by phone, call 1-800-318-2596, 24 hours a day, 7 days a week (TTY: 1-855-889-4325). A customer service representative will work with you to complete the application and enrollment process.
- You can also apply with the help of an assister who can sit with you and help you fill out a paper or online application. Read the next section for more details.

### **Find in-person help**

In all states, there are people trained and certified to help you understand your health coverage options and enroll in a Marketplace plan. They're known by different names, depending on who provides the service and where they're located. All can provide the help you need with your application and choices:

- Navigators
- Application assisters
- Certified application counselors
- Government agencies, such as State Medicaid and Children's Health Insurance Program (CHIP) Offices

Insurance agents and brokers can also help you with your application and choices.

Visit [LocalHelp.HealthCare.gov \(https://localhelp.healthcare.gov\)](https://localhelp.healthcare.gov) to find help in your area. You can search by city and state or zip code to see a list of local organizations with contact information, office hours, and types of help offered, such as non-English language support, Medicaid or CHIP, and Small Business Health Options Program (SHOP).

### **Before you apply, preview plans and estimated savings**

Before you fill out a Marketplace application, you can do 2 things to learn your options:

9

- Use a [cost and savings calculator \(/how-can-i-get-an-estimate-of-costs-and-savings-on-marketplace-health-insurance/\)](/how-can-i-get-an-estimate-of-costs-and-savings-on-marketplace-health-insurance/) to see if you may qualify for lower costs based on your household size and income.
- Preview [plans and prices \(/find-premium-estimates/\)](/find-premium-estimates/) available in your area. **Note:** Prices shown do not account for any savings you may be eligible for based on your household size and income.

**Small business coverage:** If you own a small business and want to apply for SHOP coverage for your employees, you'll follow a different process. [Begin that process now \(/marketplace/shop\)](/marketplace/shop). Select your state from the drop down menu. Then click the green button to take the next step.

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## Get plan information in your area

10

### Answer a few quick questions to see the premium estimates.

This isn't the application for Marketplace coverage. No information you enter here will carry over to your application.

**IMPORTANT NOTE: The prices shown on this tool don't reflect the lower costs you may qualify for based on household size and income.**

Most people who apply will pay lower monthly premiums than those shown here. Households with yearly incomes up to about \$46,000 for individuals or \$94,000 for a family of 4 will qualify for lower costs. You'll get final quotes for specific plans based on your income and household after you complete a Marketplace application.

### Which best describes you?

I'm looking for coverage for myself or my family

I'm looking for coverage for a small business I own or operate

11

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## Get plan information in your area

What type of coverage are you interested in for your employees?

Health

Dental

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

Dental coverage will be included in some plans. In some cases, separate, stand-alone plans will be offered.

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## Get plan information in your area

12

**In which state is this small business?**

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

Learn more about small business with employees in more than one state. (/https://www.healthcare.gov/help/what-if-my-small-business-has-employees-in-more-than-one-state/)

HELP STEPS **Employer Apply For Coverage**

## What if my small business has employees in more than one state?

An employer with employees working in more than one state has 2 options for covering employees.

### Employees in more than one state

An employer with employees working in more than one state has 2 options:

1. Cover all employees from the state in which the employer has its main place of business
2. Cover the employees in each state through the SHOP in each state, using the primary business address in that state

#### Entering your business address

Enter the business address within the state for which you're applying for SHOP coverage. In your employee roster for SHOP, list only employees working in this state.

#### SHOP accounts in multiple states

If you're establishing separate SHOP accounts in multiple states, you'll create a separate roster for each account. List only employees working in one state on each employee roster. However, the employer size you indicate in this application must count all of your employees in all states.

HealthCare.gov

## Get plan information in your area

14

In which state is this small business?

In which county is this small business?

**IMPORTANT NOTE:** The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

Learn more about small business with employees in more than one state. (/https://www.healthcare.gov/help/what-if-my-small-business-has-employees-in-more-than-one-state/)

HealthCare.gov

## Get plan information in your area

15

**Who will you apply for health coverage for? (Select one.)**

Only employees

Employees and their spouses

Employees, their spouses, and their children

Employees and their children

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

16

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## Get plan information in your area

Who will you apply for health coverage for? (Select one.)

Only employees

### How old are your employees?

49 or under

50 or older

Premium amounts in this tool are based on specific ages.

[Learn more about how employee age may affect employee premium cost \(https://www.healthcare.gov/help/choosing-how-employees-pay-their-premium-costs/\)](https://www.healthcare.gov/help/choosing-how-employees-pay-their-premium-costs/)

Employees and their spouses

Employees, their spouses, and their children

Employees and their children

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for [reduced costs through tax credits \(/how-can-i-save-money-on-marketplace-coverage/\)](/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a [Marketplace application \(/marketplace/individual/\)](/marketplace/individual/).

## Choosing how employees pay their premium costs

You have the option to have employees pay premiums (<https://www.healthcare.gov/glossary/premium/>) based on age, or have everyone pay the same amount. This won't affect your contribution.

Here's how it may affect your employees.

- Younger employees are often in better health, and if they make less money, they may not see the value of health insurance. Lower age-based premiums (<https://www.healthcare.gov/glossary/premium/>) provide more value and may encourage them to enroll. This in turn may make it easier for you to reach your group's minimum participation rate.
- Having everyone pay the same amount is most common. It helps older employees, who often have higher out-of-pocket costs, with their total cost of care. Depending on your state, this may be the only option allowed.

HealthCare.gov

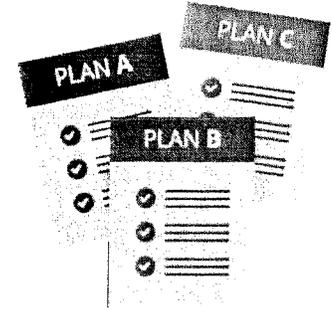
## Get plan information in your area

18

### All plans must offer the same essential health benefits.

These benefits include coverage for things like:

- Doctor visits
- Prescription drugs
- Hospitalization
- Maternity and newborn care
- Preventive Care



Plans can offer other benefits, like vision, dental, or medical management programs for a specific disease or condition. As you compare plans, you'll see what benefits each plan covers.

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

19

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# Get plan information in your area

## Most people who apply will qualify for lower costs

Most people who apply for coverage in the Marketplace will qualify for lower costs on monthly premiums based on their household size and income

Number of people in your household	Income range to qualify for lower costs
1	\$11,490 to \$45,960
2	\$15,510 to \$62,040
3	\$19,530 to \$78,120
4	\$23,550 to \$94,200
5	\$27,570 to \$110,280
6	\$31,590 to \$126,360
7	\$35,610 to \$142,440
8	\$39,630 to \$158,520

The chart on the right shows household sizes and income levels that qualify for lower costs. The lower your income within the ranges shown, the lower your premium costs will be.

Some people with lower incomes within these ranges will qualify to save money on out-of-pocket costs (/will-i-qualify-to-save-on-out-of-pocket-costs/) like deductibles and copayments.

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

HealthCare.gov

# Get plan information in your area



## Plans are put into 4 categories

These 4 categories (bronze, silver, gold, and platinum) are based on how you, your employee, and the plan expect to share costs for healthcare.

BRONZE	60%	of the total average costs of care
SILVER	70%	of the total average costs of care
GOLD	80%	of the total average costs of care
PLATINUM	90%	of the total average costs of care

The category you choose affects how much your employees' premium costs each month and what portion of the bill they pay for things like hospital visits or prescriptions.

It also affects their total out-of-pocket costs - the amount your employees will spend for the year if they need lots of care.

**IMPORTANT NOTE: The prices here don't reflect the lower costs an applicant may qualify for based on household size and income.**

Many people who apply will qualify for reduced costs through tax credits (/how-can-i-save-money-on-marketplace-coverage/) that are automatically applied to monthly premiums. These credits will significantly lower the prices shown for a majority of those applying. Final price quotes are available only after someone has completed a Marketplace application (/marketplace/individual/).

**TOPICS**

## How do I apply for coverage in the SHOP Marketplace?

To get ready to offer insurance to your employees through the SHOP Marketplace, you can do two things now:

- Review available plan options. Visit this page to [see the plans and prices available in your area \(/shop-health-plan-information/\)](/shop-health-plan-information/).
- Fill out a paper application and mail it in, and finish enrollment online in November

Or you can wait until November to handle the entire application process online.

Not ready to apply yet? [Learn more about the SHOP Marketplace \(/what-is-the-shop-marketplace/\)](/what-is-the-shop-marketplace/).

View detailed [questions and answers on SHOP procedures](http://marketplace.cms.gov/getofficialresources/publications-and-articles/key-facts-about-shop.pdf)

(<http://marketplace.cms.gov/getofficialresources/publications-and-articles/key-facts-about-shop.pdf>), including eligibility, application, enrollment, employee communications, and more.

### How to apply for SHOP coverage right now: 5 steps

If you decide to complete a paper application now, here are the steps:

1. [Set up a Marketplace account online. \(/marketplace/global/en\\_US/registration#signUpStepOne\)](/marketplace/global/en_US/registration#signUpStepOne)  
You must set up an online account to submit your paper application. Setting up an online account will allow you to access your application electronically later on, after your paper application is processed. You can fill out a SHOP application entirely online starting in November. You must be the employer's primary or secondary contact in order to set up the Marketplace account. When you create an account, you'll be assigned a "Marketplace ID" number, which you'll need to complete the paper application.
2. After you've successfully created an account, you'll see a link to the SHOP paper application on the "My Applications and Coverage" screen. Right-click the link to the PDF document and select "Save As." After you have downloaded the PDF document to your computer, open it using [Adobe Reader \(http://get.adobe.com/reader/\)](http://get.adobe.com/reader/) to complete the application. Adobe Reader is required to complete the application and is available as a free download.
3. Complete all the required fields in the employer application. An agent or broker who has signed a privacy and security agreement with the Marketplace can help you complete the application.

22

4. If you have questions about the application, call the SHOP employer call center at 1-800-706-7893 (TTY: 1-800-706-7915) Monday through Friday, 9 a.m. to 7 p.m. Eastern Time. Spanish-speaking representatives are available.
5. When you're done, print out your application, sign it, and mail it to:

Health Insurance Marketplace  
465 Industrial Blvd.  
London, KY 40750-0001

We'll contact you if we need any additional information.

### **After you mail in your SHOP Marketplace application: 4 steps**

1. By mid-November, we'll let you know if your company is eligible to participate in SHOP.
2. If you're eligible, you'll be able to log in to your online Marketplace account to finish the enrollment process. Once online, you'll compare available medical and dental plans, create your offer of coverage, and notify your employees about your offer.
3. Your employees will review your offer of coverage online and decide if they want to enroll. Your employees may also get assistance from your broker (if you have one). Or they can contact the Marketplace call center at 1-800-318-2596 (TTY: 1-855-889-4325). Note that employees use the general Marketplace phone number, **not** the special SHOP call center for employers.
4. Finally, you'll come back to your online SHOP application, review which of your employees accepted coverage, and submit your online application. You may also be able to submit your first month's premium payment online. For applications submitted by December 15, 2013, coverage can begin as soon as January 1, 2014.

Businesses not enrolling for January 1 coverage will be able to enroll on a monthly basis after that. (If you enroll by the 15th of any month, coverage can begin on the 1st of the following month. If you enroll from the 16th through the end of the month, coverage begins on the second following month. For example, if you enroll January 16th coverage could begin March 1.)

**To check on the status of your eligibility determination**, call the SHOP employer call center at 1-800-706-7893 (TTY: 1-800-706-7915) Monday through Friday, 9 a.m. to 7 p.m. Eastern Time. Support is available in Spanish and other languages.

23

HealthCare.gov ([http://www/healthcare.gov/](http://www.healthcare.gov/))

Get Insurance  
(/marketplace/individual)

Already have an account? **LOG IN**

### Create a Marketplace account

All fields are required unless they're marked optional. Don't enter any letters with special characters, like accents, tildes, etc.

#### Your Information

<b>First name</b>	<b>Middle</b> <i>optional</i>	<b>Last name</b>	<b>Suffix</b> <i>optional</i>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Select... <input type="button" value="v"/>

**State you live in**

Maine

<b>Email address</b>	<b>Confirm email address</b>
<input type="text"/>	<input type="text"/>

I want to have news and updates sent to this email address *optional*

You need an email address to sign up. You can get one now for free: [Gmail \(https://mail.google.com/\)](https://mail.google.com/)  
[Outlook \(https://login.live.com/\)](https://login.live.com/) [Yahoo \(https://login.yahoo.com/\)](https://login.yahoo.com/) [AOL \(https://mail.aol.com/\)](https://mail.aol.com/)



**CANCEL** **NEXT**

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([HTTP://WWW.HHS.GOV/](http://www.hhs.gov/))

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([HTTP://WWW.WHITEHOUSE.GOV/](http://www.whitehouse.gov/))



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Services. 7500 Security Boulevard, Baltimore, MD 21244

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24

HealthCare.gov ([http://www/healthcare.gov/](http://www.healthcare.gov/))

Get Insurance  
(/marketplace/individual)

# Success!

Your account has been created.

With this account, you can use the Health Insurance Marketplace to find health coverage that fits your budget and meets your needs.

CONTINUE

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([HTTP://WWW.USA.GOV/](http://www.usa.gov/))

HealthCare.gov ([http://www/healthcare.gov/](http://www.healthcare.gov/))

25

Get Insurance  
(/marketplace/individual)

New to HealthCare.gov? **CREATE ACCOUNT**



### Log In

All fields are required unless they're marked optional.

Username

**This field is required**

Password

[Forgot your username?](#) | [Forgot your password?](#)

[Having trouble logging in? \(/help/i-am-having-trouble-logging-in-to-my-marketplace-account/\)](#)

**LOG IN**

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Live Chat

26



### The webpage cannot be found

HTTP 400

Most likely causes:

- There might be a typing error in the address.
- If you clicked on a link, it may be out of date.

What you can try:

- Retype the address.
- Go back to the previous page.
- Go to and look for the information you want.
- More information

HealthCare.gov

# 8 Health plan(s)

27

All plans (8)
Bronze
Silver
Gold

**Narrow your results**

**Your answers**

**Coverage type**  
Small Business

**Coverage**  
Medical

**Location**  
ME - Cumberland

**Who needs coverage**  
Only employees

**Insurance company**  
Anthem Blue Cross and Blue Shield  
Maine Community Health Options

**IMPORTANT NOTE:** The prices here don't reflect the lower costs you may qualify for based on household size and income.

Most people who apply will pay lower monthly premiums (/how-can-i-save-money-on-marketplace-coverage/) than those shown here. Households with yearly incomes up to about \$46,000 for individuals or \$94,000 for a family of 4 will qualify for lower costs. You'll get final quotes for specific plans based on your income and household after you complete a Marketplace application (/marketplace/individual/).

To find out if you may qualify for lower costs, use this simple calculator (/how-can-i-get-an-estimate-of-costs-and-savings-on-marketplace-health-insurance/).

**Bronze Guided Access Plus-gqbf**

Anthem Blue Cross and Blue Shield

Estimated monthly premium  
for Only employees  
**\$338.43**

HMO | Bronze

**Community Select**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$389.69**

PPO | Bronze

**Community Select HSA**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$389.80**

PPO | Bronze

**Silver Guided Access Plus-gfqa**

Anthem Blue Cross and Blue Shield

Estimated monthly premium  
for Only employees  
**\$401.58**

HMO | Silver

**Community Choice**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$419.48**

PPO | Silver

28

**Community Preferred**  
Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$443.92**

PPO | Silver

**Gold Guided Access Plus-groa**  
Anthem Blue Cross and Blue Shield

Estimated monthly premium  
for Only employees  
**\$513.81**

HMO | Gold

**Community Advantage**  
Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$520.00**

PPO | Gold

All health plans and stand-alone dental plans may not be available at this time, due to technical issues. We'll update this information as soon as it's available.

HealthCare.gov

# 8 Health plan(s)

29

<b>All plans (8)</b>
Bronze
Silver
Gold

**Narrow your results**

Your answers

**Coverage type**  
Small Business

**Coverage**  
Medical

**Location**  
ME - Penobscot

**Who needs coverage**  
Only employees

**Insurance company**  
Maine Community Health Options  
Anthem Blue Cross and Blue Shield

**IMPORTANT NOTE:** The prices here don't reflect the lower costs you may qualify for based on household size and income.

Most people who apply will pay lower monthly premiums (/how-can-i-save-money-on-marketplace-coverage/) than those shown here. Households with yearly incomes up to about \$46,000 for individuals or \$94,000 for a family of 4 will qualify for lower costs. You'll get final quotes for specific plans based on your income and household after you complete a Marketplace application (/marketplace/individual/).

To find out if you may qualify for lower costs, use this simple calculator (/how-can-i-get-an-estimate-of-costs-and-savings-on-marketplace-health-insurance/).

**Community Select**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$446.61**

PPO | Bronze

**Community Select HSA**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$446.73**

PPO | Bronze

**Bronze Guided Access Plus-gqbf**

Anthem Blue Cross and Blue Shield

Estimated monthly premium  
for Only employees  
**\$455.98**

POS | Bronze

**Community Choice**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$480.75**

PPO | Silver

**Community Preferred**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$508.76**

PPO | Silver

30

**Silver Guided Access Plus-gfq**

Anthem Blue Cross and Blue Shield

Estimated monthly premium  
for Only employees  
**\$541.02**

POS | Silver

**Community Advantage**

Maine Community Health Options

Estimated monthly premium  
for Only employees  
**\$595.95**

PPO | Gold

**Gold Guided Access Plus-groa**

Anthem Blue Cross and Blue Shield

Estimated monthly premium  
for Only employees  
**\$692.27**

POS | Gold

All health plans and stand-alone dental plans may not be available at this time, due to technical issues. We'll update this information as soon as it's available.