

# Maine Health Exchange Advisory Committee

Monday November 18, 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<br><i>Christie Hager, Region One Director,<br/>U.S. Department of Health and Human Services</i>   |
| 11:30 to 12:00 | Kentucky’s State-based Exchange—conference call<br><i>William Nold, Deputy Executive Director, Kentucky Office of<br/>Health Benefit Exchange</i>   |
| 12:00 to 1:00  | Lunch   |
| 1:00 to 2:00   | Impact of the ACA on Hospitals; the Role of Hospitals in<br>Consumer Outreach and Enrollment<br><i>Jeff Austin, Maine Hospital Association</i>  |
| 2:00 to 2:30   | Overview of federal funding opportunities/guidelines for consumer<br>assistance<br><i>Advisory Committee Staff</i>  |
| 2:30 to 3:00   | Role of Libraries in Consumer Outreach and Enrollment<br><i>Janet McKenney, Maine State Library</i>   |
| 3:00 to 4:00   | Discussion and Development of Findings and<br>Recommendations—potential areas of discussion <ul style="list-style-type: none"><li>▪ <i>Consumer outreach and enrollment</i></li><li>▪ <i>Technical issues/website—allow direct pathway to insurance<br/>issuers??</i></li><li>▪ <i>Cancellation of existing health plans</i></li><li>▪ <i>Gaps in coverage; changes in MaineCare eligibility</i></li><li>▪ <i>Affordability of coverage</i></li></ul> |

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## Our View

Distributed by Advisory  
Committee Chairs 11/18/13

# Website's lousy, but health care goals still valid



Editorial Board

Our View | Friday, November 15, 2013

The White House is receiving a sound trashing at the hands of Congress for the roll-out of the Affordable Care Act's website.

It has been an embarrassing disappointment, and we have said so ourselves.

So what's next?

Move on? Hardly.

House Republicans will continue to investigate the site's failings until it either works or until something more outrageous comes along.

Yesterday, one congressional critic really put things in perspective when he likened the roll-out to a rocket that blew up on the launch pad.

That is so sad. And so true.

But it probably reminded many Americans with long memories of something else.

Rockets? Launch pads? Exactly how many U.S. rockets blew up on the launch pad until we finally put a man on the moon? A lot. In fact, in 1967 three astronauts were killed in a launch pad accident.

Failure usually walks hand-in-hand with progress, and doing really big things guarantees setbacks and struggle.

It's been a long time, and there have been a thousand distractions, accusations, a near default and a 16-day government shutdown, and that's just been this year.

So, let's remember what this moon-shot was all about.

For a decade or more, Americans had been complaining about a health care system that costs too much, produces poor results, bankrupts sick people and leaves millions of our fellow Americans without access to consistent care.

And the Republican response to all these critical problems has been . . .

Well, only one actual response comes to mind — the highly successful

Massachusetts health care plan, proposed by a Republican governor and enacted by a bi-partisan legislature.

That plan was first proposed by a Republican think tank that reasoned everyone should be required to buy health insurance or to make an honest attempt to do so.

That was, obviously, because the system could only work if everyone who might need health insurance participated.

It was like requiring car owners to have insurance whether they had an accident or not.

This approach seemed logical until Barack Obama picked up the ball and started running with it.

So, now, it's probably a little hard to remember where this rocket ship was going. Why was this law passed in the first place?

1. So people did not suffer and die as a result of having no insurance. That happens to about 20,000 people a year. In September, Sen. Angus King explained how his own life was saved by insurance that resulted in early detection of an often-fatal form of skin cancer.
2. To provide access to health care for people with previous conditions. Insurance companies, bless their hearts, had generally refused to help very sick people.
3. To make sure Americans were spared from losing their homes, savings and financial futures because of a serious illness.
4. To allow Americans up to 26 years of age to remain on their parents' insurance policy so they can get their lives up and running.
5. To help bend the health care cost curve by rewarding high quality care that keeps the sickest among us as healthy as possible and out of the hospital.
6. To make sure Americans have access to affordable health insurance if they lose their job, or leave it to start their own company.
7. To expand Medicaid coverage to Americans who cannot afford to buy insurance at all, even though they work and are above the poverty level.
8. To reduce the Medicare Part D "doughnut hole" prescription gap.

There's more, but which parts of that aren't worth doing?

Like our space program of decades ago, the goals are very difficult to obtain. If they were easy, we would have done this long ago.

The law clearly isn't perfect, and it must improve. The process is messy, and it will disappoint some. The website is clearly a huge disappointment.

But what's the alternative? To do none of the above, or nothing at all?

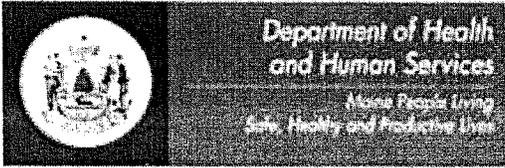
Some Republicans are committed to destroying the Affordable Care Act at all cost.

They are very good rock throwers. While that's invigorating sport, developing a better alternative, or working to fix the problems with Obamacare, might be more useful.

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The opinions expressed in this column reflect the views of the ownership and the editorial board.





Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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To: Senator Margaret M. Craven, Senate Chair  
 Representative Sharon Anglin Treat, House Chair  
 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 to the Department of Health and Human Services.

1. Please provide an update on the # of referrals DHHS has received from the Federally-facilitated marketplace (FFM) for individuals assessed as potentially eligible for MaineCare. How many individuals have been determined eligible and enrolled for coverage under current eligibility rules and under eligibility rules beginning January 1, 2014? How many individuals have been determined ineligible for MaineCare and referred back to the FFM for enrollment in a qualified health plan?

**Response:** CMS is unable to send the application/account transfers at this time. They are sending a weekly file to FFM/assessment states which provides a name and an address of those individuals they have assessed that may be MaineCare eligible. Thus far, Maine has received 733 unique households consisting of 1477 individuals that have applied at the FFM and were assessed as potentially eligible for MaineCare; approximately 21% of these applications refer to an inconsistency in citizenship and income between the self-attested application answers and FFM data sources that ultimately will require the State to reconcile once the FFM is fully functional on its Account Transfer capabilities. Due to the lack of the application/account transfer at this time from CMS, we are unable to process this information until CMS is technically prepared to transfer the required MAGI application for which a specific date has not yet been provided (ballpark estimate is end of November'13 / December'13)

For applications taken by the Department; determined eligible for MaineCare under MAGI rules after being determined ineligible under non-MAGI existing rules. These cases will be opened January 1, 2014.

Oct-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	7	9
MG20	MAGI Children age 19 '&' 20	3	3
MGCC	MAGI Cub Care	2	2
MGPC	MAGI Parent/Caretaker Relatives	5	5

Nov-13			
Code	Program	Cases	Clients
MG19	MAGI Children age < 19	9	10
MG20	MAGI Children age 19 '&' 20	4	4

MGPC	MAGI Parent/Caretaker Relatives	9	11
MGPR	MAGI Pregnant and Postpartum Women	1	1

<b>Dec-13</b>			
<b>Code</b>	<b>Program</b>	<b>Cases</b>	<b>Clients</b>
MG19	MAGI Children age < 19	42	54
MG20	MAGI Children age 19 '&' 20	41	42
MGCC	MAGI Cub Care	22	33
MGPC	MAGI Parent/Caretaker Relatives	116	134
MGPR	MAGI Pregnant and Postpartum Women	3	3

Determined ineligible for MaineCare under MAGI rules and under non-MAGI existing rules. Will be sent to the FFM.

<b>Oct-13</b>			
<b>Code</b>	<b>Program</b>	<b>Cases</b>	<b>Clients</b>
MG19	MAGI Children age < 19	16	20
MG20	MAGI Children age 19 '&' 20	4	4
MGCC	MAGI Cub Care	8	10
MGPC	MAGI Parent/Caretaker Relatives	24	35
MGPR	MAGI Pregnant and Postpartum Women	3	3
MGU1	MAGI Children under 1	1	1

<b>Nov-13</b>			
<b>Code</b>	<b>Program</b>	<b>Cases</b>	<b>Clients</b>
MG19	MAGI Children age < 19	23	28
MG20	MAGI Children age 19 '&' 20	8	8
MGCC	MAGI Cub Care	14	16
MGPC	MAGI Parent/Caretaker Relatives	42	62
MGPR	MAGI Pregnant and Postpartum Women	3	3
MGU1	MAGI Children under 1	1	1

<b>Dec-13</b>			
<b>Code</b>	<b>Program</b>	<b>Cases</b>	<b>Clients</b>
MG19	MAGI Children age < 19	114	155
MG20	MAGI Children age 19 '&' 20	20	22
MGCC	MAGI Cub Care	58	70
MGPC	MAGI Parent/Caretaker Relatives	413	574
MGPR	MAGI Pregnant and Postpartum Women	11	11
MGU1	MAGI Children under 1	2	2

2. Please provide an update on the anticipated implementation of MAGI rules (10/28/13) and the Account Transfer (AT) process (11/15/13). Have any issues been identified that may delay implementation? See DHHS response to Question #2 in October 18<sup>th</sup> memo.

**Response:** The MAGI Rules were successfully deployed on 11/4/13 and the Account Transfer deployment date will be prior to the end of the year, but we will not have a date until the final design is complete. We were asked to change direction in our priority by CMS from focus on SOM - FFM to FFM - SOM. We have since re-prioritized to our original based on CMS not being prepared to transfer full application data to the states.

3. Please provide a timeline or benchmark dates for implementation of the Business Process and IT Modernization project. See DHHS response to Question #7 in October 18<sup>th</sup> memo.

**Response:** We are in the early stages of planning and have developed and received DHHS Executive Management Team consensus on strategic guiding principles and prioritization criteria. We will be conducting workshops over the next several weeks with various subject matter experts across the DHHS offices and technology resources. These workshops are intended to develop the initial scope and milestones for the initiative which will inform the Expedited Advance Planning Document (EAPD) we plan to submit to CMS by 1/30/14. A detailed implementation roadmap based on prioritization is targeted preliminarily for end of Q2'14.

4. Please provide demographic information on the 1345 individuals enrolled in the PHIP program. What is the retention rate for those enrolled in PHIP coverage? See DHHS response to Question #8 in October 18<sup>th</sup> memo.

**Response:** Will provide at a later date.



11/18/13

From Maine Bureau of Insurance  
TO: Me Health Exchange Ad. Comm.

Please find below the Bureau of Insurance responses to the three questions you have posed. These responses are prepared without consideration of President Obama's November 13, 2013 announcement regarding the change in his Administration's policy regarding enforcement of certain provisions of the Affordable Care Act with respect to policies in effect as of October 1, 2013. The Bureau is in the process of learning the details of this change, determining its' effect on the Maine health insurance marketplace and determining the appropriate state regulatory response.

**1. Please provide an update on whether the Bureau is receiving consumer inquiries/ complaints related to health plans participating in the marketplace or the marketplace generally. What is the general nature of the inquiries or any complaints? How many have been received by BOI?**

Through November 12, the Bureau has received 601 telephone calls related to the Affordable Care Act. Most of them deal with finding out what coverage is available, trying to obtain information about the health plans themselves (MCHO), help with understanding the rates of the products, explaining the metal levels (bronze, silver, gold, platinum), what the plans cover (EHB), provider network questions, prescription drug coverage questions, how to find a navigator or an insurance producer/broker.

Callers express three areas of dissatisfaction:

- A high level of dissatisfaction and frustration that the website "Healthcare.gov" is not functioning.
- A level of dissatisfaction when the consumer is not eligible for subsidy and their rates increase because they previously had a high deductible plan.
- A level of dissatisfaction because Medicaid was not expanded.

**2. Please provide an update on the Bureau's regulatory role and relationship with the FFM and qualified health plans participating in the FFM. Are there any issues or problems that are affecting BOI's regulatory oversight?**

The Center for Consumer Information and Insurance Oversight (CCIIO), an agency within CMS, has designated a state officer who serves as our liaison for communications regarding the ACA including any communications regarding the marketplace. The Bureau is in contact with the state officer at least weekly and, in most cases, several times per week. These communications enable us to ask questions regarding CCIIO's interpretation or position regarding the many regulations that it has adopted with respect to the ACA as well as to convey the concerns we are hearing from callers with respect to the problems with accessing the FFM.

Maine has two health insurance carriers (referred to as "plan issuers" by the federal agencies) who have qualified health plans and are participating in the FFM. These are Maine Community Health Options and Anthem Health Plans of Maine. Our regulatory

oversight of these plans remains in effect, with the exception that external review appeals of multistate plans offered by Anthem on the exchange in 2014 will be subject to the exclusive jurisdiction of the federal Office of Personnel Management (OPM), not the State of Maine.

The technical problems plaguing the FFM and the federal data service hub have been well documented. There is cause for concern regarding the effect these problems will have on the ability of consumers to enroll in a plan through the FFM by December 15, 2013. Premium tax credits and cost sharing subsidies provided under the Affordable Care Act are only available through coverage written through the Exchange. For many Mainers, these credits and subsidies are critical to their ability to afford health insurance coverage in 2014 as coverage for many will be substantially more expensive than previously was the case. This problem will be especially acute for those who currently have high deductible policies which are illegal beginning in 2014 under the ACA. The recent announcement from the White House that monetary penalties will not be enforced as long as people enroll by the end of the open enrollment period will help some consumers avoid penalties, but those that depend upon health insurance coverage to treat serious medical conditions cannot afford a gap in coverage. While these consumers can still purchase off-exchange coverage for 2014 from several carriers, they will not be able to receive the financial assistance that was anticipated.

Public concern with cancellation of coverage of persons insured in the individual market without adequate and affordable replacement coverage has also been well-documented nationally. We can provide the following Maine-specific information. The individual market consists of approximately 33,000 lives, but some policies are grandfathered and will not be cancelled.

1. MEGA: No one with a MEGA policy will lose their coverage. 4,558 grandfathered lives and 6,175 non-grandfathered lives are covered by MEGA. The Bureau allowed MEGA to amend existing non-grandfathered policies to allow them to renew on December 31, 2013 for coverage until December 31, 2014. A template of MEGA's letter to its policyholders is attached.



Maine Letter (PY AE Only) 10 29 13.pdf

2. Anthem: 8,503 grandfathered lives may keep their current coverage and 9,639 non-grandfathered lives will be able to get mapped to ACA-compliant products. (The non-grandfathered lives policies are being canceled.)  
[http://www.maine.gov/pfr/insurance/Anthem\\_INS-803\\_2013/PDF/Whitmore\\_Exhibit\\_A.pdf](http://www.maine.gov/pfr/insurance/Anthem_INS-803_2013/PDF/Whitmore_Exhibit_A.pdf).  
Attached is the link to Anthem's "mapping of non ACA compliant plans to ACA compliant ones..."  
[http://www.maine.gov/pfr/insurance/ACA/PDF/Anthem\\_mapping/Proposed\\_Mapping.pdf](http://www.maine.gov/pfr/insurance/ACA/PDF/Anthem_mapping/Proposed_Mapping.pdf)
3. Dirigo – they had 8,709 individual and small group covered lives as of 12/31/12 and all will be cancelled 12/31/13 that still have it now. These terminations are

due to the termination of the Dirigo program and are not caused by ACA requirements.

4. Several small companies with old closed blocks; probably less than 10 lives.
5. Renewing sole proprietors will no longer keep their group coverage because they are not recognized as a “group” under the ACA. We don’t have an accurate figure on the number of sole proprietors affected.

The lack of information on FFM activities presents challenges for the Bureau. Along with other states we need and have been seeking a full list of all individual agents and brokers, Navigators and Certified Application Counselors (CACs) that have been trained and certified by the federal Marketplace. At this point, we have received no information from CCIIO regarding information about the individuals who are performing these functions for the federal Marketplace. We have so far been able to identify individual navigators through the development of a working relationship with the two navigator entities providing services as CMS grantees. It is expected that CCIIO may release at least some of this information sometime soon after November 22.

**3. Based on feedback from the NAIC or other state insurance bureaus, what additional activities or functions are being undertaken by state insurance regulators in states that have entered into a partnership exchange for plan management and/or consumer assistance functions? How are these activities different from what the Maine BOI is doing?**

As we understand it, States participating in a Consumer Partnership Exchange assume primary day-to-day management of the Navigator program, including ongoing monitoring and the provision of technical assistance to Navigators. States also are expected to assume direct operation of in-person assistance programs distinct and apart from the Navigator programs. Consumer partnership states also assume a substantial responsibility for marketing, outreach and the provision of enrollment assistance in the FFM within their jurisdiction. Please find below a description of partnership exchange State outreach and education functions as appearing in a January 3, 2013 CCIIO Memorandum:

*Minimum Standards for State Activities and Deliverables for a State Consumer Partnership Exchange.*

The Outreach and Education Plan should include a plan for developing:

- Consumer-focused content that clearly explains all consumer eligibility and enrollment options, program information, benefits, and services available.
- Content written in plain language, free of jargon and using active task-based labels whenever possible.

- Culturally and linguistically appropriate outreach methods a. If paid media is utilized, an overview including timing and channels (for example, television, radio, print, out-of-home, and online)

- b. A clear call to action referencing the FFE website.

- Education about: a. Eligibility and enrollment

- b. Program information

- c. Benefits and services available through the Exchange and other insurance affordability options

- Outreach and education targeted to various stakeholders.

- Performance metrics for tracking results

- Content development plans should include consumer testing, including testing among persons with limited English proficiency and persons with disabilities, to make sure content and language resonate with target audiences and should identify the types of auxiliary aids and services available and any language assistance services.

The Bureau does not have sufficient information to provide the Committee reliable information regarding the experiences of other states which may have undertaken these functions.

Maine BOI's role differs from that of a Consumer Partnership in that the Bureau has not assumed responsibility for operation or marketing of the FFM. We have been active, however in providing assistance to Maine individuals and businesses through information on our website, through responding to calls to the Bureau as discussed above and through twenty-six outreach presentations we have done to groups and communities throughout the State. Seven more outreach presentations are currently scheduled. Attached is a link to the Powerpoint presentation currently on the Bureau website and in use at our outreach presentations.

[http://www.maine.gov/pfr/insurance/ACA/ACA\\_Forum\\_August\\_2013.pptx](http://www.maine.gov/pfr/insurance/ACA/ACA_Forum_August_2013.pptx)

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STATE OF MAINE

ONE HUNDRED AND TWENTY-SIXTH LEGISLATURE  
MAINE HEALTH EXCHANGE ADVISORY COMMITTEE

October 25, 2013

Christie L. Hager, J.D., M.P.H.  
Regional Director  
U.S. Department of Health and Human Services, Region One  
John F. Kennedy Federal Building, Suite 2100  
Boston, MA 02203

Re: Implementation and Operations of Federally-facilitated Marketplace in Maine

Dear Ms. Hager,

Thank you again for your speaking with us by conference call on Monday to provide an update on the implementation and operations of the federally-facilitated marketplace in Maine. On behalf of the Maine Health Exchange Advisory Committee, we are writing to convey our concerns related to the need for Maine-specific data and increased outreach and education as well as our concerns about the functionality of the online marketplace, healthcare.gov, and the technical issues experienced by Maine consumers.

First, we want to reiterate our need for Maine-specific data. In order to fulfill our role as an adviser regarding the interests of individuals and small business with respect to the marketplace, we need to have information about the Maine consumers visiting healthcare.gov or seeking assistance from the call center, navigators or certified application counselors; the Maine consumers enrolling in health insurance plans through the marketplace; the Maine consumers determined eligible for MaineCare; and the Maine consumers who fall into the "coverage gap" due to the State's decision not to expand the MaineCare program as provided in the Affordable Care Act. During our conference call, you indicated that enrollment data may be available in mid-November. To the extent possible, we request that you provide us with the information we've requested before the next Advisory Committee meeting on November 18, 2013.

We also feel strongly that additional resources are needed to provide outreach and education and enrollment assistance throughout Maine. At this time, we understand that federal funding for navigators was provided on a one-year basis. We recommend that federal funding for navigators be extended through 2014. In addition, we are committed to

exploring all options available to the State to provide funding for consumer assistance and look forward to discussing those options with you further.

At the Advisory Committee's meeting on October 21<sup>st</sup>, we heard from representatives of consumer advocates, certified application counselors, small business advocates and others about their frustration with healthcare.gov. Specific problems logging on and creating accounts and previewing health plans and premiums have been well-documented. These technical problems must be fixed as soon as possible. In order to assist Maine individuals and small businesses seeking access to coverage through the marketplace, we recommend that a reasonable timeline be developed (and communicated to the public) to deliver a fully functional website.

We also heard from small business advocates that the terminology used with regard to the SHOP marketplace may be confusing to small businesses. When moving from screen to screen on the website using the new "preview plan" tool, terms like "full-time employee" and "full-time equivalent employee" are used interchangeably without providing context for why there may be a statutory or regulatory basis for the distinctions. We believe improvements can be made to the website's content as well as its technology infrastructure.

If the technical glitches are not resolved before the end of November, we are concerned that Maine consumers may not have their enrollment applications for private health insurance coverage through the marketplace or for MaineCare coverage processed in a timely manner to enable them to have health coverage in place on January 1, 2014. If there continues to be uncertainty as to whether all enrollment applications will be acted on in time for a January 1, 2014 effective date, we urge the Secretary of Health and Human Services to consider extending the deadline for enrollment and premium payment from December 15<sup>th</sup> to December 31<sup>st</sup>. We also support aligning the individual mandate penalty with the existing open enrollment window.

Thank you for your consideration. We look forward to working with you to fully implement Maine's federally-facilitated marketplace to provide health insurance coverage to all eligible Maine consumers.

Sincerely,



Margaret M. Craven  
Senate Chair



Sharon Anglin Treat  
House Chair

cc: Maine Health Exchange Advisory Committee members



# ASPE

## Issue BRIEF

### HEALTH INSURANCE MARKETPLACE: NOVEMBER ENROLLMENT REPORT

November 13, 2013

This issue brief highlights national and state-level enrollment-related information for the first month of the Health Insurance Marketplace (Marketplace hereafter) initial open enrollment period that began October 1, 2013 for coverage beginning January 1, 2014 (see Appendix A for state-level data). It also provides an overview of the methodology that was used in compiling these data (see Appendix B), and includes information about strategies to reach consumers.

These data represent a “snapshot” of Marketplace enrollment that uses comparable definitions for the data elements across states, and between states that are implementing their own Marketplaces (also known as State-Based Marketplaces or SBMs) and states with Marketplaces that are supported by or fully-run by the Department of Health and Human Services (including those run in partnership with states, also known as the Federally-facilitated Marketplace or FFM). Data related to Medicaid and Children’s Health Insurance Program (CHIP) eligibility in this report are based on applications submitted through the Marketplaces. Enrollment based on applications submitted through state Medicaid/CHIP agencies will be released in a subsequent report.

*It is important to note that the SBM enrollment-related data that are reported in this issue brief may differ from comparable data that have previously been publicly reported on SBM websites or in media reports due to differences in time periods and metric definitions.*

The following are highlights of Marketplace enrollment-related information for the first month.

Marketplace Monthly Enrollment-Related Information, 10-1-13 to 11-2-13 (1)	Number
Number of completed applications through the Marketplaces	846,184
Total number of individuals included in completed Marketplace applications	1,509,883
Number of individuals determined eligible to enroll in a Marketplace plan	1,081,592
Number of individuals who have selected a Marketplace plan	106,185

(1) Oct 1- Nov 2 most closely represents the first month of operations since state based Marketplaces generally compile enrollment-related metrics on a weekly basis. Any differences in reporting periods among states are noted in footnotes accompanying the Table in Appendix A.

The first month enrollment experience in the Marketplace exceeds comparable first month enrollment in the Commonwealth Care program in the Massachusetts Health Connector. In Massachusetts, the number of premium-paying enrollees who signed up during the first month of enrollment was 123 or 0.3 percent of the total enrollment of 36,167 at the end of the year.<sup>1</sup>

<sup>1</sup> Source: Commonwealth Health Insurance Connector Authority as cited in the The New Republic, Oct. 23, 2013. Available online: <http://www.newrepublic.com/article/115309/obamacare-enrollment-massachusetts-statistics-suggest-it-will-be-slow>

Marketplace plan selection of 106,185 is 1.5 percent of the estimated enrollees at the end of the 2014 open enrollment period (Congressional Budget Office (CBO) estimate, May 2013). (See Appendix C for more information on enrollment experiences in other programs.)

#### Marketplace Website and Call Center Activity

Unique Visitors on the SBM and FFM websites: 26,876,527

Calls to the SBM and FFM call centers: 3,158,436

### Overview of Enrollment to Date

To date, 106,185 persons have enrolled and selected a Marketplace plan—this includes those who have paid a premium and those who have not yet paid a premium.

Based on available data, 846,184 completed applications were submitted to Marketplaces during the first month of the initial open enrollment period (10-1-13 to 11-2-13), including applications that were submitted to the SBMs and FFM. These completed applications correspond to a total of 1,509,883 million individuals (persons) who have applied for coverage through the Marketplaces during this time period. This represents 22 percent of the Congressional Budget Office (CBO) estimated 7 million Marketplace enrollment in 2014.<sup>2</sup> (Please see Appendix A for corresponding tables containing state-level data, and see Appendix B for methodological information on how these numbers were derived).

The Marketplaces have helped a total of 1,477,853 persons by determining or assessing<sup>3</sup> that they are either eligible to enroll in a Marketplace plan (used throughout this report—also known as Qualified Health Plans or QHPs) with or without financial assistance, or in Medicaid or the Children’s Health Insurance Program (CHIP). To date, 106,185 persons have selected a Marketplace plan—this includes 79,391 in SBMs and 26,794 in FFM. An additional 975,407 persons who have been determined eligible have not yet selected a plan through the Marketplace.

To date, the Marketplaces have processed eligibility determinations and assessments for 98 percent (1,477,853) of the 1,509,883 persons who have applied for coverage – including:

- 1,081,592 persons (73 percent of the total number of persons with processed eligibility determinations / assessments) have been determined eligible to enroll in a Marketplace plan, (including 326,130 persons who have been determined eligible to enroll in a Marketplace plan with financial assistance),
  - 106,185 (10 percent) of the 1,081,592 total Marketplace plan eligible persons have already selected a plan by clicking a button on the website page.

<sup>2</sup> CBO estimates 7 million individuals will enroll in qualified health plans (QHPs) through the Marketplace in 2014. [http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190\\_EffectsAffordableCareActHealthInsuranceCoverage\\_2.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf).

<sup>3</sup> Accounts of individuals who have been determined or assessed eligible for Medicaid or CHIP are transferred to state Medicaid and CHIP agencies, which then take any action needed to effectuate enrollment. “Assessment” refers to those FFM states where the state has chosen to retain the ability make the final eligibility determination.

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Enrollment includes those who have selected a plan including those who have paid their first month premium and those who have not yet done so.

- 396,261 persons (27 percent of the total number of persons with processed eligibility determinations / assessments) who have been determined or assessed eligible for Medicaid or CHIP.<sup>4</sup>

A total of 502,446, or 1 in 3 of the 1,477,853 people whose eligibility determinations / assessments have been processed, have either been determined or assessed eligible for Medicaid or CHIP or have selected a plan in the Marketplaces. Meanwhile, 722,391 (49 percent) of the 1,477,853 whose eligibility determinations / assessments have been processed are either eligible for financial assistance through the Marketplaces, or have been determined or assessed eligible for Medicaid or CHIP.

An additional 201,137 persons who applied for coverage through the Marketplaces have eligibility determinations that are either pending, not captured in the Marketplace plan and Medicaid/CHIP eligibility counts for a given state, or negative (meaning that they have not been determined eligible to enroll in a Marketplace plan).

The available data on completed applications, eligibility determinations and assessments, and Marketplace plan selection represents a subset of the total number of Americans who have begun exploring the coverage options that are available through the new Marketplaces. There is considerable interest in the new Marketplaces as measured by unique visitors on the SBM and FFM websites (26,876,527), and calls to the SBM and FFM call centers (3,158,436).

These early enrollment-related statistics suggest that, in spite of recent information system and website issues, interest in the Marketplaces is high. For example a Commonwealth Fund survey conducted Oct. 9-27<sup>5</sup> polled adults (ages 19-64) who are uninsured or have individual market coverage and found that most (60 percent) are aware of the Marketplace. Further, the Commonwealth Fund found that 53 percent are aware that financial support is available for Marketplace coverage and 17 percent have visited the Marketplace. Most (58 percent) said they are very likely or somewhat likely to go or go back to visit the Marketplace to enroll in a plan or to apply for the premium tax credit or for Medicaid/CHIP before the open enrollment period ends on March 31, 2014. (See Appendix D for more information).

Marketplace enrollment is expected to increase as technical issues are resolved.

### **Enrollment Experience in Other Programs**

Based on the experience of the Federal Employees Health Benefits Program (FEHBP), Medicare Part D, Massachusetts' Commonwealth Care, and the Children's Health Insurance Program

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<sup>4</sup> Most FFMs assess individuals as eligible for Medicaid or CHIP, and the state Medicaid or CHIP agency takes additional steps to finalize an eligibility determination. In states that accept the FFM's eligibility determination, the state will take steps to effectuate enrollment.

<sup>5</sup> <http://www.commonwealthfund.org/Publications/Data-Briefs/2013/Nov/Americans-Experiences-Marketplaces.aspx>

(CHIP), several factors drive enrollment rates, particularly in the early months of program operation (See Appendix C):

- “Action-forcing” events — such as the end date of an open enrollment period or the start date for benefits — often result in a spike in enrollment activity.
- The length of a program’s pre-benefit period (i.e., the period between sign-up/enrollment and the receipt of benefits) also affects rates of initial enrollment: Shorter pre-benefit periods (e.g., 1 month) tend to generate higher initial enrollment rates than longer pre-benefit periods, during which the consumer may perceive little advantage to signing up or enrolling early.

Based on this experience, the Department expects Marketplace enrollment will start slowly, with peaks in December (as the January 1 coverage date approaches) and March (as the close of open enrollment approaches).

Based on available data for the first reporting period, the level of early Marketplace enrollment appears to be consistent with expectations based on the Massachusetts Commonwealth Care experience. Many of the SBMs have experienced first-month enrollment-related activity that exceeds comparable Commonwealth Care enrollment for the first month of open enrollment (See Appendix C for more information).<sup>6</sup>

The SBMs’ experience to date regarding the type of eligibility determinations and assessments appear similar to Commonwealth Care’s early months of enrollment as well. There were large differences in initial enrollment rates in Commonwealth Care between persons who qualified for plans not requiring a premium payment and persons who did not qualify. Only about 4,000 individuals signed up in the first couple months of the program for plans requiring a premium payment. *The majority of individuals who enrolled in Commonwealth Care during the first year were in plans that did not require the enrollee to pay a premium.* Many of the SBMs have experienced first-month enrollment-related activity with substantial numbers of Medicaid eligible individuals applying to the Marketplace. Enrollment of individuals anticipating paying a premium for coverage is expected to increase as the start date for benefits, January 1, 2014, approaches.

### **Methodological Overview**

This report summarizes available data on enrollment-related activity during the first month of the initial open enrollment period for the Marketplaces – including the number of completed applications, the number of processed eligibility determinations, and the number of completed Marketplace plan selections. The data that are reported in this issue brief have been generated by the information systems of the Centers for Medicare & Medicaid Services (CMS), based on information reported to CMS by SBMs, and information collected by the FFM for states with HHS- supported or fully run Marketplaces (including those run in partnership with states).

<sup>6</sup> Massachusetts auto-enrolled a large number of individuals from the state’s uncompensated care pool into Commonwealth Care, a process which began October 1, 2006, before open enrollment became available to the broader Commonwealth Care-eligible population on January 1, 2007. The population that was allowed to enroll starting in January 2007 could qualify for premium subsidies based on income.

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Unless otherwise noted, the data in this issue brief represent cumulative Marketplace enrollment-related activity for the 10-1-13 to 11-2-13 reporting period, with information available as of 11-12-13. Data for certain metrics are not yet available for some states due to information system issues. We anticipate that more comprehensive data will be available in future monthly enrollment-related reports as system issues are resolved. (Please see Appendix B for additional methodological information and technical notes, including information about any limitations or clarifications regarding specific data points.)

We believe that the information contained in this issue brief provides the most systematic “snapshot” of enrollment-related activity in the Marketplaces to date because the data for the various metrics are counted using comparable definitions for data elements across states, and between the SBMs and FFM. **It is important to note that the SBM enrollment-related data that are reported in this issue brief represent state data that have been reported to CMS, and may differ from comparable data that have previously been publicly reported on SBM websites or in media reports because that data may be based on different time periods or metric definitions from those used in this report.**

### **Details on Marketplace Enrollment-Related Activity to Date**

The following are highlights of enrollment-related activity in the Marketplaces during the first month of the initial open enrollment period (see Appendix A for state-level data).

**Completed Applications** – A total of 846,184 completed applications were submitted to the Marketplaces during the first month of the initial open enrollment period (10-1-13 to 11-2-13). This includes 326,623 completed applications (39 percent of the combined SBM-FFM total) that were submitted to the SBMs, and 519,561 completed applications (61 percent of the combined SBM-FFM total) that were submitted to the FFM. In addition to these applications, the FFM also has 259,107 additional paper and call center applications that are not included in this total.

Based on currently available data, electronically-submitted (online) applications (including applications submitted through the Marketplace websites, as well as any applications that were submitted online through in-person assisters or the call center) accounted for approximately 74 percent of the completed applications that were submitted to the Marketplaces during the reporting period. The remainder of the completed applications (26 percent) were submitted on paper (including applications that were submitted by mail, as well as any applications through in-person assisters or the call center that were filled out on paper). On average, approximately 93 percent of the completed applications that were submitted to the SBMs were submitted electronically, and 67 percent of the completed applications that were submitted to the FFM were submitted electronically.

**Number of Persons Applying for Coverage in Completed Applications** – The 846,184 completed applications correspond to a total of 1,509,883 persons who have applied for coverage through the Marketplaces during this time period. The total number of persons applying for coverage is higher than the total number of completed applications because each application can potentially include multiple persons (such as spouses or dependents). A total of 516,248 persons (34 percent of the combined SBM-FFM total) have applied for coverage through the SBMs, and

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993,635 persons (66 percent of the combined SBM-FFM total) have applied for coverage through the FFM.

***Number of Persons Determined or Assessed Eligible to Enroll in Coverage Through the Marketplace*** – Overall, the Marketplaces have processed eligibility determinations for 98 percent (1,477,853) of the 1,509,883 total persons who have applied for coverage through the Marketplaces. Of these, 1,081,592 persons have been determined eligible to enroll in a plan through the Marketplace, representing 72 percent of the total persons who have applied for coverage through the Marketplaces as a whole, and 396,261 persons have been determined or assessed eligible for Medicaid or the Children’s Health Insurance Program (CHIP), representing 26 percent of the total persons who have applied for coverage through the Marketplaces as a whole. Additionally, approximately 30 percent of the 1,081,592 total persons who have been determined eligible to enroll in a plan through the Marketplace have also been determined eligible to enroll in a plan with financial assistance (326,130, representing 22 percent of the total persons who have applied for coverage through the Marketplaces as a whole, and 22 percent of the total eligibility determinations / assessments that have been processed). The remaining 755,462 other Marketplace plan eligible persons includes individuals who: didn’t apply for financial assistance; applied for financial assistance and were found ineligible; applied for financial assistance and their applications are pending.

- ***Number of Persons Determined Eligible to Enroll in Coverage by the SBMs*** – The SBMs have processed eligibility determinations for 591,838 persons who have applied for coverage through the SBMs; however, this percentage varies by state due to differences in processing times. Within the SBMs, 378,973 persons have been determined eligible to enroll in a Marketplace plan, and 212,865 persons have been determined eligible for Medicaid or CHIP using MAGI determination criteria. Additionally, approximately 23 percent (88,953) of the 378,973 total Marketplace plan eligible persons in the SBMs have also been determined eligible to enroll in a plan with financial assistance.<sup>7</sup>
- ***Number of Persons Determined or Assessed Eligible to Enroll in Coverage by the FFM*** – The FFM has processed eligibility determinations for 89 percent (886,015) of the 993,635 persons who have applied for coverage through the FFM. Within the FFM, 702,619 persons have been determined eligible to enroll in a Marketplace plan (representing 71 percent of the total persons who have applied for coverage through the FFM), and 183,396 persons have been determined or assessed eligible for Medicaid or CHIP under MAGI determination criteria (representing 18 percent of the total persons who have applied for coverage through the FFM). Additionally, approximately 34 percent (237,177) of the 702,619 total Marketplace plan eligible persons in the FFM have also been determined eligible to enroll in a plan with financial assistance<sup>8</sup> (also representing 24 percent of the total persons who have applied for coverage through the

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<sup>7</sup> SBM data on the number of persons with processed eligibility determinations or assessments do not add to the total number of persons applying for coverage in completed applications due to missing data.

<sup>8</sup> Represents the total number of individuals determined to be eligible for plan enrollment through the Marketplace, who qualify for advance premium tax credits (APTC).

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FFM).

An additional 201,137 persons who applied for coverage through the Marketplaces (including approximately 93,245 in SBMs, and 107,892 in the FFM) have eligibility determinations in the Pending/Other category, including those who: 1) have a pending eligibility determination or assessment for a Marketplace plan or Medicaid/CHIP coverage; 2) have a processed eligibility determination or assessment for a Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace coverage.

***Number of Persons Who Have Selected a Marketplace plan*** – Overall an estimated 106,185 (10 percent) of the persons who have been determined eligible to enroll in a plan through the Marketplace have already selected a plan (including both those who have paid the first month's premium and those who have not yet paid the first month's premium). An additional 975,407 persons who have been determined eligible have not yet selected a plan through the Marketplace.

- ***Number of Persons Who Have Selected a Marketplace plan in SBMs*** – Within the SBMs, 79,391 (21 percent) of the persons who have been determined eligible to enroll in a plan through the Marketplace have already selected a plan through the SBM (including both those who have paid the first month's premium and those who have not yet paid the first month's premium).
- ***Number of Persons Who Have Selected a Marketplace plan in the FFM*** – Within the FFM, overall 26,794 (4 percent) of the persons who have been determined eligible to enroll in a plan through the Marketplace have already selected a plan through the FFM (including both those who have paid the first month's premium and those who have not yet paid the first month's premium).

## **Highlights of Marketplace Customer Service and Outreach**

***Customer Service*** – Based on available data, there have been a total of 26,876,527 unique visitors on the Marketplace websites, and a total of 3,158,436 calls to the SBM and FFM Marketplace call centers.

- ***Customer Service (Website and Call Center Utilization) in SBMs*** – Based on available data, there have been a total of 7,376,527 unique visitors on the SBM websites, and a total of 923,170 calls to the SBM call centers.
- ***Customer Service (Website and Call Center Utilization) in the FFM*** – Based on available data, there have been a total of approximately 19,500,000 unique visitors on the FFM website, and a total of 2,235,266 calls to the FFM call center.

***Outreach*** Several types of marketplace assisters help people navigate the new system. As of November 1, 2013, over 18,000 assisters have been trained in the states that are a part of the Federally-facilitated Marketplace. These assisters have informally reported that they have conducted over 2,800 education and outreach events that have reached over 450,000 consumers

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in their states.

### **Maximizing Marketplace Enrollment: SBM Experiences**

**CA:** California has conducted extensive public outreach efforts across the state, spending \$94 million dollars to help community groups, local health clinics, and labor unions reach residents and sign them up for coverage. California has used radio and television commercials, highway billboard advertisements, and a number of Twitter and Facebook posts to spread awareness of Covered California throughout the state. To reach its Latino population, California has established partnerships with Univision, Telemundo, La Opinion and impreMedia to implement Spanish-language media campaigns through TV, radio, print, and digital media. Outreach workers who speak Spanish, Tagalog, Cambodian, Mandarin and Cantonese are attending local community events such as county fairs, farmers markets, street festivals and back-to-school nights across the state.

**KY:** Kentucky reports tens of thousands of enrollees in its Marketplace, with high rates of enrollment by young adults under 35 years old (40 percent) and women (59 percent). The Kentucky Health Benefit Exchange has awarded nearly \$6.5 million in contracts to navigator programs throughout the state to ensure that Kentuckians have assisters to help them determine their health plan needs and assist them in choosing appropriate plans. The state also has 3,400 certified insurance agents trained to explain the multiple offerings available.

**NY:** New York State of Health (NYSOH) Marketplace officials report that nearly 174,000 New Yorkers had completed the full application process and were determined eligible for coverage as of October 23, 2013. The fast pace of New York's enrollment uptake indicates that many New Yorkers are seeking affordable health coverage. NYSOH's customer service operators have assisted more than 77,000 New Yorkers. Another potential factor in New York's success is the reduced rates in the individual market. NYSOH reports a 53 percent reduction compared to the previous year's rates.

## APPENDIX A

**TOTAL MARKETPLACE APPLICATIONS, ELIGIBILITY DETERMINATIONS, AND  
MARKETPLACE PLAN SELECTIONS BY MARKETPLACE TYPE AND STATE, 10-1-2013  
TO 11-2-2013**

Total Marketplace Applications, Eligibility Determinations, and Marketplace Plan Selections By Marketplace Type and State (1) 10-1-2013 to 11-2-2013							
State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
<b>States Implementing Their Own Marketplaces (SBMs)</b>							
California (9)	105,782	192,489	93,663	N/A	79,519	19,307	35,364
Colorado (10)	20,492	45,575	36,335	8,742	N/A	9,240	3,736
Connecticut	12,337	18,815	12,325	6,807	6,490	0	4,418
District Of Columbia (11)	2,541	N/A	N/A	N/A	N/A	N/A	N/A
Hawaii (12)	1,754	2,379	1,156	N/A	N/A	1,223	N/A
Kentucky	50,279	76,294	39,207	13,201	28,676	8,411	5,586
Maryland	10,917	N/A	3,498	2,638	5,923	N/A	1,284
Massachusetts (13)	14,413	N/A	N/A	N/A	N/A	N/A	N/A
Minnesota (14)	15,268	31,447	21,532	6,759	9,166	749	1,774
Nevada	9,186	14,819	N/A	N/A	5,710	9,109	1,217
New York	N/A	N/A	134,897	34,267	23,902	N/A	16,404
Oregon (15)	8,752	N/A	190	N/A	425	N/A	N/A
Rhode Island	6,670	9,581	3,326	2,086	3,447	2,808	1,192
Vermont	3,242	5,540	3,341	1,078	1,411	788	1,325
Washington (16)	64,990	119,309	29,503	13,375	48,196	41,610	7,091
<b>SBM Subtotal</b>	<b>326,623</b>	<b>516,248</b>	<b>378,973</b>	<b>88,953</b>	<b>212,865</b>	<b>93,245</b>	<b>79,391</b>
<b>States With Marketplaces that are Supported by or Fully-Run by HHS (FFM)</b>							
Idaho (17)	4,753	10,573	7,733	3,305	1,597	1,243	338
New Mexico (17,18)	4,055	7,529	4,249	1,549	3,552	N/A	172
Alabama	10,573	20,840	14,696	4,910	2,262	3,882	624
Alaska	1,253	2,203	1,606	598	368	229	53
Arizona	17,220	32,897	20,741	7,156	11,339	817	739
Arkansas	7,294	14,059	6,123	2,279	7,430	506	250

**Total Marketplace Applications, Eligibility Determinations, and  
Marketplace Plan Selections By Marketplace Type and State (1)**

10-1-2013 to 11-2-2013

State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
Delaware	1,897	3,491	2,204	674	1,200	87	97
Florida	67,366	123,870	93,456	29,637	12,887	17,527	3,571
Georgia	28,642	56,783	41,426	12,757	7,709	7,648	1,390
Illinois	30,901	56,636	35,802	11,603	19,447	1,387	1,370
Indiana	15,982	31,979	19,093	7,890	11,305	1,581	701
Iowa	5,547	10,884	6,104	2,079	4,490	290	136
Kansas	6,061	12,205	9,087	3,009	1,718	1,400	371
Louisiana	7,702	14,163	10,294	3,277	1,460	2,409	387
Maine	3,550	6,497	5,061	2,116	623	813	271
Michigan	23,987	44,025	34,197	12,468	4,978	4,850	1,320
Mississippi	4,339	8,204	5,822	1,662	925	1,457	14
Missouri	14,131	27,911	20,121	7,111	4,157	3,633	751
Montana	2,683	5,205	3,815	1,711	457	933	212
Nebraska	4,947	9,973	7,453	2,967	2,295	225	338
New Hampshire	4,006	7,817	5,767	2,016	1,643	407	269
New Jersey	23,021	42,372	23,985	8,082	17,460	927	741
North Carolina	29,547	57,653	42,110	15,051	7,404	8,139	1,662
North Dakota	969	1,845	1,180	370	585	80	42
Ohio	24,050	45,128	34,374	11,866	7,535	3,219	1,150
Oklahoma	6,905	14,169	9,952	1,432	2,412	1,805	346
Pennsylvania	31,827	57,674	43,966	15,497	3,788	9,920	2,207
South Carolina	11,249	20,980	15,257	4,973	3,112	2,611	572
South Dakota	1,491	3,081	2,279	822	525	277	58
Tennessee	17,598	33,230	24,334	8,573	4,089	4,807	992
Texas	53,904	108,410	80,960	25,520	11,682	15,768	2,991
Utah	6,186	14,580	9,318	3,883	4,816	446	357
Virginia	21,667	42,341	32,534	9,333	4,088	5,719	1,023
West Virginia	3,807	7,096	3,442	1,268	3,103	551	174
Wisconsin	19,098	34,678	22,038	8,911	10,736	1,904	877
Wyoming	1,353	2,654	2,040	822	219	395	85
<b>FFM Subtotal</b>	<b>519,561</b>	<b>993,635</b>	<b>702,619</b>	<b>237,177</b>	<b>183,396</b>	<b>107,892</b>	<b>26,797</b>

**Total Marketplace Applications, Eligibility Determinations, and  
Marketplace Plan Selections By Marketplace Type and State (1)**

10-1-2013 to 11-2-2013

State Name	Total Number of Completed Applications (2)	Total Individuals Applying for Coverage in Completed Applications (3)	Number of Individuals Determined Eligible to Enroll in a Marketplace Plan		Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace (6)	Pending/ Other (7)	Number of Individuals Who Have Selected a Marketplace Plan (8)
			Total Eligible to Enroll in a Marketplace Plan (4)	Eligible to Enroll in a Marketplace Plan with Financial Assistance (5)			
	Number	Number	Number	Number	Number	Number	Number
<b>MARKETPLACE TOTAL, All States</b>	<b>846,184</b>	<b>1,509,883</b>	<b>1,081,592</b>	<b>326,130</b>	<b>396,261</b>	<b>201,137</b>	<b>106,185</b>

## Notes:

“N/A” means that the data for the respective metric is not yet available for a given state.

(1) Unless otherwise noted, the data in this table represent cumulative Marketplace enrollment-related activity for 10/1/13 to 11/2/13.

(2) “Completed Applications” represents the total number of electronic and paper applications that were submitted to the Marketplace during the reference period with sufficient information to begin performing eligibility determinations for enrollment in a plan through the Marketplace and, if the applicant applied for insurance affordability programs, sufficient information to begin performing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, as well as to begin eligibility assessments or determinations for Medicaid and CHIP. In the case of Medicaid and CHIP, the Marketplace may perform eligibility assessments instead of determinations, at state option. Additionally, for electronic applications, Completed Applications include only those applications for which the applicant has hit the “submit” button and the application has been accepted for further processing. In addition to these applications, the FFM also has 259,107 additional paper and call center applications that are not included in this total. Note: a single Completed Application may include multiple individuals who are applying for coverage.

(3) “Individuals Applying for Coverage in Completed Applications” represents the total number of individuals included in Completed Applications that were submitted to the Marketplace during the applicable reference period. This number does not include individuals applying through the SHOP. Note: SBM data on the number of Individuals Determined Eligible to Enroll in a plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to missing data and differences in process flows for Marketplace Plans and Medicaid/CHIP eligibility determinations / assessments.

(4) “Individuals Determined Eligible to Enroll in a Plan Through the Marketplace” (i.e., a Marketplace plan) represents the total number of individuals for whom a Completed Application has been received and who are determined to be eligible for plan enrollment through the Marketplace during the reference period, whether or not they qualify for advance payments of the premium tax credit or cost-sharing reductions. These individuals may or may not have enrolled in coverage by the end of the reference period. Individuals who have been determined or assessed eligible for Medicaid or CHIP are not included.

(5) “Individuals Determined Eligible to Enroll in a Plan Through the Marketplace with Financial Assistance” represents the total number of individuals determined by the Marketplace to be eligible for enrollment through the Marketplace, who qualify for an advance premium tax credit (APTC). This number includes individuals who were

determined eligible for Marketplace plan enrollment with only an APTC, as well as individuals who were determined eligible for enrollment into a plan with both an APTC and a cost-sharing reduction (CSR).

(6) “Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace” represents the number of individuals who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP, based on modified adjusted gross income (MAGI). In some states, Completed Applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP, based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In other states, the Marketplace has been delegated the final Medicaid/CHIP determination responsibility for these individuals. Thus, this data element includes all Medicaid MAGI assessments, regardless of the state Medicaid/CHIP agency’s final eligibility determination.

Note: this data element does not include eligibility determinations made by State Medicaid/CHIP agencies based on applications originally submitted to the State agency or other Medicaid/CHIP assessments or determinations. Additionally, this column may vary slightly from accounts transferred to states by the FFM.

(7) “Pending / Other”: A derived estimate for individuals who have a completed and processed application, who either: 1) have a pending eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage; 2) have a completed eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace plan coverage.

(8) “Individuals Who Have Selected a Marketplace plan” represents the total number of “Individuals Determined Eligible to Enroll in a plan Through the Marketplace” who have selected a plan (with or without the first premium payment having been received directly by the Marketplace or the issuer) during the reference period. This is also known as pre-effectuated enrollment.

(9) For California, the total includes individuals who have been fully determined as well as those that are “pending” and also those that are “contingent.”

(10) Because the Colorado Marketplace does not have an eligibility system that is integrated with its state Medicaid department, the data for “Individuals Assessed Eligible for Medicaid/CHIP” are not available at this time.

(11) The total of completed applications for the District of Columbia reflects online applications only. Data are currently not available for the District of Columbia on the number of individuals deemed eligible for or enrolled in Marketplace plan, or eligible or enrolled in Medicaid/CHIP because the District of Columbia’s information systems record data by accounts rather than number of individuals or covered lives. In many instances, the accounts reflect two or more individuals. Thus, the District of Columbia has reported that between October 1, 2013 and November 2, 2013, 572 plans were selected, which could represent 1,000 or more individuals selecting a plan.

(12) Because the Hawaii Marketplace does not have an eligibility system that is integrated with its state Medicaid department, the data for “Individuals Assessed Eligible for Medicaid/CHIP” are not available at this time.

(13) Due to Massachusetts’s system constraints, cumulative values for “Individuals Assessed Eligible for Medicaid/CHIP” are not available at this time. Additionally, data for the total number of applications completed for Massachusetts represents time period 10/01/13 through 11/01/13

(14) Minnesota's cumulative data for “Individuals Determined Eligible to Enroll in a Marketplace plan,” “Individuals Determined Eligible to Enroll in a Marketplace plan with Financial Assistance,” and “Individuals Who Have Selected a Marketplace plan” do not include adults between 133% and 200% of the Federal Poverty Level (FPL) because these individuals are enrolled in the MinnesotaCare program. In addition, children up to 275% FPL are covered through the Medicaid program. Please note that when comparing Minnesota's cumulative data for these indicators with other State-Based Marketplaces, the number of individuals (2,505) determined eligible for MinnesotaCare should be included in the calculation.

(15) Cumulative data for Oregon represents best available data as of 11/04/13.

(16) Cumulative data for Washington represents time period 10/01/13 through 10/31/13. The total Individuals Determined or Assessed Eligible for Medicaid / CHIP may include some persons whose eligibility is being

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redetermined rather than newly determined. For example an application for a family may include parents applying to the Marketplace for initial coverage, while children are already covered.

(17) Idaho and New Mexico are Federally supported SBMs for 2014; they are using the FFM platform for 2014.

(18) New Mexico data on the number of Individuals Determined Eligible to Enroll in a Marketplace plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to differences in process flow for Marketplace plan and Medicaid/CHIP eligibility determinations / assessments.

Source: Centers for Medicare & Medicaid Services, as of 11-12-2013.

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## APPENDIX B: METHODOLOGY AND TECHNICAL NOTES

The data that are reported in this issue brief have been generated by the information systems of the Centers for Medicare & Medicaid Services, based on information reported to CMS by SBMs, and information collected by the FFM for states with HHS- supported or fully run Marketplaces (including those run in partnership with states).

Unless otherwise noted, the data in this issue brief represent cumulative Marketplace enrollment-related activity for the 10-1-13 to 11-2-13 reporting period, with information available as of 11-12-13. Data for certain metrics are not yet available for some states due to information system issues. We anticipate that more comprehensive data will be available in future monthly enrollment-related reports as system issues are resolved.

We believe that the information contained in this issue brief provides the most systematic “snapshot” of enrollment-related activity in the Marketplaces to date because the data for the various metrics are counted using comparable definitions for data elements across states, and between the SBMs and FFM (see table below). **It is important to note that the SBM enrollment-related data that are reported in this issue brief represent state data that have been reported to CMS, and may differ from comparable data that have previously been publicly reported on SBM websites or in media reports because that data may be based on different time periods or metric definitions from those used in this report.**

Summary of Marketplace Monthly Enrollment-Related Information By Marketplace Type (10-1-13 to 11-2-13)	Marketplaces Total (SBMs and FFMs)		States Implementing Their Own Marketplaces (SBMs)		States With Marketplaces that are Supported by or Fully-Run by HHS (FFM)	
	Number	% of Total*	Number	% of Total*	Number	% of Total*
Completed Applications	846,184	n/a	326,623	n/a	519,561	n/a
Number of Individuals Applying for Coverage in Completed Applications	1,509,883	100.0%	516,248	***	993,635	100.0%
Number of Individuals With Processed Eligibility Determinations or Assessments	1,477,853	97.9%	591,838	***	886,015	89.2%
Eligible for Marketplace plan Enrollment	1,081,592	71.6%	378,973	***	702,619	70.7%
Eligible for Marketplace plan with APTC (non-add)	326,130	21.6%	88,953	***	237,177	23.9%
Other Marketplace plan-Eligible Individuals (non-add)	755,462	50.0%	290,020	***	465,442	46.8%
Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace	396,261	26.2%	212,865	***	183,396	18.5%
Pending / Other	201,137	**	93,245	***	107,892	10.9%
<b>Total Individuals Eligible to Enroll in a Marketplace plan</b>	<b>1,081,592</b>	<b>100.0%</b>	<b>378,973</b>	<b>100.0%</b>	<b>702,619</b>	<b>100.0%</b>
Marketplace Eligible Individuals Who Have Selected a Marketplace plan	106,185	9.8%	79,391	20.9%	26,794	3.8%
Marketplace plan Eligible Individuals Who Have Not Yet Selected a Marketplace plan	975,407	90.2%	299,582	79.1%	675,825	96.2%

\* Percent of total represents the percent of total individuals applying for coverage in completed applications, or the percent of total individuals eligible to enroll in a Marketplace plan who have selected a Marketplace plan.

\*\* Pending/Other does not sum to 100 percent due to missing SBM data.

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\*\*\* Total SBM data on the number of persons with processed eligibility determinations or assessments do not add to the total number of persons applying for coverage in completed applications due to missing data and differences in process flow for Marketplace plan and Medicaid/CHIP eligibility determinations / assessments.

Source: Centers for Medicare & Medicaid Services, as of 11-12-2013.

While this issue brief includes some data for all states, data for certain metrics are not available for certain states. For example, CMS did not receive data on the number of individuals applying for coverage in completed applications, the number of processed eligibility determinations and assessments, or the number of individuals eligible for plan enrollment through the Marketplace who have selected a Marketplace plan from two states (Hawaii and Massachusetts) and the District of Columbia.

In the table in Appendix A, which shows the state-level data, “N/A” means that the data for the respective metric is not yet available for a given state.

### Definitions of Enrollment-Related Data Terms

- **Reference Period:** Unless elsewhere noted, the reference period for which data are reported is from 10-1-13 to 11-2-13.

Oct 1- Nov 2 most closely represents the first month of operations since state based Marketplaces generally compile enrollment-related metrics on a weekly basis.

- **Completed Applications:** The total number of electronic and paper applications that were submitted to the Marketplace during the reference period with sufficient information to begin performing eligibility determinations for enrollment in a plan through the Marketplace and, if the applicant applied for insurance affordability programs, sufficient information to begin performing eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, as well as to begin eligibility assessments or determinations for Medicaid and CHIP. In the case of Medicaid and CHIP, the Marketplace may perform eligibility assessments instead of determinations, at state option. Additionally, for electronic applications, Completed Applications include only those applications for which the applicant has hit the “submit” button and the application has been accepted for further processing. It is important to note that a single Completed Application can include multiple individuals who are applying for coverage.

These data represent completed applications that were reported as submitted across all channels by the SBMs and FFM during the reporting period. Applications can be submitted electronically (online) or on paper, by the applicant or on behalf of the applicant by an assister (navigator, in-person assister, agent/broker), or through the call center. The data on paper applications that are included in this total are likely to be undercounted because of a lag time between mailing and receiving the applications.

Applications submitted through the mail are included in the paper category. Applications submitted through the call center or in-person are included in the electronic or paper

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categories, as appropriate.

The FFM data on completed applications does not include paper applications or call center applications. An additional 259,107 applications were filed by paper and through call centers during this Oct. 1- Nov. 2 reporting period that are not included in this total.

- **Individuals Applying for Coverage in Completed Applications:** The total number of individuals included in Completed Applications that were submitted to the Marketplace during the applicable reference period. This number does not include individuals applying through the Small Business Health Options Program (SHOP).

Note: SBM data on the number of Individuals Determined Eligible to Enroll in a plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to missing data.

- **Individuals Determined Eligible to Enroll in a Plan Through the Marketplace (i.e., a Marketplace plan):** The total number of individuals for whom a Completed Application has been received and who are determined to be eligible for Marketplace plan enrollment through the Marketplace during the reference period, whether or not they qualify for advance payments of the premium tax credit or cost-sharing reductions. These individuals may or may not have enrolled in a plan through the Marketplace by the end of the reference period. Individuals who have been determined or assessed as eligible for Medicaid or CHIP are not included.
- **Individuals Determined Eligible to Enroll in a Plan Through the Marketplace with Financial Assistance:** The total number of individuals determined by the Marketplace to be eligible for plan enrollment through the Marketplace, who qualify for advance premium tax credits (APTC). This number includes persons who were determined eligible for plan enrollment with only APTC, as well as persons who were determined eligible for enrollment into a Marketplace plan with both APTC and cost-sharing reductions (CSR).

This number does not include Marketplace plan eligible individuals who: didn't apply for financial assistance; applied for financial assistance and were found ineligible; or applied for financial assistance and their applications are pending.

- **Individuals Determined or Assessed Eligible for Medicaid/CHIP by the Marketplace:** The number of individuals who have been determined or assessed by the Marketplace as eligible for Medicaid or CHIP, based on modified adjusted gross income (MAGI) eligibility criteria. In some states, Completed Applications for individuals, whom the Marketplace has assessed as potentially eligible for Medicaid or CHIP, based on MAGI, are transferred to the relevant state agency for a final eligibility determination. In other states, the Marketplace has been delegated the final Medicaid/CHIP determination responsibility for these individuals. Thus, this data element includes all

Medicaid/CHIP MAGI assessments by the Marketplace, regardless of the state agency's final eligibility determination. This data element does not include eligibility determinations made by state Medicaid/CHIP agencies based on applications originally submitted to the state agency or other Medicaid/CHIP assessments or determinations. Additionally, this column may vary slightly from accounts transferred to states by the FFM.

- **Pending/Other:** A derived estimate of the total number of individuals for whom a Completed Application has been received, who either: 1) have a pending eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage; 2) have a processed eligibility determination or assessment for Marketplace plan or Medicaid/CHIP coverage that is not captured in the relevant column in this table for a given state due to system issues; or 3) have been deemed ineligible for Marketplace plan coverage.

The data represented in the "Pending/Other" column are only an approximation; because they are not strict subsets of one another, the sum of "Individuals Eligible to Enroll in a Marketplace plan", "Individuals Assessed Eligible for Medicaid/CHIP", and "Pending/Other" does not necessarily equal the "Total Individuals Applying for Coverage in Completed Applications." Given process flows, it is sometimes very difficult to separate individuals who are assessed eligible for Medicaid [MAGI] and those determined eligible for Marketplace plans.

Pending/Other does not sum to 100 percent of total Individuals Applying for Coverage in Completed Applications due to missing SBM data.

- **Individuals Who Have Selected a Marketplace plan:** The total number of "Individuals Determined Eligible to Enroll in a Plan Through the Marketplace" who have selected a plan (with or without the first premium payment having been received directly by the Marketplace or the issuer) during the reference period, whether or not they are eligible to receive an Advanced Premium Tax Credit or cost-sharing reduction.

#### Additional Technical Notes for SBM Data

- For California, the total includes individuals who have been fully determined as well as those that are "pending" and also those that are "contingent."
- Because the Colorado Marketplace does not have an eligibility system that is integrated with its State Medicaid/CHIP agency, data for "Individuals Assessed Eligible for Medicaid/CHIP" are not available at this time.
- The total of completed applications for the District of Columbia reflects online applications only. Data are currently not available for the District of Columbia on the number of individuals deemed eligible for or enrolled in Marketplace plans, or eligible or enrolled in Medicaid/CHIP because the District of Columbia's information systems record data by accounts rather than number of individuals or covered lives. In many instances, the accounts reflect two or more individuals. Thus, the District of Columbia has reported that between October 1, 2013 and November 2, 2013, 572 plans were

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selected, which could represent 1,000 or more individuals selecting a plan.

- Because the Hawaii Marketplace does not have an eligibility system that is integrated with its State Medicaid/CHIP agency, data for “Individuals Assessed Eligible for Medicaid/CHIP” are not available at this time.
- Due to Massachusetts’s system constraints, cumulative values for “Individuals Assessed Eligible for Medicaid/CHIP” are not available at this time; additionally, data for the total number of applications completed for Massachusetts represents time period 10/01/13 through 11/01/13.
- Minnesota's cumulative data for “Individuals Determined Eligible to Enroll in a Marketplace plan,” “Individuals Determined Eligible to Enroll in a Marketplace plan with Financial Assistance,” and “Individuals Who Have Selected a Marketplace plan” do not include adults between 133% and 200% of the Federal Poverty Level (FPL) because these individuals are enrolled in the MinnesotaCare program. In addition, children up to 275% FPL are covered through the Medicaid program. Please note that when comparing Minnesota's cumulative data for these indicators with other State-Based Marketplaces, the number of individuals (2,505) determined eligible for MinnesotaCare should be included in the calculation.
- Cumulative data for Oregon represents best available data as of 11/04/13. The total Individuals Determined or Assessed Eligible for Medicaid / CHIP may include some persons whose eligibility is being redetermined rather than newly determined. For example an application for a family may include parents applying to the Marketplace for initial coverage, while children are already covered.
- Cumulative data for Washington represents time period 10/01/13 through 10/31/13. The total Individuals Determined or Assessed Eligible for Medicaid / CHIP may include some persons whose eligibility is being redetermined rather than newly determined. For example an application for a family may include parents applying to the Marketplace for initial coverage, while children are already covered.

#### **Additional Technical Notes for FFM Data**

For the data on eligibility:

- An individual found eligible with an inconsistency counts as an eligible person.
- Counts for potentially eligible for Medicaid/CHIP include FFM Assessments as well as FFM Determinations as directed by the states.
- The business logic for conducting Medicaid and CHIP eligibility assessments and determinations are based on the FFM’s interpretation of each state’s Medicaid and CHIP eligibility rules, and are subject to revision.

For the data on Marketplace plan selection:

- The “Selection of a Marketplace plan” metric reflects unique consumers who have

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enrolled in either a Marketplace plan or a Dental Plan. If a consumer selects both a Marketplace plan and a Dental Plan, they are counted as 1 plan selection. If a consumer enrolls in a Marketplace plan only, they are counted as 1 plan selection. If a consumer selects a Dental Plan only, they are counted as 1 plan selection. Any plan selection is counted at the moment the consumer hits the "Submit" button in Plan Compare. These are "active" policies.

- These data were pulled for an "As of" date of 11-2-2013, with the following logic:
  - If a policy is created in October and cancelled in October, that policy, and the individuals on it, are NOT included in October counts.
  - If a policy is created in October and cancelled after November 2, 2013 that policy, and the individuals on it, WOULD be included in October counts.
- During an enrollment-related transaction, if a consumer clicks either the "Enroll" or the "Cancel" button more than once, the system may improperly generate multiple transactions. In addition, duplicate transactions have been sent concerning the same person due to minor name differences. Until these technical issues are corrected, the number of transactions may underestimate or overestimate the number of people who will ultimately be actively enrolled.

New Mexico data on the number of Individuals Determined Eligible to Enroll in a Marketplace plan through the Marketplace and the number of Individuals Determined or Assessed Eligible for Medicaid / CHIP by the Marketplace do not add to the total number of persons applying for coverage in completed applications due to differences in process flow for Marketplace plan and Medicaid/CHIP eligibility determinations / assessments.

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**APPENDIX C: PAST EXPERIENCES IN HEALTH COVERAGE ENROLLMENT**

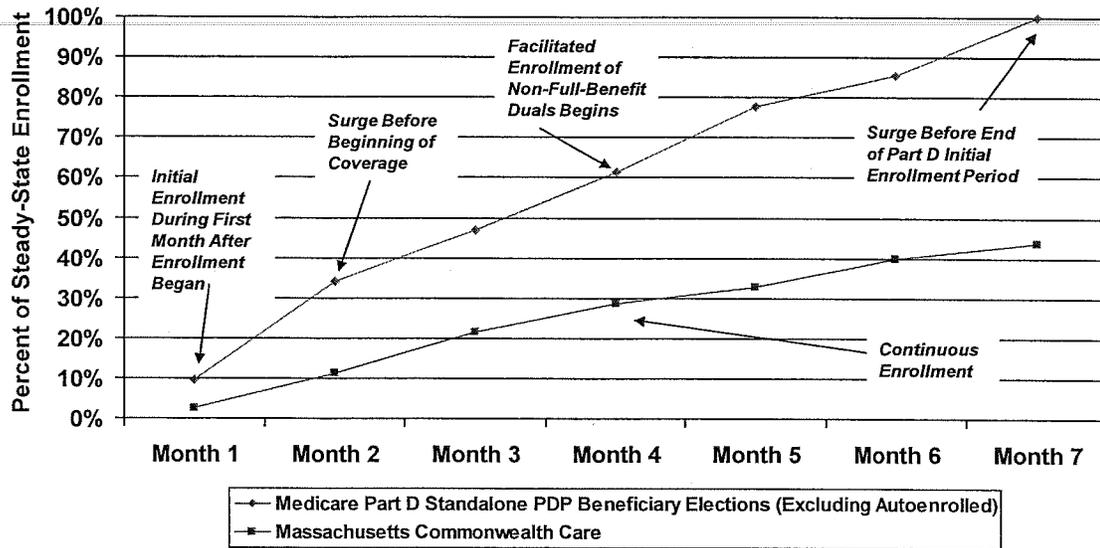
Past enrollment experiences from other health coverage programs inform the Department's expectations for enrollment in the new Marketplace. Based on the experience of the Federal Employees Health Benefits Program (FEHB), Medicare Part D, Massachusetts' Commonwealth Care, and the Children's Health Insurance Program (CHIP), we have learned that several factors drive enrollment rates, particularly in the early months of program operation.

1. "Action-forcing" events — such as the end date of an open enrollment period or the start date for benefits — often result in a spike in enrollment activity.
2. The length of a program's pre-benefit period (i.e., the period between sign-up/enrollment and the receipt of benefits) affects rates of initial enrollment. Shorter pre-benefit periods (e.g., 1 month) tend to generate higher initial enrollment rates than longer pre-benefit periods, during which the consumer may perceive little advantage to signing up or enrolling early.
3. A requirement to pay the initial premium to complete enrollment creates a financial disincentive to enroll early. Consumers are generally required to pay their first month's premium prior to the first day of coverage. This can result in last-minute enrollment activity by consumers to minimize the lag time between payment and access to benefits. Marketplace enrollees must pay premiums by December (even if they enroll in October) for coverage to begin January 1, this fact may affect enrollment in October and November.
4. The use of "auto" or "passive" enrollment, where a group of consumers is enrolled in coverage without any action on the consumers' part, results in higher enrollment rates.
5. Public education campaigns and outreach efforts tied to deadlines that correspond to benefits coverage build consumer awareness and encourage enrollment.

Graphs included in this Appendix illustrate initial enrollment in Medicare Part D, Massachusetts Commonwealth Care, and CHIP, plus enrollment from the FEHB's annual open season for 2012. Each program differs in terms of pre-benefit periods, length of the open enrollment period, and the use of auto-enrollment, which in turn affected enrollment rates during initial months of operation. For example, Medicare Part D experienced faster rates of enrollment compared to Massachusetts Commonwealth Care due to a six-month open enrollment period.

## Comparison of Early Part D and Massachusetts Commonwealth Care Enrollment Experience

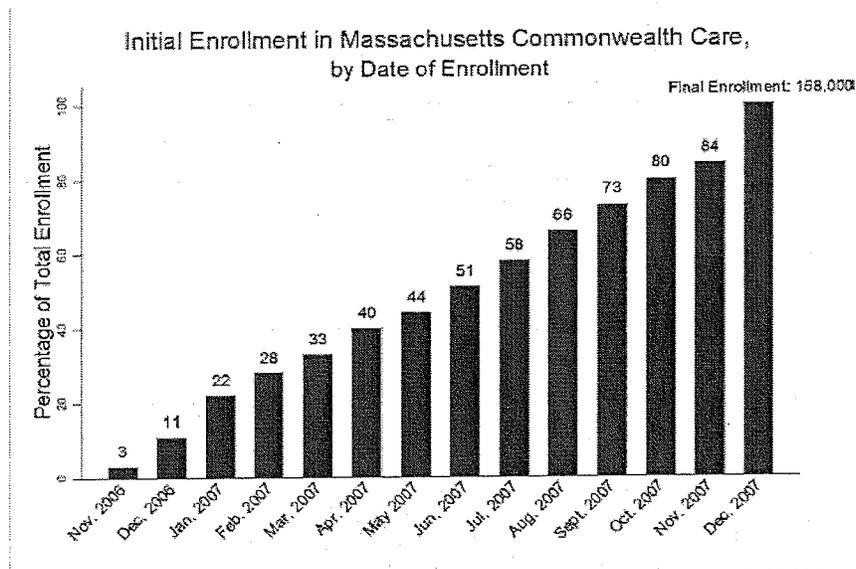
*Part D experienced faster rates of enrollment due to a six-month open enrollment period*



Notes: Medicare Part D Standalone PDP (Prescription Drug Plan) Beneficiary Elections represents beneficiaries who submitted applications to enroll in a Standalone PDP (excluding Medicare/Medicaid full-benefit dual eligible beneficiaries who were initially autoenrolled into a PDP (including those who subsequently switched plans) and including beneficiaries qualifying for the low income subsidy who received facilitated enrollment); Part D had a 6-month initial open enrollment period. Massachusetts Commonwealth Care represents total enrollees (including auto-enrolled individuals from the state's uncompensated care pool; the program has continuous enrollment, allowing people to sign up at any time during the year.

Source: CMS and HHS Part D Enrollment Press Releases, 12/22/2005 – 6/14/2006; CMS Administrative Data (Facilitated Enrollments). Data on initial Commonwealth Care enrollment, available at <http://www.mass.gov/chia/docs/r/pubs/09/key-indicators-02-09.pdf> and <http://www.mass.gov/bb/h1/fy10h1/exec10/hbudbrief20.htm>

**Massachusetts Commonwealth Care.** Commonwealth Care is a means-tested subsidized insurance program for uninsured individuals who do not qualify for Medicaid (MassHealth) and is part of the Massachusetts Health Connector. Enrollment and benefits for subsidized coverage in Commonwealth Care began January 1, 2007, although Massachusetts auto-enrolled a large number of individuals from the state's uncompensated care pool beginning October 1, 2006. Commonwealth Care enrollment appears to have reached a steady state a year after coverage began.<sup>9</sup> By December 2007, 158,000 people had enrolled in Commonwealth Care.

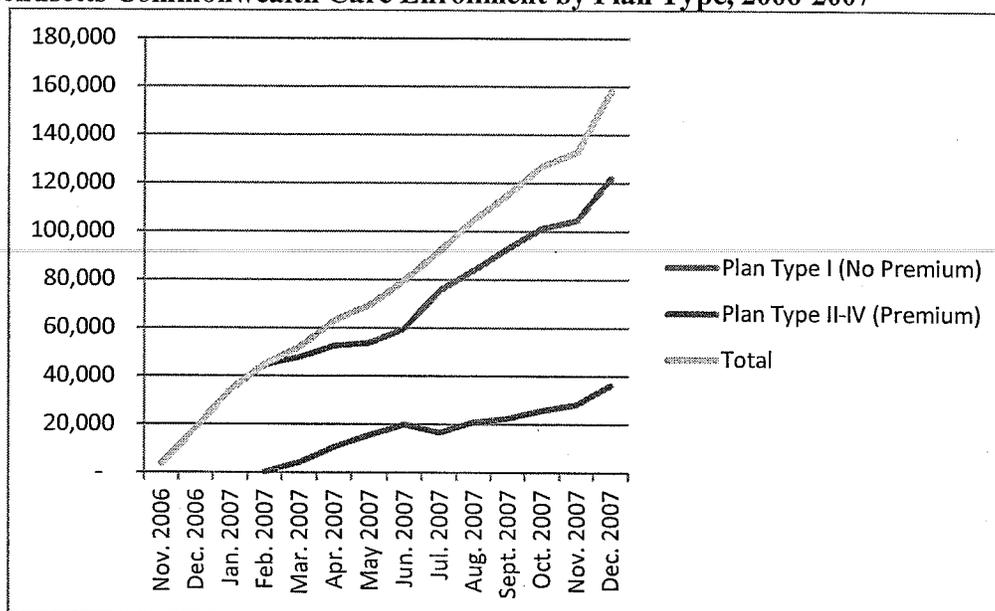


The majority of individuals who enrolled in Commonwealth Care during the first year were in “Type I” plans and not responsible for paying a premium. There were large differences in initial enrollment rates between those who qualified for plans without having to pay a premium and those who were required to pay a premium (see chart below).<sup>10</sup> For the plan types that may require a premium payment (Type II, III and IV), only about 4,000 individuals signed up in the first couple of months of the program.

<sup>9</sup> For data on initial Commonwealth Care enrollment, see <http://www.mass.gov/chia/docs/r/pubs/09/key-indicators-02-09.pdf> and <http://www.mass.gov/bb/h1/fy10h1/exec10/hbudbrief20.htm>

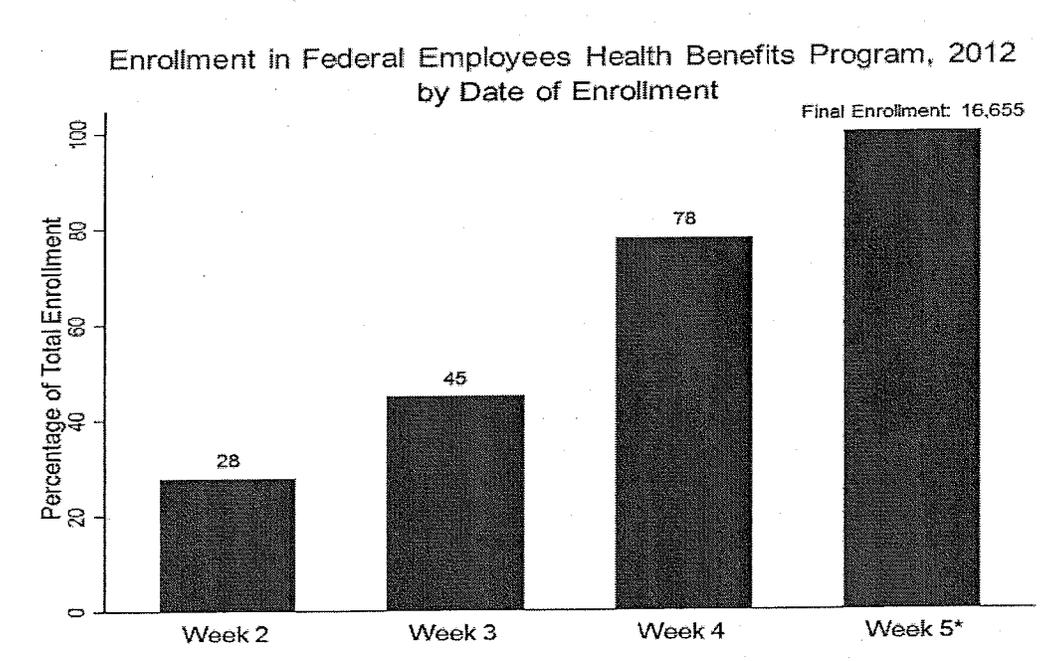
<sup>10</sup> Individuals who have Commonwealth Care Plan Type I (available to those with incomes below 100 percent of the FPL) do not pay premiums for coverage. Individuals who have incomes above 150 percent of the FPL and are enrolled in Plan Type II-IV (available to those with incomes 100.1 to 300 percent of the FPL) pay premiums unless their income is below 150 percent FPL. Data on enrollment by plan type through May 2007 are available here: <https://www.mahealthconnector.info/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%252520Us/Publications%252520and%252520Reports/2007/2007-05-10/CommCare%252520Program%252520Update.pdf>

**Massachusetts Commonwealth Care Enrollment by Plan Type, 2006-2007**



Source: Boston Globe, October 16, 2013:  
[http://www.boston.com/lifestyle/health/health\\_stew/2013/10/how\\_much\\_aca\\_enrollment\\_is\\_enough.html](http://www.boston.com/lifestyle/health/health_stew/2013/10/how_much_aca_enrollment_is_enough.html)

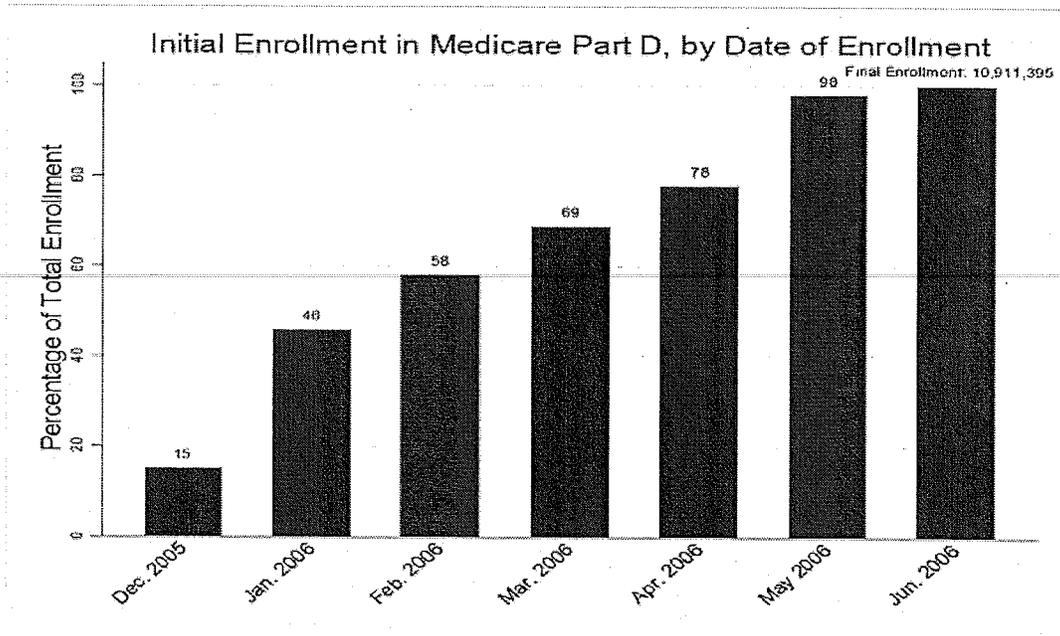
**Federal Employees Health Benefits Program.** The Office of Personnel Management reports that enrollment spikes in the last few days before the end of the open enrollment period. This is consistent with the experience of private employers as well. The FEHB program has an annual, month-long open season during which employees are allowed to change their insurance coverage status and switch plans. Data from the FEHB’s 2012 open season shows that relatively few employees make changes to their coverage in the first couple weeks of the period. Nearly a quarter (22 percent) of those employees who changed their enrollment during the open season made their selection in the last two days before the season’s deadline. In the table below, Week 5 of 2012 open season consisted of only 2 days.



\*Week 5 comprises only 2 days

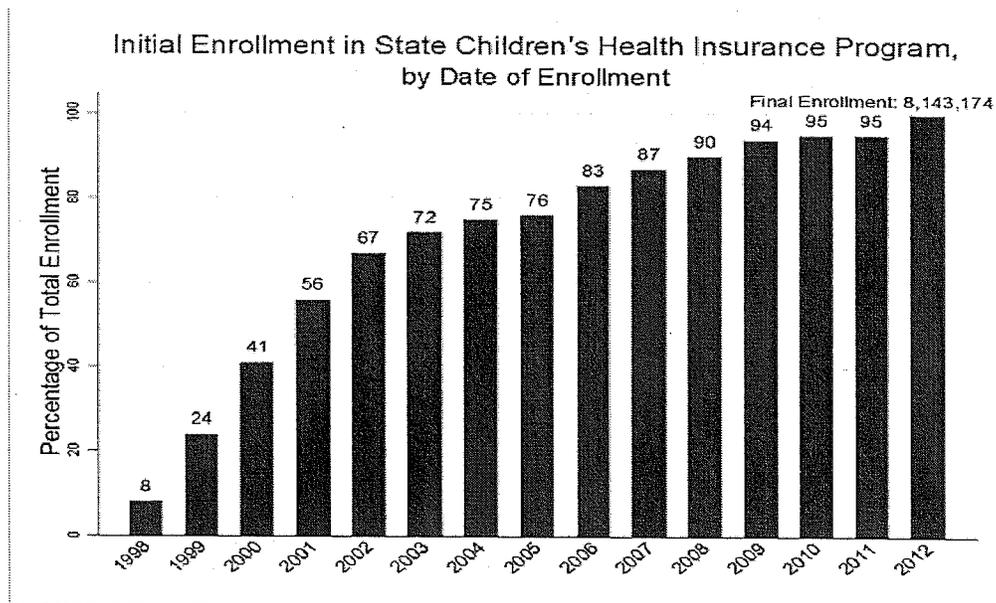
Source: Office of Personnel Management

**Medicare Part D.** Initial enrollment for Part D opened November 15, 2005 and closed on May 15, 2006. Coverage began January 1, 2006, approximately six weeks after the start of open enrollment. The enrollment rate was 15 percent at the end of December 2005, the end of the “pre-benefit period,” and rose to 98 percent by May 2006, the end of the open enrollment period. *This data (and graph) includes only those who affirmatively enrolled and paid a premium for a standalone Medicare Part D plan.* Medicare Part D had auto-enrollment for Medicare-Medicaid dual eligibles and those in Medicare Advantage plans that added drug coverage, but we do not include those enrollees in the chart below.



Source: Centers for Medicare & Medicaid Services

**Children’s Health Insurance Program.** CHIP experienced low enrollment rates in the early years of the program. Despite extensive outreach and streamlining of application procedures, only 60 percent of eligible children participated in CHIP fully five years after states began implementing their CHIP programs in 1998. At that point the program reached an enrollment plateau. Currently, CHIP, combined with Medicaid, reaches 86 percent of all eligible children.



Source: Centers for Medicare & Medicaid Services

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*Expectations for Marketplace Enrollment*

Looking forward, the Department expects that Marketplace enrollment will start slowly, with peaks in December 2013 (shortly before benefits begin January 1) and March 2014 (at the end of open enrollment). There is a three-month lag between the beginning of open enrollment on October 1, 2013, and January 1, 2014 when Marketplace benefits begin. As a result, the Department anticipates the enrollment trend will start gradually, with low enrollment in the first two months of open enrollment (October 2013 and November 2013). Enrollment activity is expected to increase in December in anticipation of coverage starting January 1, 2014 and again in March as the March 31, 2014 deadline for open enrollment approaches.

## APPENDIX D: CONSUMER AWARENESS OF THE MARKETPLACE

National surveys show that awareness of the Marketplaces increased over the month of October, and nearly one in five Americans who is uninsured or covered by individual market insurance has visited the Marketplace to shop for a plan.

A Commonwealth Fund survey conducted Oct. 9-27<sup>11</sup> polled adults (ages 19-64) who are uninsured or have individual coverage and found:

- Most (60 percent) are aware of the Marketplace.
  - 53 percent are aware that financial support is available for Marketplace coverage.
  - 17 percent have visited the Marketplace.
- Most (58 percent) said they are very likely or somewhat likely to go or go back to visit the Marketplace before the end of open enrollment on March 31, 2014 to enroll in a plan or to apply for a premium tax credit or for Medicaid.
- Of those who have visited the Marketplace, 21 percent enrolled in a plan.
  - 47 percent tried to find out if they were eligible for financial assistance (through APTCs or CSRs) or Medicaid.
  - 27 percent rated their Marketplace experience excellent or good, and 70 percent said it was fair or poor.
  - 56 percent said it was difficult, very difficult, or impossible to find a plan with the type of coverage they needed; 38 percent said it was somewhat easy or very easy.
- Of those who did not enroll in October, the most frequently cited reasons were: not being certain they could afford a plan (48 percent), still trying to decide on a plan (46 percent), and thinking deductibles and copayments were too high (42 percent).

The polling firm Gallup found in its October surveys:

- Among all uninsured adults, 18 percent have visited or attempted to visit the online Marketplace. Among uninsured adults who are planning to obtain or who have already obtained coverage through the Marketplace, 22 percent have visited or attempted to visit the online Marketplace.<sup>12</sup>
- The share of the uninsured who consider themselves familiar with the Marketplace was larger at the end of October (27 percent) than at the end of September (25 percent).<sup>13</sup>

According to a national survey by the Pew Research Center, conducted Oct. 9-13,<sup>14</sup> awareness of the Marketplaces is higher in states that are involved in running their Marketplaces:

<sup>11</sup> <http://www.commonwealthfund.org/Publications/Data-Briefs/2013/Nov/Americans-Experiences-Marketplaces.aspx>

<sup>12</sup> Poll conducted Oct. 23- Nov. 6. <http://www.gallup.com/poll/165776/uninsured-americans-ignoring-health-exchange-sites.aspx>

<sup>13</sup> The October poll was conducted Oct. 18-29, 2013. <http://www.gallup.com/poll/165668/uninsured-aware-health-insurance-requirement.aspx>

<sup>14</sup> <http://www.people-press.org/2013/10/21/public-registers-bumpy-launch-of-health-care-exchange-websites/>

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- In the 24 states (including D.C.) with State-based Marketplaces or state-federal Partnership Marketplaces, 72 percent are aware that a Marketplace is available.
  - In the 27 states that have federally-run Marketplaces, 59 percent are aware that a Marketplace is available in their state.

Copy provided to Maine Health Exchange Advisory Committee 11/18/13  
UNITED STATES SENATE

COMMITTEE ON SMALL BUSINESS AND ENTREPRENEURSHIP

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TESTIMONY OF WILLIAM NOLD, DEPUTY EXECUTIVE DIRECTOR  
OFFICE OF THE KENTUCKY HEALTH BENEFIT EXCHANGE

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November 20, 2013

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Thank you, Chairwoman Landrieu, Ranking Member Risch and members of the Committee for inviting me to testify this morning about Kentucky's success in the operation of our state-based health benefit exchange, and especially about the very positive response we have received from the small business community.

First, please allow me to introduce myself to the committee.

My name is Bill Nold and I am the Deputy Executive Director of the Office of the Kentucky Health Benefit Exchange. We call our exchange "kynect". I am pleased to appear before you today to provide some background and answer any questions members of the committee have about Kentucky's decision to fully participate in the Affordable Care Act by operating a state-based exchange, participating in the expansion of Medicaid and proceeding with the Small Business Health Options Program, or SHOP, for Kentucky's small employer groups.

I would like to begin with a brief timeline of some of the major milestones along the way of Kentucky's implementation of the Affordable Care Act.

On July 17, 2012, Kentucky Governor Steve Beshear issued an executive order directing our office to take the necessary steps to be approved as a state-based exchange. He did so with the vocal support of several interest groups representing employers, health care advocates, and citizens. These include the Kentucky Hospital Association, the Kentucky Chamber of Commerce, Kentucky Voices for Health, and Anthem Blue Cross Blue Shield, all of which expressed their strong preference that the Commonwealth, not the federal government, operate the exchange for our state. The Office operates under the Cabinet for Health and Family Services.

On September 18, 2012, Governor Beshear appointed 19 members to the Health Benefit Exchange Advisory Board. The board, which includes representatives with relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy related to the small group and individual markets and the uninsured, provided valuable

input into the policies and procedures of the exchange. Subcommittees were also established including one to deal with SHOP issues.

On May 9, 2013, Governor Beshear announced his decision to expand Medicaid to Kentuckians whose income does not exceed 138 percent of the Federal Poverty Level, providing access to healthcare for many low-income, working Kentuckians who do not qualify for Medicaid under the current threshold, but would not be eligible for subsidies available through the Affordable Care Act.

According to the 2010 Census, Kentucky's population is a little more than 4.4 million. Of those more than 4 million Kentuckians, approximately 640,000 currently are uninsured.

By expanding Medicaid eligibility, an estimated 308,000 Kentuckians will now qualify for health care coverage. The remaining 332,000 uninsured Kentuckians are now eligible to purchase insurance through Kentucky's exchange, which we call kynect. Of those 332,000, approximately 85 percent will qualify for some level of premium assistance to help offset the cost of their health insurance plan.

Gov. Beshear cited Kentucky's dismal rankings in multiple health outcomes as one of the reasons he chose to participate in the expansion, giving lower-income Kentucky families access to reliable, quality health care.

In 2012, Kentucky's overall health ranking was 44th. Kentucky is at the bottom of many national health rankings, including 50th in smoking, 40th in obesity, 41st in diabetes, 50th in cancer deaths, 49th in heart disease, 43rd in high cholesterol, 44th in annual dental visits and 48th in heart attacks.

The poor physical health of our citizens has contributed to Kentucky perpetually being a fiscally poor state. Providing Kentuckians with access to affordable health care coverage will help us tackle these abysmal health statistics.

Multiple state and national reports show that when someone has or gains health coverage, there are measurable improvements in health status, including a decrease in delayed care and reduction of mortality rate. And with improved health, our education levels and job opportunities will also improve. When larger groups gain health coverage, the workforce improves.

Kentucky small business owners know how important the health of their workforce is to the success of their business. Their employees truly are the lifeblood of their businesses. And the numbers show that Kentucky small businesses are eager to offer health insurance to their workers.

The Office submitted its Blueprint application to HHS in November 2012 and in January 2013 Kentucky was conditionally approved to operate its own exchange. Since that time, our exchange has been working closely with HHS, CCIIO and our state officer to comply with all of the conditions necessary for approval. Kentucky is offering an

individual exchange and a SHOP exchange. The two exchanges have been combined for administrative purposes as permitted by the ACA. Small employers may offer a full range of plans available from all participating issuers or plans from a single issuer.

In June 2013, Kentucky issued its final administrative regulation describing its Small Business Health Options Program. I have included this regulation along with other documents describing Kentucky's SHOP program and ask that they be included in the record.

In Kentucky, Anthem, Bluegrass Family Health, Kentucky Health Cooperative and UnitedHealthcare of Kentucky are offering plans in the small group market. With the exception of Bluegrass Family Health, which is offering only regional coverage, these insurers are offering plans in all 120 counties. Between these carriers, employers have 24 plan options from which to choose. Additionally, we anticipate that Humana, the only remaining insurer in the individual and small group market in Kentucky, will participate in SHOP beginning in 2015.

By using kynect, employers can choose the level of coverage they wish to provide to their employees. All health plans are classified in one of four metal levels; bronze, silver, gold and platinum. As the metal level increases in value, so does the percentage of medical expenses that the plan will cover.

We are thrilled with the response we have received from the small business community and we believe this is in no small part due to the active role our advisory board played in developing the policies and procedures for the SHOP program. Agents, insurers and health care providers all had input and the process was very collaborative and transparent.

We have also received a very positive response to the SHOP from our agent community. At this time, Kentucky has approximately 1,300 licensed agents that have been trained, certified, on-boarded and identity-proofed and are standing by to assist their employer clients in selecting health plans available on the exchange.

Since kynect, launched on October 1, 2013, consumer interest has been overwhelming. As of last Friday, over 450,000 visitors to our kynect website; almost 48,000 have enrolled in new health coverage with over 8,780 individuals enrolled in a qualified health plan.

In addition, with respect to the SHOP exchange, and as of November 15<sup>th</sup> a total of 913 small businesses have started applications to be eligible to offer employee coverage. Of those 913 businesses, 343 have completed applications and are eligible to offer coverage to employees and 97 of those small businesses are currently in the enrollment process. Approximately half of the small businesses that have selected health plans using the SHOP are offering their employees a full choice of plans.

These numbers have truly exceeded our expectations. Small businesses with 50 or fewer employees are not required to provide health insurance to their workers, but many Kentucky small businesses are turning to kynect to seek insurance anyway. Business owners know that a healthy workforce is a dependable workforce. Plus, small businesses with 25 or fewer employees may be eligible for tax credits by using kynect.

To qualify for tax credits through kynect, a business must employ 25 or fewer full-time employees; pay at least 50 percent of the premium for their employees and meet a group average annual wage of less than \$50,000

kynect allows small business owners to easily compare a variety of health plans offered by private insurers. There is no designated open enrollment period for small businesses. Small employer groups can enroll whenever they choose. Employers can choose the level of coverage, the amount they wish to contribute toward their employees' coverage so long as it is at least 50% and any amount they may want to contribute toward family or dependent care.

Employers also have one monthly bill for employee coverage and they can continue to work with their current insurance agent. If they do not have an agent, kynect can help them find one.

Employer-sponsored health insurance coverage is valuable for a number of reasons. People who are insured are protected against uncertain and high medical expenses. They are more likely to get healthcare. Health insurance also improves health outcomes and lowers mortality.

Employees with health insurance are more likely to be productive workers. Offering health insurance can also help businesses attract and retain employees. It is a good business decision because of the favorable tax treatment to both the employer and the employee.

With almost half of all Americans receiving their health insurance from their employers, business owners play an important role. Many small businesses already offer health coverage to their employees and with SHOP, more soon will. It helps them recruit and retain employees who are healthier, happier and more productive. It is good business for the employers and the employees.

Thank you for allowing me the opportunity to appear before you today to testify about Kentucky's extremely positive experience with the implementation of the Affordable Care Act and its SHOP exchange.

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## State-by-State Estimates of the Number of People Eligible for Premium Tax Credits Under the Affordable Care Act

Key provisions of the 2010 Affordable Care Act (ACA) create new Marketplaces for people who purchase insurance directly and provide new premium tax credits to help people with low or moderate incomes afford that coverage. We estimate that about 17 million people who are now uninsured or who buy insurance on their own (“nongroup purchasers”) will be eligible for premium tax credits in 2014. This issue brief provides national and state estimates for tax credit eligibility for people in these groups. We also estimate that about 29 million people nationally could look to new Marketplaces as a place to purchase coverage.

### ELIGIBILITY FOR PREMIUM TAX CREDITS

A key focus of the ACA is to reduce the number of uninsured by expanding the number of people who buy nongroup coverage. It does this by removing existing barriers that keep people with health problems from obtaining coverage and by providing financial assistance through premium tax credits for low and moderate income people who purchase coverage through new state Marketplaces operated by states or the federal government. The Congressional Budget Office estimates that by 2018 around 20 million people covered in marketplaces will receive premium tax credits to assist them with their premium costs.<sup>1</sup>

Under the law, people with incomes between 100 percent and 400 percent of the federal poverty level may be eligible for premium tax credits when they purchase coverage in a Marketplace. People who are eligible for other types of public or private coverage, for example Medicaid or coverage through an employer-provided plan, generally cannot claim a premium tax credit. These tax credits also are not available to people who are not lawfully present in the country or who are incarcerated. Legally residing immigrants who recently arrived in the country are eligible for premium tax credits despite being ineligible for Medicaid; they may qualify if their income does not exceed 400 percent of the federal poverty level.<sup>2</sup>

The amount of tax credit that a person receives depends on their family income and the cost of health insurance where they live. The law establishes a maximum percentage of income that people within the 100 to 400 percent of poverty income range must pay for a benchmark plan where they live. The percentages range from 2% of income for people with income at the federal poverty line to 9.5% of income for people with incomes at four times federal poverty. If the premium that a person or family faces for the benchmark plan in their area is higher than the maximum percent of income defined in the law for their income, they are eligible for a tax credit, and the tax credit is equal to the difference between the premium for the benchmark plan and the defined percent of their income. The benchmark plan is the second-lowest-cost plan in the silver cost-sharing tier offered through the marketplace for the area where they live.<sup>3</sup> Additional explanations and examples are available by using the [Kaiser Premium Subsidy Calculator](#).

People who are eligible for a premium tax credit can apply it to reduce the premium for any plan (other than catastrophic plans) offered in the marketplace. Their cost will be the actual premium for the plan that they enroll in minus the value of the premium tax credit they receive. One thing to note is that because marketplace premiums vary by age in most states, people with the same income but different ages will qualify for different premium tax credit amounts. In some cases, the premium for a benchmark plan for people at younger ages will be less than the defined percentage of income specified in the law; in this case the person would not receive a premium tax credit and would have to pay the full premium for any plan that they choose. However, they would still be able to purchase coverage, and their cost as a share of income will match the cost for others with comparable incomes. Premiums also vary by geographic area, which means that premium tax credits may differ for otherwise similar people if they live in different places.

## HOW MANY PEOPLE ARE ELIGIBLE FOR PREMIUM TAX CREDITS

We used data from the 2012 and 2013 Current Population Survey (CPS) Annual Social and Economic Supplement (ASEC) to estimate the number of people eligible for premium tax credits for marketplace coverage. The ASEC provides detailed information on family composition, income and insurance status for national and state samples of residents. We use that information to determine whether each individual would be eligible to purchase coverage through a marketplace and whether they would be eligible to receive a premium tax credit.

The analysis starts with a pool of people who have no insurance or who purchase nongroup insurance. People who are covered by a public program or by employer-based coverage are assumed to retain that coverage and would not be eligible for premium tax credits. Two other groups of people were then removed from this potential pool of tax-credit eligible individuals: uninsured adults and children whose incomes would make them eligible for Medicaid or CHIP and people who are not legally residing in the United States. Neither group is eligible for premium tax credits under the ACA. For those remaining in the pool, we looked at their family incomes under ACA rules and the premiums that they would face for benchmark coverage to determine whether they would qualify for a premium tax credit. The vast majority of potential eligibles with incomes between 100 percent and 400 percent of poverty would qualify for a tax credits; those who do not qualify in this income range are younger people who face a premium that is lower than the defined percent of income under the law. As a final step, we removed approximately 16 percent of potential eligibles because research shows that some people who are uninsured or have nongroup coverage have access to employer-based coverage, either through an offer from their own employer or through an offer through a spouse or parent. Those that remain in the potential pool constitute our estimate of tax-credit eligible individuals. A more complete description of this data and our methods is provided in the methods section below.

We estimate that over 17 million people nationally will be eligible for tax credits in 2014. The national and state totals are shown in Table 1. Three states (Texas, California, and Florida) each have more than 1 million tax-credit-eligible residents, and another seven states have more than 500,000 tax-credit-eligible residents. At the lower end, seven states have fewer than 50,000 tax-credit-eligible residents, with the District of Columbia (9,500) and Vermont (27,000) having the fewest. The five states with the most tax-credit-eligible individuals account for about 40 percent of all such individuals nationally.

Table 1

Estimated Number of Tax-Credit-Eligible Individuals and Potential Market for Marketplace Coverage, By State		
	Number of Tax Credit Eligible Residents	Potential Market Size
<b>National</b>	<b>17,187,000</b>	<b>28,605,000</b>
Alabama	270,000	464,000
Alaska	55,000	78,000
Arizona	313,000	551,000
Arkansas	150,000	227,000
California	1,903,000	3,291,000
Colorado	254,000	501,000
Connecticut	109,000	216,000
Delaware	29,000	48,000
District of Columbia	9,000	36,000
Florida	1,587,000	2,545,000
Georgia	654,000	1,063,000
Hawaii	29,000	58,000
Idaho	130,000	202,000
Illinois	501,000	937,000
Indiana	354,000	525,000
Iowa	127,000	262,000
Kansas	161,000	298,000
Kentucky	192,000	302,000
Louisiana	344,000	489,000
Maine	77,000	122,000
Maryland	201,000	419,000
Massachusetts	118,000	259,000
Michigan	436,000	725,000
Minnesota	90,000	298,000
Mississippi	204,000	298,000
Missouri	386,000	657,000
Montana	97,000	152,000
Nebraska	122,000	239,000
Nevada	155,000	249,000
New Hampshire	81,000	137,000
New Jersey	400,000	628,000
New Mexico	118,000	193,000
New York	779,000	1,264,000
North Carolina	684,000	1,073,000
North Dakota	43,000	77,000
Ohio	544,000	812,000
Oklahoma	256,000	446,000
Oregon	187,000	337,000
Pennsylvania	715,000	1,276,000
Rhode Island	40,000	70,000
South Carolina	336,000	491,000
South Dakota	70,000	118,000
Tennessee	387,000	645,000
Texas	2,049,000	3,143,000
Utah	206,000	331,000
Vermont	27,000	45,000
Virginia	518,000	823,000
Washington	272,000	507,000
West Virginia	71,000	117,000
Wisconsin	301,000	482,000
Wyoming	47,000	80,000

Source: KFF analysis of March 2012 and 2013 CPS. See Methods for more details.

## HOW MANY PEOPLE MIGHT LOOK TO STATE MARKETPLACES FOR COVERAGE?

People eligible for premium tax credits are likely to look to new marketplaces when they want coverage because tax credits are only available to marketplace enrollees. Others looking to purchase coverage on their own also might want to purchase in new marketplaces, although nongroup policies will be available outside of marketplaces as well. Generally, nongroup policies written inside and outside of marketplaces will provide the same benefits, have the same cost-sharing tiers, and be subject to the same market rules.

We estimate the potential market for coverage in marketplaces by starting with current nongroup purchasers and uninsured people who are legally residing in the United States and who are not eligible for Medicaid or CHIP. We then excluded two groups from among the current uninsured. The first group is people with incomes above Medicaid eligibility levels but below poverty, referred to as the gap group. Because they are not eligible for financial assistance, few will have the means to afford nongroup coverage. We also excluded current uninsured people who are in a household of a full-time worker who either has or is offered employer-based insurance. As noted above, these people would be ineligible for premium tax credits, so we assume that they would choose employer-based coverage rather than nongroup coverage if they choose to become insured.<sup>4</sup>

This calculation leaves about 29 million people nationally who might look to the new marketplaces. The largest potential markets are in the states with the largest tax-credit eligible population: California, Texas, and Florida. Six states have a potential market of more than 1 million people, and another 12 have a potential market of more than 500,000 people.

## DISCUSSION

The Congressional Budget Office (CBO) projects that 7 million people will enroll in health insurance exchanges in 2014, including 6 million who will be receiving tax credits to subsidize their premiums. Based on our analysis above, these enrollment levels would mean that 25% of potential exchange enrollees would choose to participate in year one of the ACA, with a slightly higher proportion of people eligible for tax credits (35%) buying coverage in an exchange.

From the perspective of delivering assistance to people eligible for it, enrollment in exchanges is a key measure, since tax credits are only available to those who buy coverage on their own in an exchange. It often takes time for enrollment in a new program to ramp up, and consistent with this view, CBO projects the number of people receiving tax credits in exchanges to triple by 2016.

The take-up of tax credits may vary significantly across states, for a variety of reasons. In the early stages of open enrollment, it's clear that the enrollment process is working more smoothly in some state-based exchanges than in others, and the difficulties with the federal marketplace have been widely reported. In addition, significantly greater outreach and consumer assistance resources are available in state-based exchanges due to the availability of federal grants under the ACA and limited budget for implementation of the federal marketplace. Our estimates of the number of people eligible for tax credits by state can serve as a barometer for tracking the success of enrollment efforts.

The overall enrollment in Marketplace coverage is likely to be a metric that is watched closely. While it is not, in fact, the most relevant measure for assessing the stability of the individual insurance market, it may provide some signals as to the health of the market and where premiums may be heading in 2015.

More important than how many enroll is who enrolls – Are they disproportionately younger and healthier or older and sicker? And, it is the composition of the entire individual market that is important, not just who enrolls in exchanges. That is because insurers are required to set premiums for individual insurance market coverage across all plans they offer, inside and outside of exchanges. Also, the risk adjustment system – which will redistribute money from plans that serve disproportionately healthy enrollees to those that enroll a disproportionately sick population – applies to plans inside and outside exchanges as well.

However, the likelihood of getting a balanced mix of enrollees in the individual market is related to the total number of new signups. It is expected that people who have a pre-existing condition and have been excluded from the individual insurance market previously will likely be among the early entrants. In addition, many people in state-based high risk pools will likely switch over to the individual market as well. Therefore, low enrollment levels may indicate a disproportionately sick risk pool, while higher enrollment levels may suggest a more balanced pool. And, it is likely that many new entrants to the individual market will enter through Marketplaces, so the number and composition of Marketplace enrollment may be suggestive of how the market is doing overall. Because insurance pools operate at the state level, the composition of enrollment state-by-state will be what drives the stability of insurance markets. Enrolling a large number of young and healthy people in California, for example, would not offset low take-up in Texas.

## METHODS

The 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 that can be used for national and state estimates.

Estimating eligibility for Medicaid, CHIP and premium tax credits for marketplace coverage requires grouping individuals together in different ways to determine their income under the different program rules. Our approach is described [here](#). We analyzed people without coverage or with nongroup coverage to determine their potential eligibility for premium-tax-credits and as potential marketplace participants. The first step was to remove adults and children with incomes below [Medicaid and CHIP eligibility levels](#) in their state.<sup>5</sup> We also removed people who are not legal residents from the pool of potential eligibles. The ASEC does not ask about legal status of non-citizens, so we imputed documentation status as described [here](#). Programming code to create the households and to perform the immigration status imputation is available upon request.

**Premium tax credits.** We analyzed the sample of remaining uninsured and nongroup people to determine eligibility for premium tax credits based on the income for their tax household and the premiums in the state where they lived. More than 40 percent of the unweighted records in the 2012-2013 CPS have a county identified -- so a second lowest silver plan premium for that county was directly merged on to these records. Other records were assigned a premium based on the within-state average premium for all undisclosed counties, weighted by the Census Bureau's 2010 Small Area Health Insurance Estimates (SAHIE) of the uninsured population of those counties. Premiums were adjusted for age based on the age-rating curve in each state. We assumed that all eligible members of a tax household would enroll in nongroup coverage and calculated their premium as a percent of household income. This premium percentage was compared to the maximum percentages in the ACA that families in the tax credit range (100 to 400 percent of poverty) must pay

toward the cost of the second-lowest cost silver plan where they live. People in families with incomes between 100 and 400 percent of poverty and whose household premium exceeded the maximum ACA percentage were identified as potentially tax credit eligible, subject to one additional adjustment described below.

As a final step, we reduced the number of people eligible for premium tax credits to reflect offers of employer-sponsored coverage. Under the law, people offered employer-sponsored coverage that meets minimum standards are not eligible to receive premium tax credits, even if they purchase nongroup coverage in a marketplace. The ASEC does not ask whether respondents were offered coverage at work, so we derived offer rates using data from Wave 6 of the 2008 Survey of Income and Program Participation (SIPP). Wave 6 asks respondents if they were offered health insurance at their main job. We assume that people who live with a spouse or parent that has coverage or an offer of coverage through a job also was offered coverage. We calculated offer rates for people without insurance and with nongroup insurance, stratified by age and income. We applied these percentages to the ASEC sample to reduce each state's count of uninsured and current nongroup individuals potentially eligible for premium tax credits.

**Potential Market.** As with our estimates for tax-credit eligibles, the estimate for the number of people who might look for coverage in Marketplaces starts with people legally residing in the United States who are uninsured or have nongroup coverage and have incomes above Medicaid and CHIP eligibility levels. We retain all remaining nongroup purchasers, even those with low incomes, as potential Marketplace purchasers because they are purchasing nongroup coverage now. Among the current uninsured, we excluded two groups from potential purchasers. The first group is people with access to employer-based coverage. As discussed above, we assume that these people would choose coverage through a job rather than nongroup coverage if they want to get insurance. We used information from Wave 6 in SIPP, as described above, to remove them from the number of potential marketplace purchasers. Excluding currently uninsured people with access to employer-sponsored insurance reduces the number of potential purchasers by a little over five million people. The second group we excluded was uninsured people with incomes below poverty, referred to as the gap group. These uninsured adults live in states that elected not to adopt the ACA Medicaid expansion and are not eligible for financial assistance to help them get coverage in exchanges. We assume that few would have sufficient resources to purchase nongroup coverage. Excluding this gap group reduces the number of potential purchasers by about 4.8 million people.

*The issue brief was prepared by Gary Claxton, Larry Levitt, Anthony Damico, Rachel Garfield, Nirmita Panchal, Cynthia Cox and Matthew Rae.*

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<sup>1</sup> [http://cbo.gov/sites/default/files/cbofiles/attachments/44190\\_EffectsAffordableCareActHealthInsuranceCoverage\\_2.pdf](http://cbo.gov/sites/default/files/cbofiles/attachments/44190_EffectsAffordableCareActHealthInsuranceCoverage_2.pdf)

<sup>2</sup> Recent legally residing immigrants with incomes below the poverty line are treated as if their income were at the poverty line, making them eligible for premium tax credits.

<sup>3</sup> Health plans sold in the individual market in a state all have essentially the same benefits. Plans are organized into five tiers based on the amount of cost sharing (e.g., deductibles, copayments, coinsurance) they have. The five tiers are catastrophic, bronze, silver, gold and platinum. For more information, see <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8303.pdf>.

<sup>4</sup> We did not remove current nongroup purchasers with an offer of employer-based coverage from the potential market total. These people have already made the decision not to take employer-provided coverage and to purchase nongroup coverage.

<sup>5</sup> Because some states have chosen to take the optional Medicaid expansion under the ACA and others have not, people with incomes from 100 to 138 percent of poverty will have different forms of financial assistance dependent on the state's decision. These people will be eligible for Medicaid in states taking the expansion but will be potentially eligible for premium tax credits in states not expanding Medicaid.

# Maine Health Exchange Advisory Committee

## Section 1311 Funding for States—State Planning and Establishment Grants for Exchanges

### **Funding Availability**

Under Section 1311 of the Affordable Care Act (ACA), federal funds may be awarded to States, the District of Columbia, and consortia of States, to provide financial assistance for the establishment of exchanges. See the attached table listing the total awards to States from [www.statehealthfacts.org](http://www.statehealthfacts.org).

### **Grant Application Deadlines; Timing of Awards**

Applications are accepted on quarterly basis; awards are made based on available funding. Remaining application deadlines are February 15, 2014; May 15, 2014; August 15, 2014 and October 15, 2014. The anticipated notice of award is 45 days after the application due date. Applicants are encouraged to consult with the Center for Consumer Information and Insurance Oversight regarding the use of section 1311 funds before submitting applications. It is also recommended that a Letter of Intent be submitted one month prior to each application deadline.

### **Requirements**

Grants are available for States seeking to establish a State-based Exchange, to build functions that a State elects to operate under a State Partnership Exchange, and to support State activities to build interfaces with a Federally-facilitated Exchange. Grants may be awarded through December 31, 2014 for all types of Exchanges, and grant funds are available for approved and permissible establishment activities.

The Governor may designate a governmental agency or quasi-governmental entity to apply for grants on behalf of that State. Quasi-governmental organizations serving as the grantee must have been created or established by the State (through legislation or other legal authority), and have State oversight (i.e. the governing body is established, appointed, and overseen by the State and the entity is subject to specific limitations on its authority to act as established by the State). Each applicant must submit a letter from the Governor officially endorsing the grant application and the proposed Cooperative Agreement along with letters from the State's Medicaid director and insurance regulator, if relevant to the grant application.

### **Consumer and Stakeholder Engagement and Support Activities**

States interested in a Federally-facilitated Exchange or State Partnership model may apply for funding for consumer outreach, educational and assistance activities. The ACA prohibits States from using Section 1311 grants to fund navigator grants. See the attached FAQ describing the allowable activities for the use of Section 1311 funds.

## Total Health Insurance Exchange Grants

Location	Exchange Planning Grant Amount	Exchange Establishment Grant Amount	Early Innovator Grant Amount	Total Exchange Grant Amount
United States	\$44,137,908	\$4,159,177,032	\$138,122,850	\$4,341,437,790
Alabama	\$1,180,312	\$8,592,139	NA	\$9,772,451
Alaska	NA	NA	NA	NA
Arizona	\$999,670	\$29,877,427	NA	\$30,877,097
Arkansas	\$1,200,928	\$42,731,407	NA	\$43,932,335
California	\$529,894	\$909,606,370	NA	\$910,136,264
Colorado	\$1,247,599	\$177,693,424	NA	\$178,931,023
Connecticut	\$996,848	\$163,469,612	NA <sub>1</sub>	\$164,466,460
Delaware	\$999,999	\$11,936,639	NA	\$12,936,638
District of Columbia	\$999,999	\$132,573,928	NA	\$133,573,927
Florida	NA <sub>2</sub>	NA	NA	NA
Georgia	\$1,000,000	NA	NA	\$1,000,000
Hawaii	\$1,000,000	\$204,342,270	NA	\$205,342,270
Idaho	\$998,220	\$68,395,587	NA	\$69,393,807
Illinois	\$1,071,784	\$153,741,352	NA	\$154,813,136
Indiana	\$965,415	\$6,895,126	NA	\$7,860,541
Iowa	\$1,000,000	\$58,683,889	NA	\$59,683,889
Kansas	\$1,000,000	NA	\$10,390 <sub>3</sub>	\$1,010,390
Kentucky	\$469,088	\$252,698,351	NA	\$253,167,439
Louisiana	\$29,391 <sub>4</sub>	NA	NA	\$29,391
Maine	\$999,841	NA <sub>5</sub>	NA <sub>1</sub>	\$999,841
Maryland	\$999,226	\$163,786,430	\$6,277,454	\$171,063,110
Massachusetts	\$1,000,000	\$134,581,413	\$44,486,362 <sub>1</sub>	\$180,067,775
Michigan	\$999,772	\$40,517,249	NA	\$41,517,021
Minnesota	\$1,000,000	\$154,020,465	NA	\$155,020,465
Mississippi	\$670,125	\$20,143,618	NA	\$20,813,743
Missouri	\$1,000,000	\$20,865,716	NA	\$21,865,716
Montana	\$1,000,000	NA	NA	\$1,000,000
Nebraska	\$895,075	\$5,481,838	NA	\$6,376,913
Nevada	\$1,000,000	\$82,775,083	NA	\$83,775,083
New Hampshire	\$334,000 <sub>6</sub>	\$6,267,088	NA	\$6,601,088
New Jersey	\$1,223,166	\$7,674,130	NA	\$8,897,316
New Mexico	\$1,000,000	\$52,879,483	NA	\$53,879,483
New York	\$1,000,000	\$400,633,975	\$27,431,432	\$429,065,407
North Carolina	\$999,999	\$86,357,315	NA	\$87,357,314
North Dakota	\$231,978	NA	NA	\$231,978
Ohio	\$1,000,000	NA	NA	\$1,000,000
Oklahoma	\$897,980	NA	NA <sub>2</sub>	\$897,980
Oregon	\$1,000,000	\$242,094,375	\$59,917,212	\$303,011,587
Pennsylvania	\$1,000,000	\$33,832,212	NA	\$34,832,212
Rhode Island	\$1,000,000	\$98,128,661	NA <sub>1</sub>	\$99,128,661
South Carolina	\$304,996	NA	NA	\$304,996
South Dakota	\$1,000,000	\$5,879,569	NA	\$6,879,569
Tennessee	\$1,000,000	\$8,110,165	NA	\$9,110,165
Texas	\$96,425 <sub>8</sub>	NA	NA	\$96,425
Utah	\$1,000,000	\$1,000,000	NA	\$2,000,000
Vermont	\$1,000,000	\$167,124,081	NA <sub>1</sub>	\$168,124,081
Virginia	\$1,000,000	\$5,567,803	NA	\$6,567,803
Washington	\$996,285	\$180,396,014	NA	\$181,392,299
West Virginia	\$1,000,000	\$19,832,828	NA	\$20,832,828
Wisconsin	\$999,873	NA	NA <sub>2</sub>	\$999,873
Wyoming	\$800,000	NA	NA	\$800,000



Centers for Medicare & Medicaid Services

[CCIIO Home](#) > [Fact Sheets and FAQs](#) > Frequently Asked Questions on Allowable Uses of Section 1311 Funding for States in a State Consumer Partnership Marketplace

## The Center for Consumer Information & Insurance Oversight

### Frequently Asked Questions on Allowable Uses of Section 1311 Funding for States in a State Consumer Partnership Marketplace

This Frequently Asked Question (FAQ) provides clarification about grant funding under Affordable Care Act Section 1311(a) available to states in which the federal government will operate a Federally-facilitated Marketplace (FFM), including State Consumer Partnership Marketplaces (SPMs). This FAQ is applicable to the amended Funding Opportunity Announcement (FOA) released on November 30, 2012 ("Cooperative Agreement to Support Establishment of Affordable Care Act's Health Insurance Exchanges"), and related section 1311 (a) funding opportunities, which can be found at <http://www.grants.gov>, under Catalog of Federal Domestic Assistance number 93.525.

These FAQs are considered general guidance only and are in no way guaranteeing approval of funding requests. All requests for funding are reviewed for allowability, allocability, and reasonableness and other requirements set forth in the funding announcement.

**Q1:** If a state is in a State Consumer Partnership Marketplace, what types of activities are allowable uses of 1311 funds?

**A1:** For states that are in a State Consumer Partnership Marketplace, the list in the table below outlines generally allowable activities for the use of 1311 funds. This list is not exhaustive, but provides examples of potential eligible activities. States are encouraged to consult with HHS regarding the use of 1311 funds for these and other activities before submitting grant applications or expending funds.

As CMS recently advised, Affordable Care Act section 1311(j)(6) prohibits Marketplaces from using section 1311(a) grant funds to fund Navigator grants. See 78 Fed. Reg. 20581, 20583-84: <http://www.gpo.gov/fdsys/pkg/FR-2013-04-05/pdf/2013-07951.pdf>. In State Consumer Partnership Marketplaces, Navigators are a federal responsibility funded by a separate federal grant program.

Section 1311(a) grant funds are available for non-Navigator assistance programs (also known as "in-person assistance programs") in Consumer Partnership Marketplaces because the state has elected to establish and operate outreach, educational, and assistance activities as a condition of its participation in the Consumer Partnership Marketplace and to assist in its possible transition to a State-based Marketplace. See the 1/3/2013 Guidance on the State Partnership Marketplace. In State Partnership Marketplaces, the non-Navigator Assistance Program will supplement – not supplant – the Navigator Program, which is administered by HHS.

Additionally, while section 1311(j)(1) directs that the federal Navigator program be a grant program, state partners in a Consumer Partnership Marketplace have the flexibility to build a non-Navigator assistance program through contracts, direct hiring, or grants, subject to state law.

Operational Area	State Activities
Consumer and Stakeholder Engagement and Support	<ul style="list-style-type: none"> <li>• Build and fund first year operations of an in-person assistance personnel (IPAs) program (also known as "non-Navigator assistance personnel")</li> <li>• Help HHS ensure that Navigators and IPAs have completed required federal training and passed required federal exam</li> <li>• If the state so chooses, create supplemental training materials for Navigators and IPAs that include state-specific component</li> <li>• Help HHS ensure that Navigators and IPAs are educated about and know how to refer consumers to Consumer Assistance Programs (CAPs) throughout the state as appropriate</li> <li>• Assist HHS in monitoring the conduct and performance of Navigators and report any noncompliance</li> </ul>

	<ul style="list-style-type: none"> <li>• Establish mobile units throughout the state to help individuals complete Marketplace eligibility applications and choose a Qualified Health Plan (QHP)</li> <li>• Provide consumers/stakeholders with information about how the Pre-existing Insurance Plan (PCIP) program transition will occur and assist PCIP enrollees transitioning to the Marketplace</li> <li>• Develop and execute, with HHS approval, activities to publicize Marketplace activities in the state</li> <li>• Engage local stakeholders in the role of disseminating Marketplace information to eligible populations</li> <li>• Coordinate with other health and human services organizations in the state to broaden outreach (such as Marketplace information on applications for other programs, websites, emails or through IPA call centers)</li> <li>• Develop state-specific materials – or use those developed by the FFM – to educate consumers about eligibility and enrollment options as well as benefits and services available through the Marketplace</li> <li>• Produce and disseminate marketing/campaign materials, including but not limited to: brochures, direct mail, print ads, social media and digital/online ads, and TV and radio buys. Materials must use federal messages and language and conform to other requirements detailed in the Marketing FAQ</li> <li>• Ensure that public education and outreach materials are culturally and linguistically appropriate, and accessible for persons with limited English proficiency and disabilities</li> <li>• Brand the State’s consumer assistance program (Navigators, IPAs) with a single identity such as a distinct name and tagline to use on a consumer website, earned and paid media, and outreach and education activities</li> <li>• Provide tailored search capabilities on any branded in-person assistance website</li> <li>• Ensure that the IPA program is consistent with all applicable federal regulations and guidance</li> <li>• Manage State IPA program so that it coordinates with the Federal Navigator program in order to avoid duplication of efforts</li> <li>• Identify and recruit in-person assistance personnel</li> <li>• Help ensure that all Navigators and IPAs adhere to federal conflict-of-interest standards; all materials comply with Culturally and Linguistically Appropriate Services (CLAS) standards; and all categories of in-person assisters have received training on privacy and security standards concerning the handling of Personally Identifiable Information (PII)</li> <li>• With HHS, resolve any problems or complaints about IPAs reported directly to the State Marketplace or referred from the federal complaint tracking system</li> </ul>
SHOP	<ul style="list-style-type: none"> <li>• Help HHS monitor Navigators to ensure that Navigators are reaching out to and trained to assist small businesses with enrollment in SHOP plans.</li> </ul>

	<ul style="list-style-type: none"><li>• Operate an IPA program that will assist small businesses with enrollment in SHOP plans</li></ul>
Contracting, Outsourcing, and Agreements	<ul style="list-style-type: none"><li>• Inform HHS about contracting and outsourcing agreements</li></ul>

**CMS.gov**

A federal government website managed by the Centers for Medicare & Medicaid Services  
7500 Security Boulevard, Baltimore, MD 21244







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November 14, 2013

Dear Insurance Commissioners,

Some individuals and small businesses with health insurance coverage have been notified by their health insurance issuers that their coverage will soon be terminated. We understand that, in some cases, the health insurance issuer is terminating or cancelling such coverage because it would not comply with certain market reforms that are scheduled to take effect for plan or policy years starting on or after January 1, 2014, such as the new modified community rating and essential health benefits package standards.<sup>1</sup> Although affected individuals and small businesses may access quality health insurance coverage through the new Health Insurance Marketplaces, in many cases with federal subsidies, some of them are finding that such coverage would be more expensive than their current coverage, and thus they may be dissuaded from immediately transitioning to such coverage.

In light of this circumstance, under the following transitional policy, health insurance issuers may choose to continue coverage that would otherwise be terminated or cancelled, and affected individuals and small businesses may choose to re-enroll in such coverage. Under this transitional policy, health insurance coverage in the individual or small group market that is renewed for a policy year starting between January 1, 2014, and October 1, 2014, and associated group health plans of small businesses, will not be considered to be out of compliance with the market reforms specified below under the conditions specified below.<sup>2</sup> We will consider the impact of this transitional policy in assessing whether to extend it beyond the specified timeframe.

The specified market reforms are the portions of the following provisions of the Public Health Service Act that are scheduled to take effect for plan or policy years starting on or after

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<sup>1</sup> Health plans that are grandfathered pursuant to section 1251 of the Affordable Care Act and its implementing regulations are not subject to most market reforms. Because there is no need for transitional relief for such plans, the transitional relief afforded in this document is not applicable to grandfathered health plans.

<sup>2</sup> The Department of Health and Human Services has conferred with the Departments of Labor and the Treasury with respect to those market reforms with respect to which there is shared jurisdiction. With respect to those market reforms, the Departments of Labor and the Treasury concur with the transitional relief afforded in this document.

January 1, 2014, and any corresponding portions of the Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (Code):

- Section 2701 (relating to fair health insurance premiums);
- Section 2702 (relating to guaranteed availability of coverage);
- Section 2703 (relating to guaranteed renewability of coverage);
- Section 2704 (relating to the prohibition of pre-existing condition exclusions or other discrimination based on health status), with respect to adults, except with respect to group coverage;
- Section 2705 (relating to the prohibition of discrimination against individual participants and beneficiaries based on health status), except with respect to group coverage;<sup>3</sup>
- Section 2706 (relating to non-discrimination in health care);
- Section 2707 (relating to comprehensive health insurance coverage);
- Section 2709, as codified at 42 U.S.C. § 300gg-8 (relating to coverage for individuals participating in approved clinical trials).

The specified conditions are the following:

- The coverage was in effect on October 1, 2013;<sup>4</sup>
- The health insurance issuer sends a notice to all individuals and small businesses that received a cancellation or termination notice with respect to the coverage, or sends a notice to all individuals and small businesses that would otherwise receive a cancellation or termination notice with respect to the coverage, that informs them of (1) any changes in the options that are available to them; (2) which of the specified market reforms would not be reflected in any coverage that continues; (3) their potential right to enroll in a qualified health plan offered through a Health Insurance Marketplace and possibly qualify for financial assistance; (4) how to access such coverage through a Marketplace; and (5) their right to enroll in health insurance coverage outside of a Marketplace that complies with the specified market reforms. Where individuals or small businesses have already received a cancellation or termination notice, the issuer must send this notice as soon as reasonably possible. Where individuals or small business would otherwise receive a cancellation or termination notice, the issuer must send this

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<sup>3</sup> We note that sections 702 of ERISA and 9802 of the Code remain applicable to group health plans.

<sup>4</sup> In light of this condition, the transitional relief afforded in this document is not applicable to newly obtained health insurance coverage. It applies only with respect to individuals and small businesses with coverage that was in effect on October 1, 2013; it does not apply with respect to individuals and small businesses that obtain new coverage after October 1, 2013.

notice by the time that it would otherwise send the cancellation or termination notice.

State agencies responsible for enforcing the specified market reforms are encouraged to adopt the same transitional policy with respect to this coverage.

Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance.

Sincerely,

/Signed, GC, November 14, 2013/

Gary Cohen  
Director  
Center for Consumer Information and Insurance Oversight

113TH CONGRESS  
1ST SESSION

# H. R. 3350

To authorize health insurance issuers to continue to offer for sale current individual health insurance coverage in satisfaction of the minimum essential health insurance coverage requirement, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

OCTOBER 28, 2013

Mr. UPTON (for himself, Mr. HALL, Mr. BURGESS, Mr. OLSON, Mrs. BLACKBURN, Mr. HARPER, Mr. ROGERS of Michigan, Mr. CASSIDY, Mrs. MCMORRIS RODGERS, Mr. GRIFFITH of Virginia, Mr. GARDNER, Mr. WALDEN, Mrs. ELLMERS, Mr. WHITFIELD, Mr. MURPHY of Pennsylvania, Mr. LONG, Mr. BILIRAKIS, Mr. LANCE, Mr. SCALISE, Mr. JOHNSON of Ohio, Mr. PITTS, Mr. GUTHRIE, Mr. BARTON, Mr. GINGREY of Georgia, Mr. KINZINGER of Illinois, Mr. POMPEO, Mr. LATTA, Mr. TERRY, Mr. MCKINLEY, and Mr. SHIMKUS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To authorize health insurance issuers to continue to offer for sale current individual health insurance coverage in satisfaction of the minimum essential health insurance coverage requirement, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*  
2 *tives of the United States of America in Congress assembled,*

1 **SECTION 1. SHORT TITLE.**

2 This Act may be cited as the “Keep Your Health  
3 Plan Act of 2013”.

4 **SEC. 2. IF YOU LIKE YOUR HEALTH CARE PLAN, YOU CAN**  
5 **KEEP IT.**

6 (a) **IN GENERAL.**—Notwithstanding any provision of  
7 the Patient Protection and Affordable Care Act (including  
8 any amendment made by such Act or by the Health Care  
9 and Education Reconciliation Act of 2010), a health insur-  
10 ance issuer that has in effect health insurance coverage  
11 in the individual market as of January 1, 2013, may con-  
12 tinue after such date to offer such coverage for sale during  
13 2014 in such market outside of an Exchange established  
14 under section 1311 or 1321 of such Act (42 U.S.C. 18031,  
15 18041).

16 (b) **TREATMENT AS GRANDFATHERED HEALTH**  
17 **PLAN IN SATISFACTION OF MINIMUM ESSENTIAL COV-**  
18 **ERAGE.**—Health insurance coverage described in sub-  
19 section (a) shall be treated as a grandfathered health plan  
20 for purposes of the amendment made by section 1501(b)  
21 of the Patient Protection and Affordable Care Act.

○

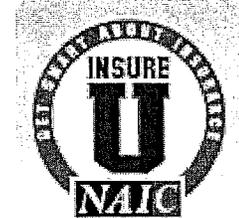


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**FOR IMMEDIATE RELEASE**

## NAIC STATEMENT ON PRESIDENT OBAMA'S ANNOUNCEMENT REGARDING ONE YEAR EXTENSION FOR EXISTING PLANS



### Contacts

WASHINGTON, D.C. (Nov. 14, 2013) — *The following is a statement from NAIC President and Louisiana Insurance Commissioner Jim Donelon on the Obama Administration's announcement regarding policy cancellations and the role of state insurance regulators.*

Communications Division  
[news@naic.org](mailto:news@naic.org)

We share the President's and Congress' concerns about policy cancellations and issues including gaps in coverage that may result from them, and fully understand the anxiety of the residents of our states who have received these notices. This anxiety is especially heightened given the issues with the federal exchange.

Scott Holeman  
Communications Director

For three years, state insurance regulators have been working to adapt to the Affordable Care Act in a way that best meets the needs of consumers in each state. We have been particularly concerned about the way the reforms would impact premiums, the solvency of insurance companies, and the overall health of the marketplace. The NAIC has been clear from the beginning that allowing insurers to have different rules for different policies would be detrimental to the overall market and result in higher premiums.

Jeremy Wilkinson  
Electronic Communications Manager

We have expressed these concerns with the Administration and are concerned by the President's announcement today that the federal government would use its "enforcement discretion" to delay enforcement of the ACA's market reforms in 2014 for plans that are currently in effect. This decision continues different rules for different policies and threatens to undermine the new market, and may lead to higher premiums and market disruptions in 2014 and beyond.

Miun Gleeson  
Sr. Communications Specialist

Erin Yang  
Media Strategist

Carly Erickson  
Communications Specialist

In addition, it is unclear how, as a practical matter, the changes proposed today by the President can be put into effect. In many states, cancellation notices have already gone out to policyholders and rates and plans have already been approved for 2014. Changing the rules through administrative action at this late date creates uncertainty and may not address the

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underlying issues. We look forward to learning more details of this policy change and about how the administration proposes that regulators and insurers make this work for all consumers.

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Report to the Maine Health Exchange Advisory Committee  
November 18, 2013  
Maine State Library

**The Role of Libraries in Consumer Outreach and Enrollment**

**National Level:**

Information began flowing to state library agencies and public libraries after an official announcement at the American Libraries Association (ALA) national conference in June 2013 about the anticipated role libraries would play in Affordable Care Act outreach and access. The Maine State Library's federal funder, the Institute of Museum and Library Services (IMLS) collaborated with WebJunction, a national organization that works with educating libraries), to sponsor a series of webinars about the Affordable Care Act and how libraries can assist citizens with the process.

The Maine State Library (MSL) has promoted these webinars through our statewide listservs and that reach someone at each public library in the state. We point to the archives as a resource from our website.

**Coming up:**

**Health Happens in Libraries: Supporting Patron Information Needs**

In this November 26 webinar we'll hear from library representatives about the types of information requests they have received in the first several weeks of open enrollment for the Affordable Care Act, and what they have learned in responding.

**Archived:**

**Federal Depository Libraries and the Affordable Care Act**

This September 23 webinar will be directed towards Federal Depository Libraries and the role they can play to promote awareness of available resources for the Affordable Care Act.

**Meaningful Use: Libraries connecting patrons to ACA resources**

This August 28 webinar will explore strategies for libraries to identify ACA resources, hear from libraries that are working to prepare for patron requests, and obtain key policy and resource updates from ACA experts.

**Libraries & Health Insurance: Preparing for October 1**

This July 26 webinar provides information about plans to provide library staff with online resources to respond to increased patron information needs related to the Affordable Care Act.

**Maine State Library Outreach:**

After MSL attended the July and August webinars we began updating the information about health literacy on our website to include resources from Healthcare.gov and WebJunction.

In August, just after the Maine Navigators were announced the MSL contacted Jake Grindle at Western Maine Community Action and the Fishing Partnership Support Services/Maine Lobsterman Association (April Gilmore, navigator) to offer to explore how we could collaborate. We provided contact information, hours, # of computers and other information so libraries could be contacted directly by the navigator organizations to hold sign up and/or outreach sessions. Libraries were provided contact information for the eight Navigator organizations working with Western Maine Community Action through our website. MSL staff attended the August 19th Health Policy Colloquia at USM in Portland to obtain more information so we could keep Maine public libraries informed.



On September 25, the state library hosted a webinar **The Affordable Care Act Navigator Program and Maine Public Libraries** featuring Jake Grindle. Fifty—seven libraries registered and many others have listened to the archive since.

The Maine State Library maintains and updates 2 webpages regarding the ACA, one for libraries and one for citizens. Many small libraries point patrons to that page for reliable information because they know we will keep that information up to date.

We have communicated and shared resources and information with Maine Health Access Foundation and the Maine Equal Justice Partners to develop the resources for both patrons and librarians.

**At the local level:**

Libraries are offering local programs, working with local navigator organizations, area social service organizations, plus local legislators to bring information, answer questions, and offer access to computers to assist with enrollment. Libraries are also sharing information on our state listserv with each other. A great example was Lewiston Public Library sharing information they learned about requirements and resources for immigrant populations.

Brief summary of local library efforts:

- Gardiner Public Library held a forum titled Maine Health Insurance Marketplace Explained organized by Reps. Sharon Treat and Gay Grant.
- Wells Public Library held three programs and collaborated with York County Community Action, AARP and Southern Maine Agency of Aging
- Winslow Public Library hosted sessions with Western Maine Community Action and KVCAP.
- Southern Maine Medical center Librarians shared dates of events at the hospital for area libraries to advertise and/or attend
- Waterville Public Library, Oakland Public Library, Skowhegan Public Library and the Maine State Library hosted events with Western Maine Community Action
- Maine State Library is holding sessions with a navigator from KVCAP
- Lewiston Public Library held sessions with AARP and Western Maine community Action
- Portland Public Library is holding on-going Health Insurance Assistance sessions with a certified application counselor volunteer
- Stonington Public Library collaborated with the Penobscot East Resource Center and Island Medical Center to offer a program
- Rice Public Library in Kittery held a session with local navigators at the town hall. Next is scheduled at the local high school so they can utilize the computer lab
- Windham Public Library is working with Opportunity Alliance to hold sessions for patrons
- Bangor Public held a series of programs and trained staff and partnered with Maine State Nurses Association, Maine Community Health Options and Penquis Cap
- Porter Memorial Library in Machias sponsored 2 events, one at the University of Maine in Machias and one at the library with navigators, Maine Community Health Options and Eastport Health Care.
- In Dover-Foxcroft, the Thompson Free Library has offered a program and a staff member has become a certified application counselor.

Libraries all over Maine, in small and large communities are working with local organizations to offer programs and access that best serves their communities. As a trusted community resource, libraries are unbiased information facilitators that Maine citizens can rely on.



## McKenney, Janet

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**From:** Barbara McDade <bmcdade@bpl.lib.me.us>  
**Sent:** Friday, November 15, 2013 10:22 AM  
**To:** McKenney, Janet  
**Subject:** ACA programs

Janet,

All our staff were briefed about the ACA in August so they could help patrons with basic questions (nothing in depth). We also held the following programs described in this media release.

Barbara

**FOR IMMEDIATE RELEASE**

Contact: Lisa Frazell  
(207) 947-8336

### **BANGOR PUBLIC LIBRARY TO HOLD AFFORDABLE CARE ACT PROGRAMS**

*Library to Help Navigate Affordable Care Act Programs Free for the Public*

[Bangor, ME] October 10, 2013 – As the Bangor Public Library will be hosting a series of programs in the coming weeks to help the public address the new Affordable Care Act. These are informative programs that are free and open to the public.

“There is a lot of uncertainty with the Affordable Care Act and we want to help the public get a better understanding of the changes.” says Barbara McDade, Director of the Bangor Public Library. “This is an opportunity for the public to get informed to make the best decision for them and their families.”

On October 1, 2013, the Affordable Care Act also known as Obamacare began open enrollment for citizens who need health care. Citizens will use the Health Insurance Marketplace to see options and enroll for coverage. Open enrollment ends on March 31, 2014. Insurance coverage under the Affordable Care Act will take effect on January 1, 2014 for those who have enrolled.

The first public program is on **Saturday, October 12** from **12:00 – 2:00 p.m.** Dick Streubel will be at the Bangor Public Library to answer questions and give out information to the public regarding the Healthcare Reform Act (in the Lecture Hall).

**Tuesday, October 15<sup>th</sup>** in the Lecture Hall from **3:00 – 8:00 p.m.** will be split between “Healthcare Is a Human Right” (**6 – 7 p.m.**) and “Townhall Meeting/Free Screening” (**3 – 5 p.m.**); sponsored by the Maine State Nurses Association.

**Wednesday, October 23<sup>rd</sup>** in the Lecture Hall from **3:30 – 5:00 p.m.** is “The Affordable Care Act and What It Means to You” presented by Michael Gendreau, of Maine Community Health Options.

Lastly, on **Wednesday, November 6<sup>th</sup>** in the Bangor Public Library Computer Lab from **3:30 – 5:00 p.m.** the public is invited to “Healthcare Signup Help,” providing computer access and direction to resources (sponsored by the Bangor Public Library and Penquis Cap).

For more information, contact the Library at (207) 947-8336.

Barbara A. McDade  
Director  
Bangor Public Library  
145 Harlow St





## Programs & Events » Health

**NOV Health Insurance Assistance**

**10:00am - 12:00pm**

**20**

**Location:** Main Library, meeting room (3)

**Audience:** Adults, Seniors

Unsure about the Affordable Care Act? Need to know how it affects you? Thinking about signing up for insurance? Need help? Meet with a Health Insurance Assistance volunteer.

**NOV Health Insurance Assistance**

**10:00am - 12:00pm**

**22**

**Location:** Main Library, meeting room (3)

**Audience:** Adults, Seniors

Unsure about the Affordable Care Act? Need to know how it affects you? Thinking about signing up for insurance? Need help? Meet with a Health Insurance Assistance volunteer.

**NOV Health Insurance Assistance**

**10:00am - 12:00pm**

**27**

**Location:** Main Library, meeting room (3)

**Audience:** Adults, Seniors

Unsure about the Affordable Care Act? Need to know how it affects you? Thinking about signing up for insurance? Need help? Meet with a Health Insurance Assistance volunteer.

**NOV Health Insurance Assistance**

**10:00am - 12:00pm**

**29**

**Location:** Main Library, meeting room (3)

**Audience:** Adults, Seniors

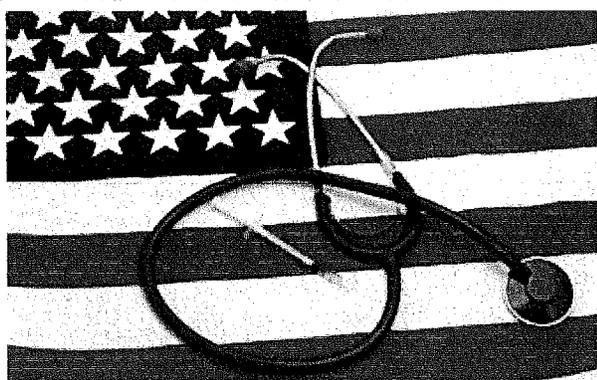
Unsure about the Affordable Care Act? Need to know how it affects you? Thinking about signing up for insurance? Need help? Meet with a Health Insurance Assistance volunteer.





## The Affordable Care Act 101: an enrollment kickoff event!

Oct 01, 2013– 6:00 pm



At 6:00 p.m. on Tues, Oct 1, in Callahan Hall, LPL is hosting Jake Grindle from Western Maine Community Action for an Affordable Care Act (ACA) enrollment kickoff event. Oct 1 marks the start of the enrollment period for Mainer to sign up for health insurance under ACA and experts from WMCA will be on hand to present a video and detailed overview on the new federal law. This informational event is free and open to the public.

The program will walk participants through the basics of ACA and will explain newly available resources every Mainer should know about in order to

fully understand the law. The presentation will explore the coming changes and review what it all means for those that are currently uninsured. The presentation will also review the law's impact on Maine businesses and on all of us.

Jake Grindle joined the staff of Western Maine Community Action in February of this year and took the lead in their successful grant application for WMCA to serve as a "Navigator" under the Affordable Care Act. Over the next six months Jake and his support staff will be conducting public outreach and education sessions about the law and assisting consumers and small businesses in applying for and enrolling in the new insurance options.

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See more in: [Adults](#) | [Lecture](#)

Written on: Sep 30, 2013



## McKenney, Janet

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**From:** Vicki Zelnick <stoningtonlibrary@stonington.lib.me.us>  
**Sent:** Friday, November 15, 2013 10:54 AM  
**To:** McKenney, Janet  
**Subject:** ACA at Stonington Library

**Follow Up Flag:** Follow up  
**Flag Status:** Flagged

Hi,

We just hosted an evening seminar. Two navigators presented information about the ACA and then answered questions. We collaborated with the Penobscot East Resource Center and the Island Medical Center to publicize the event. In fact, we held the meeting at PERC as they have facilities we don't have (screens, projectors, etc.).

Much to all of our surprise (and delight) 50 people attended. It is the first time I have been to an event on the island where I was the oldest person in the room. We had many small business owners in attendance, as well as young singles. The library has offered to help further by opening up at non-regular times for people who want to use our comps and internet access. I am also working with the navigators to arrange times for them to return and meet one-on-one with people.

The audience we had was so very appreciative--many told me they felt this was the first quality, helpful information they had heard/seen.

I personally have found the webinar (archived) very helpful and I really appreciate all the information on the MSL website. I think it is the most comprehensive, easy-to-use site available for my patrons and I have been directing the health professionals on the island to it as well.

Vicki Zelnick  
Director  
Stonington Public Library  
PO Box 441  
Stonington, Maine 04681  
207-367-5926



# City of Gardiner, ME

6 Church Street, Gardiner, ME 04345  
ph: (207) 582-4200

## Affordable Health Care Act Forum

*Forum organized by Representatives Grant and Treat takes place Nov. 13, 2013 at the Gardiner Public Library*

**GARDINER** – A group of experts will participate in “The Maine Health Insurance Marketplace Explained,” a forum organized by Reps. Gay Grant, D-Gardiner, and Sharon Treat, D-Hallowell.

“Understanding the Affordable Care Act can be a daunting task,” said Grant. “Our expert panel is a great resource for learning about the new law and the Health Care Exchange where coverage can be purchased. This is an opportunity for the public to learn what the Affordable Care Act means for them.”

The forum will be held on Wednesday, Nov. 13, from 5:30 to 7:00 p.m. at the Gardiner Public Library located at 152 Water St. in Gardiner.

“It’s important that people have access to accurate information about the Affordable Care Act, particularly at this early stage of implementation,” said Treat, the House chair of the Maine Health Exchange Advisory Committee. “This forum will help individuals better understand the ACA and will provide resources to help them get the health insurance they need.”

The panel of health care policy experts will discuss how individuals and businesses are affected by the Affordable Care Act and how they can use the Maine Health Insurance Marketplace to purchase affordable health insurance policies.

Panelist Mitchell Stein, policy director of Maine Consumers for Affordable Health Care conducts policy research for health care advocacy efforts. Stein serves on the Legislature’s Health Exchange Advisory Committee.

Ann Schwab and Emily Owen, also on the panel, are from HealthReach Community Health Centers, an organization comprised of 11 Federally Qualified Health Centers in Central and Western Maine that provides primary care to 30,000 Maine people of all ages each year. They completed Certified Application Counselor training this fall and assist the public with the new Health Insurance Marketplace education and enrollment.

The presentation from the panel will be followed by a question and answer session. For more information, please call 207-582-3312.



## **TWO LIBRARY-SPONSORED PUBLIC HEALTH EVENTS**

### **Forum: Affordable Care Act-Make It Work For You**

Thursday, October 24                      6-8 p.m.

Rm. 102, Science Building, University of Maine at Machias

*Co-hosted by Porter Memorial Library and the Psychology and Community Studies Program at UMM*

*Guest Speakers*

at 6 p.m.

Deidre DeRoche

Outreach and Education Specialist  
Maine Community Health Options

at 7:30 p.m.

Deb Shields

Outreach and Enrollment Coordinator  
Eastport Health Care, Inc.

What does the Affordable Care Act mean to you? Learn where to look for answers to your questions about the new health insurance Marketplace. Make an appointment with a health insurance Navigator, or a Certified Application Counselor, to walk you through your health insurance application. Info session followed by question-and-answer period.

### **Find Your Way in the Health Insurance Marketplace**

Saturday, November 9                      2-6 p.m.

Porter Memorial Library, 92 Court Street, Machias

*Guests*

Kristine and Cole Knabenshue

Health Insurance Marketplace Navigators

Info session followed by one-on-one assistance from a trained Navigator

*Want to know more about these events? Call Lee at Porter Memorial Library 255-3933*





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Learn

What You Need to Know About Health Insurance

LearningExpress Library

Families and Individuals

Latest from Maine

Getting a Job

Sites to use while Healthcare.gov is being repaired:

- [State Officials Warn Consumers About Scams Related to Federal Health Reform \(ACA\)](#)
- [Health Reform and Your Affordable Care Act 101 - Bangor Daily News Series](#)

Health Information

[HealthShops](#) is a temporary alternative until the federal Healthcare.gov website is functioning at full capacity. Maine citizens can compare plans using this website. Plans can't be purchased through the site, but for users who want to enroll, they are provided with links to the private insurance companies' web sites and telephone numbers.

About Health Insurance

[Consumer Reports](#) has also built a website that can provide some basic assistance as well. This site uses your state, income range and current insurance status to provide recommendations and next steps in a simple step by step process.

HealthCare.gov

Learn more about options in [Maine](#)

Key Gov Websites

Health Marketplace for Maine Individuals

Apply online at [Healthcare.gov](#)

Your Maine Connection to the New Health Insurance Marketplace

Egov Online

[HealthCare.gov](#)

[enroll207.com](#)

Legal Assistance

Healthcare.gov Help Line

Maine Consumer for Affordable Health Care Help Line

Digital Literacy

1-800-318-2696

1-800-965-7476

Maine Navigators for Health Insurance Marketplace

Two organizations, Western Maine Community Action and Fishing Partnership Support Services, were selected to provide "Navigators" for Maine citizens and will partner with other local agencies. Navigators will serve as an in-person resource for Americans who want additional assistance in shopping for and enrolling in plans in the Health Insurance Marketplace this fall. These organizations will be providing people assistance in enrolling. Find a Navigator for your area. [Download the list of Navigators.pdf, 89 kb.](#) This file requires the free [Adobe Reader](#).

- [HealthCare.gov](#)
- [Health Marketplace for Maine Individuals](#)
- [Health Marketplace for Maine Small Businesses](#)
- [Enroll207](#)
- [Small Business Resources](#)





# Learn

LearningExpress Library

Getting a Job

Health Information

About Health Insurance

HealthCare.gov

Health Marketplace for Maine Individuals

EGov Online

Legal Assistance

Digital Literacy

## Sites to use while Healthcare.gov is being repaired:

HealthSherpa is a temporary alternative until the federal healthcare.gov website is functioning at full capacity. Maine citizens can compare plans using this website. Plans can't be purchased through the site, but for users who want to enroll, they are provided with links to the private insurance companies' web sites and telephone numbers.

Consumer Reports has also built a website that can provide some basic assistance as well. This site uses your state, income range and current insurance status to provide recommendations and next steps in a simple step by step process.

### The Affordable Care Act

All Maine citizens who need health care under the affordable care act should go to the Health Insurance Marketplace at <https://www.healthcare.gov/> to apply for coverage, compare options, and enroll. Maine citizens can get specific Maine information and assistance by going to Enroll207 at <http://www.enroll207.com/>

Maine was one of the states that chose not to create its own Health Insurance Marketplace therefore Maine citizens will use the Federal Marketplace for health insurance.

[Affordable Care Act and Maine Libraries - Handy Information Sheet for libraries.](#) [pdf, 91 kb] This file requires the free Adobe Reader.

### 3 Key Dates

- October 1, 2013: Marketplace open enrollment started
- January 1, 2014: Health coverage can start
- March 31, 2014: Open enrollment ends

[HealthCare.gov](#) is the portal for individuals, families and small businesses. For both these groups there is a "see your options" button.

### Easy Widgets & Badges to Add to Your Websites

Give visitors to your organization's website a link to enroll207.com or the Health Insurance Marketplace at [healthcare.gov](http://healthcare.gov) by simply copying and pasting a widget (samples below) at <http://www.enroll207.com/resources-easy-widgets-badges-enrollsh/> on the [Enroll.com](http://enroll.com) website. [your](#)

### Latest from Maine

[State Officials Warn Consumers about Scams Related to Federal Health Reform \(ACA\)](#)

[Health Reform and Your Affordable Care Act 101 Baragar Daily News Serie](#)

### Key Gov Websites

- [HealthCare.gov](#)
- [Health Marketplace f](#)
- [Maine Individuals](#)
- [Health Marketplace f](#)
- [Maine Small Businesses](#)
- [Enroll207](#)

### Webinar

The Maine State Library held a webinar with Jake Grindle from Western Maine Community Action about how Maine libraries can work with local Navigator programs

