Milliman

Iowa Department of Public Health
Affordable Care Act Impact Study

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I. EXECUTIVE SUMMARY

The mission of the Iowa Department of Public Health (IDPH) is "Promoting and Protecting the Health of Iowans." In addition to its larger role in population health preparedness, surveillance, and response, IDPH has historically funded a broad array of health-related services to a "covered population" of approximately 1,000,000 Iowa residents through a varied network of local community-based "safety-net" provider contractors. Those health-related services range from funding direct healthcare services like immunizations and vision screening to providing or funding facilitative services like transportation and care coordination. While all Iowans may be eligible for some IDPH-funded direct healthcare service, such as smoking cessation, the individuals most often eligible for these services have traditionally been the uninsured and under-insured. As uninsured Iowans become enrolled in health plan options available through the Iowa Health and Wellness Plan (IHAWP) and the Marketplace, IDPH anticipates that many direct healthcare services funded by IDPH will become covered benefits or services under new plans, changing the demand for IDPH-funded services.

Specifically, in reviewing the intent of the IHAWP and Marketplace health plan options, IDPH has projected that:

- Some individuals in the current IDPH-covered population will be eligible for enrollment in a health plan option available through the IHAWP/Marketplace.
- Some local contractors in IDPH's current provider network will be eligible to contract with an IHAWP/Marketplace health plan to provide covered benefits to plan members.
- Some healthcare services currently funded by IDPH will be covered benefits available through IHAWP/Marketplace health plans because of the Essential Health Benefits (EHBs). EHBs consist of ten benefits categories that are required to be covered by plans in the individual and small group markets. The ten required benefits are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- Many current IDPH-funded healthcare services do not appear to fall under any IHAWP/Marketplace health plan option because they are not required by the Essential Health Benefits.

IDPH contracted with Milliman to better understand the impact of state level healthcare reform on certain IDPH programs and the healthcare services they have historically funded. IDPH provided Milliman with background information on these public health services, including eligibility, covered benefits, and historical utilization, as well as available related data.

Milliman was asked by IDPH to prepare a comprehensive analysis of the IHAWP and new Marketplace plans to understand their full effects on specific IDPH programs. A breakdown of eligible demographics, enrollment estimates, and projections was modeled to assess the impact

IHAWP and Marketplace plans have had and will have on Iowa's uninsured and under-insured residents historically served by IDPH. Milliman estimated the impact of the IHAWP and Marketplace on four specific IDPH programs. Four programs were selected for analysis because they fund direct healthcare services statewide, often through a combination of State and Federal funding, and because the direct healthcare services they support may fall under the definition of Essential Health Benefits and, therefore, likely to become covered benefits or services under ACA health plans.

The four IDPH programs analyzed are listed below.

- Substance Abuse Treatment
- Home Care Aide and Nursing
- Tobacco Quitline
- Cervical Cancer Screening

In conducting its analysis, Milliman modeled the future enrollment in IHAWP and Marketplace plans, reviewed the level of the coverage currently being provided by IDPH, and projected changes in coverage provided to individuals historically eligible for IDPH programs as they become enrollees in new health plans. Milliman also reviewed the potential impact of IHAWP and Marketplace plan implementation on contractors in IDPH's current provider network.

To accomplish this analysis, Milliman conducted interviews with IDPH staff and certain current IDPH-funded healthcare providers. Along with the information and insight gained from these interviews and the data provided by IDPH, Milliman used census data from the U.S. Census Bureau, Medicaid enrollment data from the Centers for Medicaid and Medicare Services (CMS), and Marketplace enrollment data from the U.S. Department of Health and Human Services (HHS).

While the exact impacts of the ACA are not known, this study uses a model developed by Milliman to illustrate the potential landscape of the insurance market in 2014 after full implementation of the ACA and also in 2017. These estimates take into account the potential behavior of individuals and employers based on their income levels, ages, and health status. Health status is a relative measure that considers illness burden after controlling for other variables including age/gender distribution, provider reimbursement levels, access to providers, and benefit plan coverage.

Throughout this report, Milliman discusses potential changes to IDPH service delivery's associated with the ACA, including implementation of IHAWP and Marketplace plans. Some of the major projected changes on the four IDPH programs analyzed are discussed below.

Substance Abuse Treatment

ACA-related changes to the IDPH Substance Abuse Treatment program are mixed. IHAWP and Marketplace plans will have little, if any, impact on utilization of the program's residential treatment services. However, the demand for outpatient treatment is projected to decrease. In

this analysis, Milliman assumed a constant level of the current Federal Substance Abuse Prevention and Treatment Block Grant and no increase in provider reimbursement rates. As a result, the State's total costs for the treatment services provided through this program are projected to increase slightly for SFY 2014, decrease in 2015, and then increase slightly thereafter, assuming no other underlying changes.

An ancillary impact of ACA which might impact substance abuse treatment services relates to changes in the method of payment for providers. IDPH's panel of providers has historically been paid through a block grant methodology for the services provided to IDPH eligibles. While experienced with fee-for-service payment from Medicaid and other payers, the movement of a portion of the historical IDPH population to fee-for-service IHAWP and Marketplace plans, where reimbursement rates are perceived to be low, these providers are concerned that they will not be able to sustain the existing safety-net service system infrastructure, leading to reduced provider capacity and participation, and corresponding reductions in access to care for all patients, regardless of health plan or payer type.

Home Care Aide and Nursing

Under ACA, the Home Care Aide and Nursing Program can expect to see a shift in the population being covered as younger adults move to at least partial insurance coverage of these benefits. As indicated earlier, a large portion of the population served, over 75% according to the data provided to Milliman, is 65 or older and their services will not be impacted by ACA. Even among those who do obtain health insurance coverage under ACA, not all of the home health services provided by IDPH will be covered by the IHAWP and Marketplace plans.

As openings in available services are created due to those individuals who do find other sources of coverage, some counties will reduce their current waiting lists for services and/or increase service levels that had previously been reduced due to budget constraints.

Tobacco Quitline

In the cost model Milliman assumed that the total funding for the Tobacco Quitline program stays constant and that the state's direct funding for the program decreases as other Medicaid funding increases due to an increased number of Medicaid enrollees. However, Medicaid funding is split between the state and the federal government resulting in slight increases in the state's portion of the Medicaid funding but ultimately a slight decrease in the total state funding of the program. Although some Iowans may be able to access other tobacco cessation services through their newly obtained insurance coverage, this analysis anticipates that state services will be more readily available. In addition, any decrease in the newly insured population accessing the state's hotline Quitline and website have been assumed to be offset by the state's recent offering of an 8 eight-week Nicotine Replacement Therapy regimen.

Cervical Cancer Screening and Other Services

The entirely state-funded costs of this program are expected to decrease as more of the previously served populations obtain health insurance coverage of the services provided. Although state funding of the costs of the services is projected to decrease, the program will continue to require administration by IDPH. As part of the future administration of this program IDPH may want to seek out populations that have opted out of available health insurance coverage.

Figure 1 summarizes the projected change in demand for all four programs. It should be noted that all references to fiscal year (FY) throughout the report refer to state fiscal year.

Figure 1
All Programs
Projected Change in Demand for Services by Number of Clients Served

	Actual		Projected		
Program	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Substance Abuse Treatment	15,753	14,020	13,753	13,745	13,775
Home Care Aide and Nursing*	7,204	7,186	7,271	7,424	7,582
Tobacco Quitline	12,243	10,474	11,007	11,527	12,036
Cervical Cancer Screening	92,236	36,988	32,454	30,311	28,408

* Home Care Aide and Nursing figures include Local Board of Health funds and do no not account for counties with waiting lists.

Figure 2 summarizes current and projected state funding for all four programs.

Figure 2
Select Programs
State Funding Projections

	Actual		Projected		
Program	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Substance Abuse Treatment	$14,550,439	$16,333,329	$12,568,135	$11,927,964	$11,760,463
Home Care Aide and Nursing*	$8,461,770	$8,461,770	$8,461,770	$8,461,770	$8,461,770
Tobacco Quitline	$2,067,796	$2,037,093	$2,038,715	$2,040,957	$2,043,000
Cervical Cancer Screening	$500,000	$500,000	$500,000	$500,000	$500,000
Total	**$25,580,005**	**$27,332,192**	**$23,568,620**	**$22,930,691**	**$22,765,233**

* Home Care Aide and Nursing figures include Local Board of Health funds and do no not account for counties with waiting lists.

This table summarizes the expected funding requirements of the four IDPH programs. While Home Care Aide and Nursing and Cervical Cancer Screening are kept at constant total funding, as can be seen in Sections VIII and X, the various services increase or decrease in spending to accommodate the changing demands. In contrast, Substance Abuse Treatment is expected to see a decrease in demand as some, but not all, of the services provided by the program are

included in the EHBs. Therefore, those that obtain coverage in the marketplace or in IHAWP will not use IDPH's Substance Abuse Treatment program as the initial source of coverage, but instead as a secondary source.

Tobacco Quitline is affected by increased Medicaid enrollment, but overall funding remains fairly level. Other factors, such as reduced tobacco usage, and a slight transition to a more cost effective web-based Quitline also create some trend variations in projected costs.

II. AFFORDABLE CARE ACT (ACA)

The primary ACA requirements for the commercial employer-sponsored insurance (ESI) small group and individual health insurance markets, both inside and outside the Insurance Marketplace include:

- Guaranteed issue of insurance coverage regardless of preexisting medical conditions or health status.

- Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1).

- Premium rate consistency among plans offered inside and outside the Marketplace.

- Definition and requirements of the Essential Health Benefits that are necessary for a plan to be considered qualified health insurance.

- Individual tax penalty if not covered by minimum essential insurance coverage. The tax penalty is the larger of 1% of household income or $95 per year for an uninsured adult in 2014 and increases to the larger of 2.5% of household income or $695 in 2016 and then remains at that level. Each uninsured child in the household is penalized half as much. **Note a delay has been introduced for this rule allowing insurance companies to continue to offer plans that do not meet these requirements into 2016. The Essential Health Benefits will be required for plans renewed after October 1, 2016.**

- Employer tax penalty if not offering qualified insurance coverage (groups under 50 employees are exempt). The employer tax penalty is a penalty designed to penalize companies of a particular size for not providing health insurance to its full time workers. The penalty can vary from $2,000 to $3,000 per employee that receives a federal subsidy for coverage per year. **Note the implementation of this penalty was recently delayed until 2015 for large employers. Employers with between 50 and 99 employees are exempt until 2016.**

The ACA also includes an option to significantly expand state Medicaid programs. The expansion includes all U.S. citizens and qualified legal aliens who are not eligible for Medicare and with household income up to 133% of the federal poverty level (FPL) based on modified adjusted gross income (MAGI), or 138% of FPL with the 5% income disregard. This report acknowledges that Iowa decided to expand Medicaid through the Iowa Health and Wellness Plan (IHAWP).

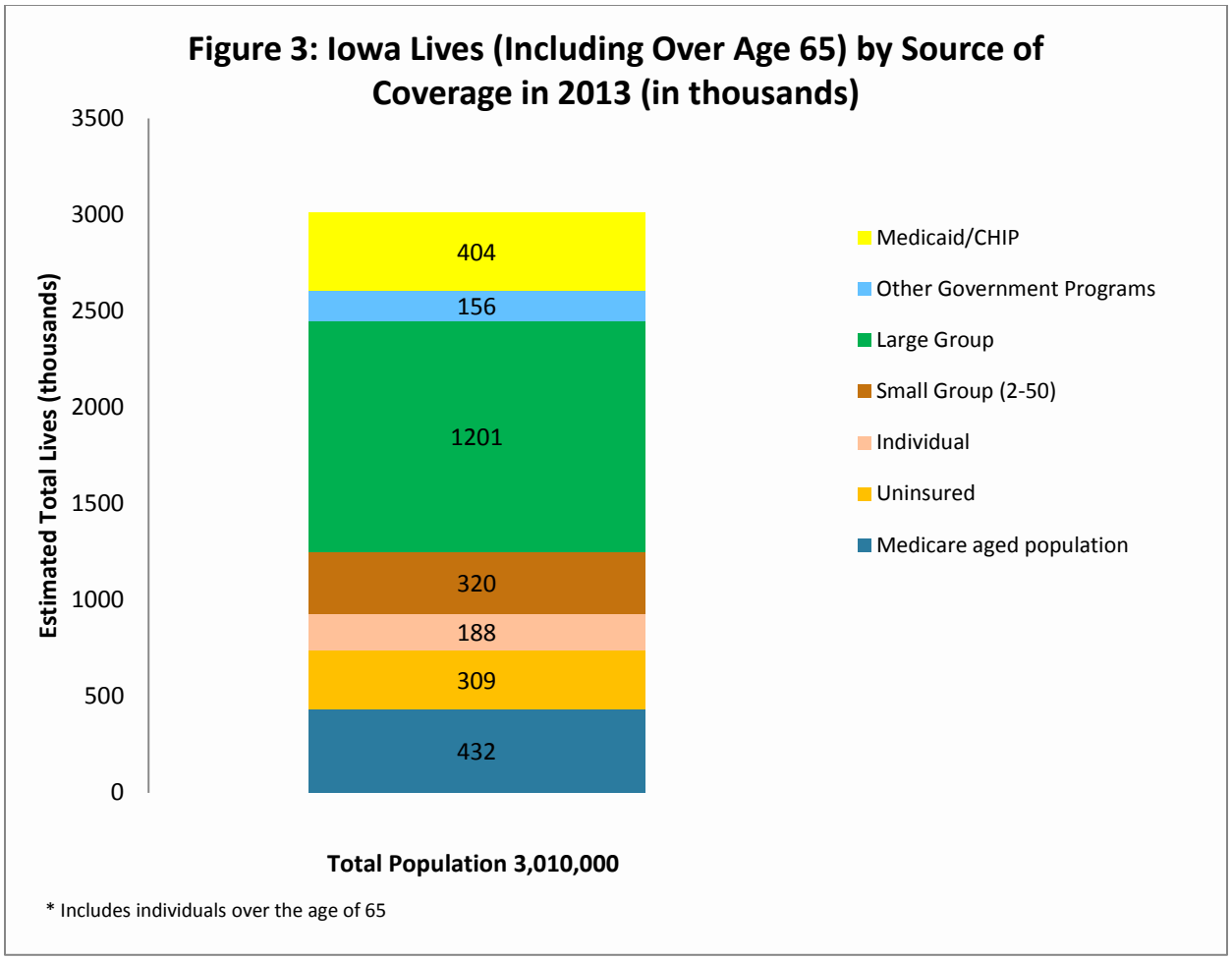
The IHAWP offers coverage to adults ages 19-64 with an income up to 133% of the Federal Poverty Level ($15,282 per year in 2014). The plan began on January 1, 2014, and currently serves more than 100,000 Iowans. The IHAWP consists of two components:

- **Iowa Wellness Plan**: The Iowa Wellness Plan is an Iowa Medicaid program that covers adults ages 19 to 64. Eligible member income is at or below 100% of the Federal Poverty Level ($11,490 for individuals or $15,510 for a family of two in 2014). Members can choose a provider from the statewide Medicaid provider network and are able to get care from local providers.

- **Iowa Marketplace Choice Plan**: The Iowa Marketplace Choice Plan covers adults age 19 to 64 with income from 101% through 133% of the Federal Poverty Level (between $11,491 and $15,282 for individuals or $15,511 to $20,628 for a family of two in 2014). The Marketplace Choice Plan allows members to get health care coverage through select insurers with plans on the Health Insurance Marketplace. Medicaid pays the premiums of the health plan for the member. Members then get care from providers approved by the health plan.

Pre-ACA

Key demographic characteristics of the 2013 Iowa population for the current insurance markets are provided in Section V. The graph in Figure 3 depicts the 2013 Iowa population by source of insurance coverage.

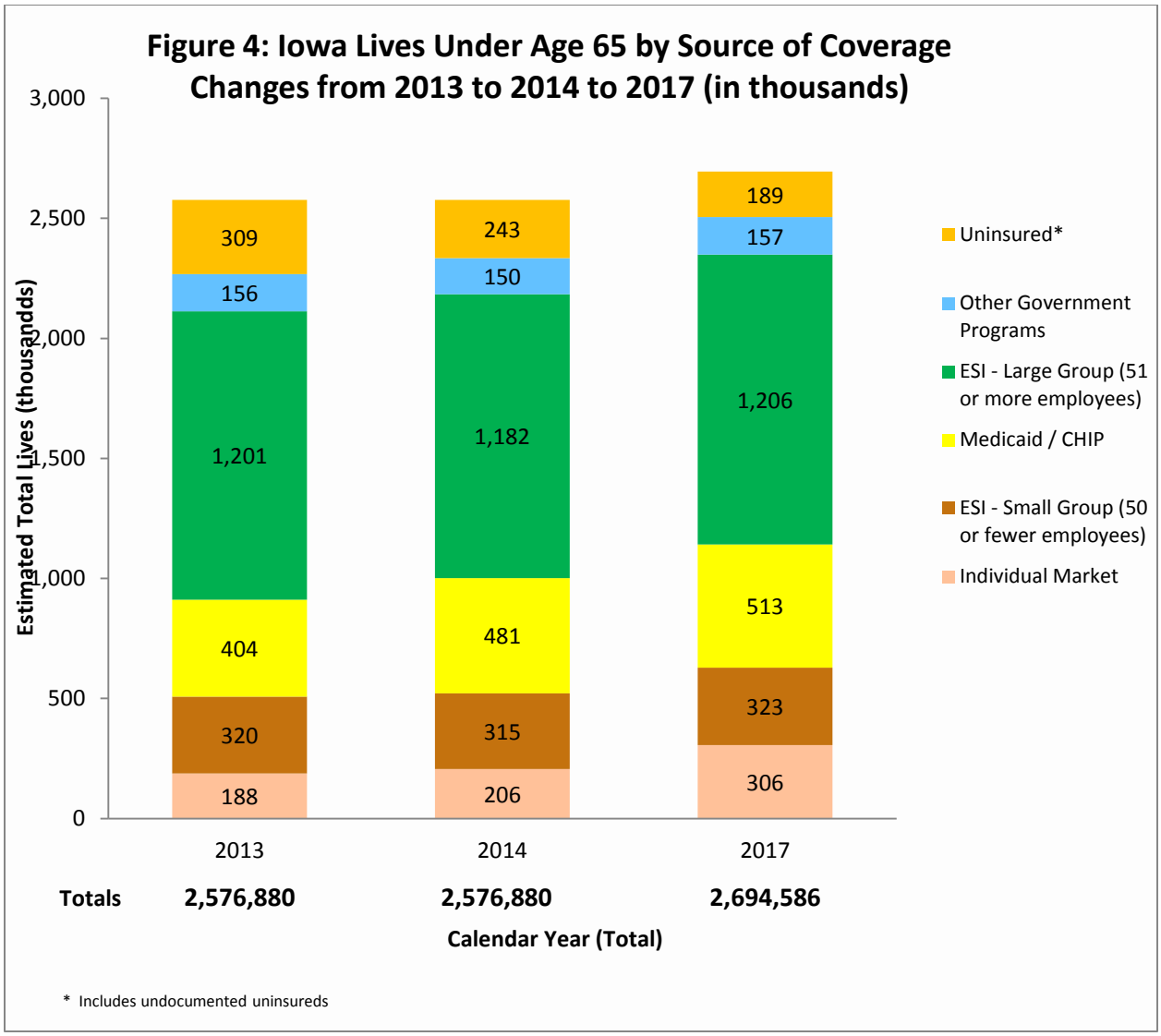


Based on US Census: Current Population Survey. http://www.census.gov/cps/data/cpstablecreator.html

Some key observations regarding the pre-ACA insurance coverage in Iowa include:

- About half of the population (1.52 million people) was covered by Employer Sponsored Insurance (ESI). This population is not largely affected by the ACA. Also, due to the delay of the employer mandate penalties, the number covered under this population is not expected to grow until 2015. Figure 3 includes a large number of individuals age 65 and older (432,000). Much of the rest of the report will only include under 65 year olds as this population is not impacted significantly by ACA.
- Prior to ACA, 10% of the population was uninsured.

The graph in Figure 4 illustrates estimated changes in the source of insurance coverage from 2013 to 2014 and to 2017 for the under age 65 population.



Based on US Census: Current Population Survey. http://www.census.gov/cps/data/cpstablecreator.html
ESI - Employer Sponsored Insurance
CHIP – Children's Health Insurance Program

A few observations based on this projection include:

- There is a projected decrease in the uninsured population in Iowa.
- The increase in the insured population shows up in the Medicaid expansion (Iowa Wellness Plan) and the individual market which includes the Marketplace and the Iowa Marketplace Choice Plan component of the IHAWP. Both components are described on Page 7.
- A delayed increase in ESI shows up in 2017 due to the delay in ACA employer penalties.

Figure 5 below provides a breakdown on the estimated distribution of Iowa's under age 65 population across insurance coverage types, sorted by age. Note that throughout the report, the figures may not sum to exact totals due to rounding.

Figure 5
Estimated Iowa Population Under Age 65
By Type of Insurance Coverage and Age Group
2013

Market	19 and Under	20 to 34	35 to 49	50 to 64	Total
Individual Market	49,935	34,878	49,171	53,745	187,731
ESI - Small Group (50 or fewer employees)	83,075	51,871	84,696	100,536	320,178
ESI - Large Group (101 + employees)	329,864	261,558	308,893	300,616	1,200,932
Medicaid / CHIP	263,882	68,398	37,113	34,443	403,836
Other Government Programs	34,310	12,883	35,380	73,028	155,601
Uninsured*	54,367	110,803	96,261	47,170	308,602
Total Non-Aged Population	**815,434**	**540,391**	**611,514**	**609,538**	**2,576,880**

** Includes undocumented uninsureds not eligible for Medicaid or ACA expansions or subsidies.*
Source: US Census: Current Population Survey. http://www.census.gov/cps/data/cpstablecreator.html

A different prospective is provided in Figure 6 below which displays the breakdown of the under age 65 population across insurance coverage types, sorted by Federal Poverty Level.

Figure 6
Estimated Iowa Population Distribution by Type of Insurance Coverage and FPL
Non-Aged Population Only (Under Age 65)
Calendar Year 2013

Market	Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
Individual Market	13,811	35,341	29,197	24,173	85,209	187,731
ESI – Small Group (50 or fewer employees)	4,336	39,080	69,117	67,510	140,136	320,178
ESI – Large Group (51 or more employees)	24,783	110,971	214,130	210,468	640,579	1,200,932
Medicaid / CHIP	136,100	139,137	74,819	32,029	21,751	403,836
Other Government Programs	18,744	38,875	26,326	11,781	59,875	155,601
Uninsured*	74,300	84,026	62,685	40,492	47,098	308,602
Total Non-Aged Population	**272,073**	**447,431**	**476,274**	**386,453**	**994,649**	**2,576,880**

** Includes undocumented uninsureds not eligible for Medicaid or ACA expansions or subsidies.*
Source: US Census: Current Population Survey. http://www.census.gov/cps/data/cpstablecreator.html

The remainder of the report will focus on projections of these demographics to 2017, and then more specifically on four IDPH programs, their demographic projections, and financial projections.

III. PURPOSE AND SCOPE OF THIS STUDY

The Iowa Department of Public Health (IDPH) has historically funded a broad array of health-related services to a "covered population" of approximately 1 million Iowa residents through a varied network of local community-based "safety-net" provider contractors. In addition to its duties for population health preparedness, surveillance and response, IDPH has funded direct healthcare services like immunizations and vision screenings as well as facilitative or enabling services like transportation and care coordination. While all Iowans may be eligible for some IDPH-funded healthcare services such as smoking cessation, the individuals most often receiving IDPH-funded healthcare services have traditionally included the uninsured and under-insured. As uninsured Iowans become enrolled in health plan options available through the Iowa Health and Wellness Plan (IHAWP) and the Marketplace, IDPH anticipates that many direct healthcare services funded by IDPH will become covered benefits or services under new plans, changing the demand for IDPH-funded services.

Specifically, in reviewing the intent of the IHAWP and Marketplace health plan options, IDPH has projected that:

- Some individuals in the current IDPH-covered population will be eligible for enrollment in a health plan option available through the IHAWP/Marketplace.
- Some local contractors in IDPH's current provider network will be eligible to contract with an IHAWP/Marketplace health plan to provide covered benefits to plan members.
- Some healthcare services currently funded by IDPH will be covered benefits available through IHAWP/Marketplace health plans because of the Essential Health Benefits.
- Many current IDPH-funded individuals, contractors, and healthcare services do not appear to fall under any IHAWP/Marketplace health plan option because they are not Essential Health Benefits.

IDPH contracted with Milliman to better understand the impact of state level healthcare reform on certain IDPH programs and the healthcare services they have historically funded. IDPH provided Milliman with background information on its public health services, including eligibility, covered benefits, and historical utilization, as well as available related data.

Milliman was asked by IDPH to prepare a comprehensive analysis of the IHAWP and new Marketplace plans to understand their full effects for specific IDPH programs. The four programs were selected for analysis because they fund direct healthcare services statewide, often through a combination of State and Federal funding, and because the direct healthcare services they support can be considered to fall under the definition of Essential Health Benefits and, therefore, likely to become covered benefits or services under ACA health plans. Milliman modeled a breakdown of eligible demographics, enrollment estimates, and projections to assess the impact IHAWP and Marketplace plans have had and will have on Iowa's uninsured and under-insured residents historically served by IDPH. Milliman estimated the impact of the IHAWP and Marketplace on four specific IDPH programs.

The four IDPH programs analyzed are listed below.

- Substance Abuse Treatment
- Home Care Aide and Nursing
- Tobacco Quitline
- Cervical Cancer Screening

In conducting this analysis, Milliman modeled the future enrollment in IHAWP and Marketplace plans, reviewed the level of the coverage currently being provided by IDPH, and projected changes in coverage provided to individuals historically eligible for IDPH programs as they enroll in health plans. Milliman also reviewed the potential impact of IHAWP and Marketplace plan implementation on contractors in IDPH's current provider network.

To accomplish this analysis, Milliman conducted interviews with IDPH staff and certain current IDPH-funded healthcare providers. Along with the information and insight gained from these interviews and the data provided by IDPH, Milliman used census data from the U.S. Census Bureau, Medicaid enrollment data from the Centers for Medicare and Medicaid Services (CMS), and Marketplace enrollment data from the U.S. Department of Health and Human Services (HHS).

While the exact impacts of the ACA are not known, this study uses a model developed by Milliman to illustrate the potential landscape of the insurance market in 2014 after full implementation of the ACA, and also in 2017. These estimates take into account the potential behavior of individuals and employers based on their income levels, ages, and health status. Health status is a relative measure that considers illness burden after controlling for other variables including age/gender distribution, provider reimbursement levels, access to providers, and benefit plan coverage.

IV. LIMITATIONS AND DATA RELIANCE FOR THIS STUDY

This report is intended to provide actuarial projections of health care coverage in the State of Iowa in the years following the introduction of the ACA. It is Milliman's understanding that IDPH will use this report to understand the potential impacts of the ACA on certain IDPH programs and the services they provide. The report may not be suitable for other purposes.

This report has been prepared solely for the internal use of, and is only to be relied upon by, the Iowa Department of Public Health (IDPH). Although Milliman understands that this report may be distributed to third parties, Milliman does not intend to benefit, or create a legal duty to, any third party recipient of its work. If this report is distributed to third parties, it should be distributed only in its entirety.

The results in this report are technical in nature and dependent upon specific assumptions and methods. No party should rely upon this report without a thorough understanding of those assumptions and methods.

Differences between the projections contained in this analysis and actual future experience depend on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual experience will deviate from these projections because of a variety of influences, including emerging experience, changes in enrollee and eligible activities, changes in insurance products and practices, and adjustments to reflect new regulations.

The projections included in this report are based on Milliman's understanding of the ACA and its associated regulations issued to date. Forthcoming ACA-related regulations and additional legislation may materially change the impact of the ACA, necessitating an update to the projections included in this report. For this reason, this report should be considered time-sensitive material, which may change as new information becomes available.

In developing the projections, Milliman relied on data and other information provided by IDPH and other public sources of information. Milliman did not audit or verify this data and other information. Milliman performed a limited review of the data used directly in its analysis for reasonableness and consistency. If the underlying data or information is inaccurate or incomplete, the results of the analysis may likewise be inaccurate or incomplete.

Milliman's consultants are not attorneys and are not qualified to give legal advice. Milliman recommends that users of this report consult with their own legal counsel regarding interpretation of legislation and administrative rules, possible implications of specific ACA-required features, or other legal issues related to implementation of an ACA-compliant entity.

V. DESCRIPTION OF THE AFFORDABLE CARE ACT AND HOW IT MAY AFFECT IDPH PROGRAMS

The ACA, enacted in 2010, requires the establishment of new ACA-compliant mechanisms in each state by January 1, 2014. The Federal government developed a national version of the health insurance marketplace for use in states that chose not to create their own entity or for temporary use in states that did not complete implementation by January 1, 2014. The duties of the state through direct functions or oversight responsibilities vary depending on the selection among a state-facilitated program, federally facilitated program, or state-federal partnership. However, the state may have responsibilities toward the program no matter which program was selected. Iowa opted to partner with the federal government to implement the Marketplace.

The Marketplace functions as a place for buyers of individual and small group health insurance to compare and purchase coverage options. Plans offered through this marketplace entity are called "Qualified Health Plans" (QHP). The Marketplace provides information and educational services to help consumers research and compare their options, and enroll in the product of their choice. The Marketplace also facilitates eligibility determinations for Medicaid or other state programs and federal subsidies for premium and/or cost-sharing assistance.

In addition to the requirements to be met by the Marketplace, the ACA also makes a number of market changes that apply to all individual and small group health insurance policies:

- Guaranteed issue of insurance coverage regardless of pre-existing medical conditions or health status (applicable to the individual market as the small group market is already guaranteed issue)

- Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1)

- Premium rate consistency among products offered inside and outside the marketplace entity (such as the Marketplace)

- Option to merge the small group and individual health insurance markets (including the newly implemented marketplace entities such as the Marketplace) for risk pool purposes

- Option to expand the definition of small group up to 100 employees in 2015 (this expansion will become mandatory by January 1, 2016)

- Definition and requirements for Essential Health Benefits

- Individual tax penalty if not covered by minimum essential insurance coverage

An employer tax penalty referred to as the employer mandate was to be introduced in 2014. This penalty would apply if an employer did not offer qualified insurance coverage (groups under 50 employees are exempt). On July 2, 2013, the employer mandate was delayed until 2015. Another modification to the employer mandate was announced on February 10, 2014, further delaying the penalty for employers that employ 50 to 99 employees until 2016. Employers with 100 or more employees will now be able to transition into the employer mandate, avoiding the penalty if they offer compliant coverage to 70% of employees in 2015 and 95% of employees in 2016. This new guidance has a significant effect on the Employer Sponsored Insurance (ESI) projections presented later in this report.

Another key factor that this report takes into consideration is that non-Qualified Health Plans (non-QHPs), or health plans that do not meet the minimum actuarial values and/or include the EHBs, are now allowed to be renewed until 2015 without incurring individual mandate penalties. This change in policy was announced on December 19, 2013. More recently, on March 5, 2014, another delay was introduced to allow these non-QHPs to be renewed until Oct. 1, 2016. This means some people will retain catastrophic level coverage without penalties well into 2017. This matter is discussed in detail in Section VI. G.

VI. POST-ACA INSURED/UNINSURED POPULATION PROJECTIONS

This section addresses the following topics as they relate to the establishment of the Marketplace:

- "Best estimate scenario" projections of the insurance market
- Projected results in a "high take-up" or "low take-up" scenario resulting in higher and lower enrollment shifts to the Marketplace, respectively
- Data sources and assumptions underlying these projections

On April 1, 2014, the day after the Marketplace enrollment deadline[1], the Federal government announced that it had reached and surpassed its goal of enrolling 7 million people through the federal and state-run marketplaces.[1] Later in the month, on April 17, 2014, it was announced that this figure had risen to 8 million enrollees. [2]

Controversy has surrounded these enrollment figures, as the methodology used did not take into account all considerations. Prior to the announcement, the trend of enrollment suggested that the Administration's goal of 7 million enrollees was far out of reach. The Department of Health and Human Services Assistant Secretary of Planning and Evaluation (ASPE) Issue Brief summarized the data concluding that there had in fact been a surge near the deadline. It also revealed that the numbers had included those enrollees that had not paid their first premium. So, in effect, these enrollees would remain uninsured if they do no pay their premium. The estimations of how many of the 8 million have failed to pay their first premium vary greatly, but insurance companies have stated 80% to 90% have paid their first premium.[3]

"Best Estimate Scenario" Projections of the Insurance Market

The projection of Iowan's insured status into 2014 and beyond is dependent of a number of factors:

- The first phase of the ACA, for the time period up to the enrollment deadline of April 19, 2014.
    - Estimated market breakdowns are consistent across all the scenarios ("best estimate", "high take-up", and "low take-up".

[1] WhiteHouse.gov: 7.1 Million Americans Have Enrolled in Private Health Coverage Under the Affordable Care Act. http://www.whitehouse.gov/blog/2014/04/01/more-7-million-americans-have-enrolled-private-health-coverage-under-affordable-care

[2] WhiteHouse.gov: President Obama: 8 Million People Have Signed Up for Private Health Coverage. http://www.whitehouse.gov/blog/2014/04/17/president-obama-8-million-people-have-signed-private-health-coverage

[3] WhiteHouse.gov: Press Briefing by Press Secretary Jay Carney, 5/1/2014. http://www.whitehouse.gov/the-press-office/2014/05/01/press-briefing-press-secretary-jay-carney-512014

- A portion of the individual market is supported by HHS's Marketplace enrollment data for the 2013-2014 open enrollment period.

- The months and years after April 19, 2014
  - Estimated market breakdowns will vary by scenario.
  - Marketplace participation is modeled for the 2015, 2016, and 2017 enrollment periods.

Figure 7
Iowa Under Age 65 Market Migration Projection
Best Estimate Scenario - 2014

Post Reform Market	Individual	Small Group	Large Group	Medicaid	Other Gov.	Uninsured	Total
Individual Market	172,990	1,362	5,110	0	0	26,619	**206,081**
ESI - Small Group (50 or fewer employees)	0	315,083	0	0	0	0	**315,083**
ESI - Large Group (51 or more employees)	0	0	1,181,827	0	0	0	**1,181,827**
Medicaid / CHIP	12,335	529	1,986	403,836	5,196	56,908	**480,790**
Other Government Programs	0	0	0	0	150,405	0	**150,405**
Uninsured	2,406	3,202	12,009	0	0	225,074	**242,691**
Total Under Age 65 Population	**187,731**	**320,176**	**1,200,932**	**403,836**	**155,601**	**308,601**	

The table above shows the migration of individuals from one type of coverage to another in 2014. These are based on Milliman's best-estimate scenario. The right column represents the post-reform totals in each category of coverage while the bottom row represents 2014 pre-reform totals. For example, the Individual column indicates that of the 187,731 pre-reform individually covered 172,990 will remain in this category, 12,335 will move to some form of Medicaid (IHAWP, CHIP, or Marketplace) and 2,406 will become uninsured. The individual market row shows that the estimated enrollment in the marketplace will actually cause the individual market to grow to 206,081 in 2014 after marketplace enrollment has enrolled 26,619 previously uninsured and 6,437 previous insured by their employer.

The shifts shown in Figure 7 reflect a variety of changes that will occur in 2014. Those having the greatest impact on coverage shifts are:

- Individual insurance market rating and underwriting changes that will require individual insurance to be guaranteed issue at defined premium rates that cannot vary with an applicant's health status (except as indicated by their age and tobacco usage).

- Availability of premium and cost-sharing subsidies for plans sold in the Marketplace.

Figure 8 below shows market migration projections for 2015. Again, this is the best estimate scenario based on Milliman's modeling.

Figure 8
Iowa Under Age 65 Market Migration Projection
Best Estimate Scenario - 2015

Post Reform Market	Individual	Small Group	Large Group	Medicaid	Other Gov.	Uninsured	Total
Individual Market	209,173	4,342	16,288	0	546	14,941	**245,290**
ESI - Small Group (50 or fewer employees)	0	313,824	0	0	0	4,278	**318,102**
ESI - Large Group (51 or more employees)	0	0	1,177,102	0	0	16,854	**1,193,956**
Medicaid / CHIP	0	0	0	488,002	0	3,844	**491,846**
Other Government Programs	0	0	0	0	152,115	360	**152,475**
Uninsured	0	1,643	6,164	0	0	206,055	**213,862**
Total Under Age 65 Population	**209,173**	**319,809**	**1,199,554**	**488,002**	**152,661**	**246,332**	

Figure 9 further projects Milliman's best-estimate scenario to 2017. By 2017, modeling suggests that the ACA's effects will be all but completely realized. Many of those who currently choose to pay the individual mandate penalty will join the Marketplace as the penalty increases year to year. Nearly all, if not all, of the complications and issues associated with the roll-out will no longer substantially affect enrollment. In addition, those eligible for subsidized coverage will

become aware of it and choose to become insured or pay the penalty accordingly. Essentially, all lag and barriers to enrollment will be eliminated by 2017.

Figure 9
Iowa Under Age 65 Market Migration
Best Estimate Scenario – 2017

Post Reform Market	Individual	Small Group	Large Group	Medicaid	Other Gov.	Uninsured	Total
Individual Market	279,695	4,390	16,463	0	553	4,896	**305,997**
ESI - Small Group (50 or fewer employees)	0	319,373	0	0	0	3,547	**322,920**
ESI - Large Group (51 or more employees)	0	0	1,195,823	0	0	10,642	**1,206,465**
Medicaid / CHIP	0	0	0	510,116	0	3,058	**513,174**
Other Government Programs	0	0	0	0	156,307	302	**156,609**
Uninsured	0	1,666	6,243	0	0	181,514	**189,423**
Total Under Age 65 Population	**279,695**	**325,429**	**1,218,529**	**510,116**	**156,860**	**203,959**	

Note that the U.S. Department of Health and Human Services recently announced that the Federally Facilitated Small-Business Health Options Program (FF-SHOP) has been delayed until 2015.[4] This exchange was expected to have much less impact on the market as a whole due to a number of factors including a lack of employer penalties pushing these small groups to seek coverage for their employees. These changes will still be reflected in the 2017 forecasts throughout this document.

[4] http://www.nytimes.com/2013/04/02/us/politics/option-for-small-business-health-plan-delayed.html?_r=0

Below in Figure 10 is a summary of the total enrollment projections in 2013, 2014, and 2017. It should be noted that a 1.5% yearly population growth is assumed after 2014.

Figure 10
Iowa Under Age 65 Market Migration Projection
Scenario Summary – 2013 Actual to 2014 and 2017 Projections

	Year				
	Actual	Projected	Projected		
Market	**2013**	**2014**	**2017**		
			Low	**Best Estimate**	**High**
Individual Market	187,731	206,081	249,286	305,997	356,553
ESI - Small Group (50 or fewer employees)	320,177	315,083	333,309	322,920	317,292
ESI - Large Group (51 or more employees)	1,200,932	1,181,827	1,245,222	1,206,465	1,185,746
Medicaid / CHIP	403,836	480,790	509,969	513,174	518,684
Other Government Programs	155,601	150,405	156,727	156,609	152,834
Uninsured	308,601	242,691	200,075	189,423	163,478
Total Under Age 65 Population	**2,576,878**	**2,576,877**	**2,694,588**	**2,694,588**	**2,694,588**

Projected Results in a "High Take-Up" or "Low Take-Up" Scenario Resulting in Higher and Lower Enrollment Shifts to Marketplace, Respectively

While the previous results demonstrate what Milliman believes to be a best estimate of the number of people to enroll through the Marketplace, there are several external factors that could result in greater or lesser enrollment through the Marketplace in 2014 as well as subsequent years. For example, the complications, delays, and law changes associated with the healthcare reform implementation have led to many people who are eligible for subsidized coverage to remain uninsured. Similarly, the level of marketing associated with the Marketplace and other aspects of healthcare reform can drastically affect the enrollment through the Marketplace. Considering these unknowns, Milliman has developed a number of scenarios to better reflect the possible enrollment rates in 2014.

It is important to note that the implementation of the FF-SHOP has been delayed until 2015. This delay is reflected in the table above. This is the reason for the decline in the small group market by 2014 and the rebound of small-group market by 2017.

If external factors encourage more participation by the uninsured in the marketplaces, a greater percentage of individuals would be expected to enroll in individual coverage through the Marketplace to take advantage of premium and cost-sharing subsidies by 2014 (2015 for small-group). Relative to the "best estimate" scenario, Milliman assumed:

- People in the individual market were more likely to enroll through the Marketplace from 2014 onwards

- People in the uninsured market were more likely to enroll through the Marketplace from 2014 onwards

If external factors discourage participation by the uninsured in the markets, fewer people may enroll in individual Marketplace coverage by 2014. Relative to the "best estimate" scenario, Milliman assumed:

- People in the individual market were less likely to enroll through the Marketplace from 2014 onwards
- People in the uninsured market were less likely to enroll through the Marketplace from 2014 onwards

Figure 11 shows the population change by income level from 2014 to 2017 in the individual market. This population is displayed by FPL.

Figure 11
Enrollment by Income Level for Individual Market (Under Age 65)
Best-Estimate Scenario

FPL Level	2014	2017
Under 100%	8,304	9,632
100% to 199%	43,833	70,668
200% to 299%	40,174	66,599
300% to 399%	28,807	46,589
Over 400%	84,963	112,509
Total	**206,081**	**305,997**

Figure 12 shows a detailed breakdown of the 2014 uninsured population by age, gender, and FPL level.

Figure 12
Estimated Uninsured Population Breakdown by Age/Gender/FPL
Best Estimate - 2014

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	**Male**	3,039	2,324	3,846	1,940	3,094	**14,243**
	Female	1,739	5,376	2,275	3,227	2,406	**15,023**
18-25	**Male**	4,365	7,571	5,937	8,255	4,795	**30,923**
	Female	3,742	4,250	2,412	1,386	3,560	**15,350**
26-34	**Male**	2,866	5,155	11,665	1,224	8,467	**29,377**
	Female	3,101	5,538	6,148	4,169	5,400	**24,356**
35-44	**Male**	3,578	2,973	8,998	7,497	7,024	**30,070**
	Female	6,435	4,986	3,094	3,578	2,539	**20,632**
45-54	**Male**	2,040	6,767	2,661	3,215	7,298	**21,981**
	Female	1,656	5,985	3,495	1,308	7,009	**19,453**
55-64	**Male**	1,467	813	1,743	2,686	0*	**6,709**
	Female	1,458	3,540	4,464	1,557	3,554	**14,573**
Total	**Male**	**17,355**	**25,603**	**34,850**	**24,817**	**30,678**	**133,303**
	Female	**18,131**	**29,675**	**21,888**	**15,225**	**24,468**	**109,387**
Grand Total		35,486	55,278	56,738	40,042	55,146	242,690

Source: Milliman projected the latest available US Census Data to estimate the future uninsured population.
** - When splitting US Census Data into increasingly smaller/more specific subsets, some zeroes occur. These occurrences should be considered data anomalies and should not influence the reader's conclusions.*

Figure 13 shows a detailed breakdown of the 2014 Marketplace enrolled population by age, gender, and FPL level.

Figure 13
Estimated Marketplace Population Breakdown by Age/Gender/FPL
2014

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	0	230	263	98	92	**683**
	Female	0	193	221	82	77	**573**
18-25	Male	0	457	524	195	182	**1,358**
	Female	0	384	440	164	153	**1,141**
26-34	Male	0	989	1,134	422	395	**2,940**
	Female	0	830	952	354	332	**2,468**
35-44	Male	0	860	986	367	343	**2,556**
	Female	0	722	828	308	288	**2,146**
45-54	Male	0	1,165	1,337	497	465	**3,464**
	Female	0	979	1,122	417	391	**2,909**
55-64	Male	0	1,632	1,872	696	652	**4,852**
	Female	0	1,370	1,571	584	547	**4,072**
Total	Male	0	5,333	6,116	2,275	2,129	**15,853**
	Female	0	4,478	5,134	1,909	1,788	**13,309**
Grand Total		**0**	**9,811**	**11,250**	**4,184**	**3,917**	**29,162**

Source: HHS ASPE Issue Brief. Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period. For the period: October 1, 2013–March 31, 2014.
http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014Apr_enrollment.pdf

See Appendix E for detailed uninsured and Marketplace enrollment projections from 2014 to 2017.

VII. SUBSTANCE ABUSE TREATMENT

A. Program Background, Historical Eligibility and Covered Services

In addition to regulatory and surveillance duties for substance related disorders, IDPH provides a broad range of substance abuse education, prevention, treatment, and recovery support services. *This analysis focuses solely on the potential change in demand for IDPH-funded substance abuse treatment.*

Iowa Code chapter 125 gives IDPH the duty to develop, implement, and administer a comprehensive substance abuse program. The chapter's declaration of policy states "It is the policy of this state … that persons with substance-related disorders be afforded the opportunity to receive quality treatment and [be] directed into rehabilitation services which will help them resume a socially acceptable and productive role in society." In carrying out its duties under Iowa Code, IDPH has historically funded substance abuse treatment services for uninsured and under-insured Iowa residents with incomes at or below 200% of the Federal Poverty Level. Funding has been sufficient to support a minimum level of assessment and treatment services to approximately 23,000 individuals each year. IDPH-funded treatment services are provided through competitively procured contracts with a limited panel of local licensed community-based programs that together serve all 99 Iowa counties as a statewide safety-net provider network. IDPH substance abuse treatment funding is a combination of State General Fund appropriations and Federal Block Grant dollars and is considered the payer of last resort. Individuals who receive IDPH-funded substance abuse treatment are assessed co-payments based on a sliding fee scale that considers income and family size.

Covered services for IDPH-funded substance abuse treatment include assessment, individual and group outpatient counseling, intensive outpatient, residential treatment, and halfway house services. Some providers have waiting lists for certain services. IDPH-funded providers are contractually obligated to serve a minimum number of clients each year and are paid monthly $1/12^{th}$ disbursements of their annual capitated contracts. The base funding amounts assigned to each discrete treatment service were established in 2009 based on Medicaid rates in force at that time for like services. Providers are expected to address clients' co-occurring medical and mental health needs, either through their own staff or through other appropriately licensed professionals. There are no utilization limits or maximum number of sessions for IDPH-funded substance abuse treatment. Hospitalization and detoxification are not covered by IDPH funding.

B. Projected Change in Demand for Program Services

Figure 14 below shows the projected number of individuals who are enrolled in IHAWP and Marketplace plans as well as the uninsured population. Some of these individuals are also projected to be eligible for IDPH-funded substance abuse treatment because residential treatment is not a covered service under the Marketplace or under the IHAWP, except in limited cases for those individuals determined retrospectively by Medicaid to be Medically

Exempt. Individuals in those populations who are at or below 200% of the FPL and who require residential treatment will receive such services through IDPH. In addition, because of IHAWP and Marketplace plan limits on mental health and substance abuse outpatient services, Milliman estimates that 19% of the services needed by IHAWP and Marketplace plan members could be provided by IDPH.

Figure 14
Projected Number of Eligible Persons:
Estimated Uninsured, IHAWP, and Marketplace Populations - Under 200% FPL

	Actual	Projected			
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Uninsured	158,326	90,764	77,671	70,691	64,540
IHAWP	275,237	351,565	360,683	369,446	378,045
Marketplace	N/A	9,810	20,210	27,338	34,221
Subtotal: IHAWP/Marketplace enrollees at/under 200% FPL	275,237	361,375	380,893	396,784	412,266
Total	**433,563**	**452,139**	**458,564**	**467,475**	**476,806**
Of line above, estimated population receiving or requiring treatment services	15,753	14,020	13,753	13,745	13,775

Note: IHAWP contains only those populations from 0-100% FPL. The marketplace contains the marketplace choice population in between 101-133%.

As Figure 14 shows, Milliman estimates that while the eligible population as a whole increases, the overall usage of the full range of treatment services by this population will decrease. In the cases of IHAWP or Marketplace coverage, IDPH will be the primary payer for residential treatment and the secondary payer for outpatient services. Therefore, although the IHAWP and Marketplace populations are growing, these populations will rely on IDPH for residential treatment and for 19% of the outpatient services.

C. Financial Projections

See Figure 15 for projections of the funding needed to provide IDPH-covered substance abuse treatment services to all eligible persons based on the projected demand for such services by the uninsured and by those in need of historically available services that are not covered or may be limited by the IHAWP or Marketplace plans.

Figure 15 Financial Projections: Substance Abuse Treatment					
	Actual		Projected		
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Residential Treatment	$6,773,901	$7,181,103	$7,488,778	$7,595,195	$7,742,788
Outpatient	$15,805,769	$16,755,908	$12,683,039	$11,936,451	$11,621,358
Total	**$22,579,670**	**$23,937,011**	**$20,171,817**	**$19,531,646**	**$19,364,146**
Federal Funding	$8,029,231	$7,603,682	$7,603,682	$7,603,682	$7,603,682
State Funding	**$14,550,439**	**$16,333,329**	**$12,568,135**	**$11,927,964**	**$11,760,464**

D. Discussion of Related Issues

An ancillary impact of ACA which might impact the substance abuse services offered relates to the changes in the method of payments for providers. IDPH's panel of providers has historically been paid through a block grant methodology that tied payment to contractual service utilization projections and performance requirements while allowing for flexibility in how each provider met those requirements. With the movement of a portion of this historical population to fee-for-service plans where reimbursement rates were described as a reduced payment per services rendered, these providers are concerned that rates are not sufficient to support their safety-net infrastructure which generally includes 24-hour access to care, provision or coordination of related mental health and medical services, and provision of education, prevention and recovery support services. In addition, providers have expressed concern that their programs or certain professional staff employees are not eligible to participate in some of the new health plan options, which they believe will lead to decreased service capacity and worker shortages and decreased access to care. In addition, IDPH facilitating services such as transportation are not covered services under IHAWP or Marketplace health plans. The potential increase or decrease in demand for such services was not considered in this analysis.

VIII. HOME CARE AIDE AND NURSING

A. Program Background, Historical Eligibility and Covered Services

In addition to general health promotion and education, IDPH provides a broad range of chronic disease screening and management services. *This analysis focuses solely on the potential change in demand for IDPH-funded home care aide and nursing services.*

The Local Public Health Service grant provides flexible support to all local boards of health and local public agencies across Iowa in order to assist Iowans from birth to death to remain independent at home. Funds are used to fill the gaps for Home Care Aide and Nursing services not paid for by other funding sources. This includes nursing services delivered by a Registered Nurse as prescribed by the client's physician as well as Home Care Aide services such as environmental support, personal care, and custodial care. Local Public Health providers bill third party payers such as Medicare, Medicaid, and Private Insurance as the primary funding sources for these services for clients who are eligible. For services beyond what these payers will cover, the LPHS Healthy Aging appropriation is used to pay for Home Care Aide and Nursing services and is considered the funder of last resort. This prevents those who have no other options from "falling through the cracks." Funding these personal health services helps to avoid more costly residential or institutional services for those able to remain living independently at home.

Some counties in Iowa utilize waiting lists. A survey was conducted to estimate the number of counties that encountered the waiting lists. The survey led Milliman to model two scenarios in the following sections.

B. Projective Change in Demand for Program Services

The demand for Home Care Aide and Nursing services will be largely unchanged due to a number of factors. Primarily, the majority of the served population (approximately 77%) is over age 65 and is therefore not affected by the Marketplace, uninsured rate, or IHAWP enrollment. Another major factor is that some aspects of Home Care Aide services will not be covered by IHAWP or Marketplace plans; these services will continue to be covered by IDPH's Home Care Aide and Nursing program. A third factor to consider is that a number of counties have maintained waiting lists or provided a reduced level of services in the past. IDPH conducted a county survey to assess the prevalence of waiting lists and/or instances where services were reduced for budgetary reasons. It was found that 34.5% of the counties that responded had waiting lists and 71.3% of these respondents had limited services for budgetary reasons. Figure 16 lists details of the survey's questions and responses.

Figure 16 County Waiting List and Reduced Services Survey Results		
Question	**Responses**	**Respondents**
1. Does the agency currently have or have they in the past had a waiting list for new home health care clients?	Yes 34.5% No 65.5%	87
2. Has the agency at any time decreased the frequency of visits/ hours of home health care services due to budgetary/ staffing constraints?	Yes 70.1% No 29.9%	87
3. Has the agency experienced or do they anticipate any change in demand in home health care services following the start of health reform? This change can be either an increase or decrease in demand.	Yes 71.3% No 28.7%	87
4. If the agency had a waiting list or had previously reduced services, do they anticipate improvements due to reduced demand under health reform?	Yes 12.6% No 51.7% NA 35.6%	87

Given these issues, two scenarios were projected. The first scenario does not consider these additional eligibles/services in FY 2014 and adjusts the served population and budget accordingly. The second estimates the additional enrollment and budget necessary to cover the entire service seeking population without limiting services rendered.

Figure 17
Projected Number of Eligible Persons:
Estimated Medicare, Uninsured, IHAWP, and Marketplace Populations and Projected Usage

	Actual	Projected			
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Uninsured	308,601	242,691	213,862	200,945	189,422
IHAWP	403,836	480,791	491,847	502,577	513,174
Marketplace	N/A	29,163	64,959	91,240	117,239
Medicare	432,996	439,491	446,083	452,775	459,566
Total	**1,145,434**	**1,192,136**	**1,216,751**	**1,247,537**	**1,279,401**
Without Waiting Lists Considered					
Nursing Seeking Population	2,563	2,240	2,223	2,248	2,274
Home Care Aide Population	4,641	4,946	5,048	5,176	5,308
If Waiting Lists were Filled in FY 2014					
Nursing Seeking Population	2,563	2,240	2,607	2,635	2,666
Home Care Aide Population	4,641	4,946	5,919	6,068	6,223

Note: IHAWP contains only those populations from 0-100% FPL. The marketplace contains the marketplace choice population in between 101-133%.

C. Financial Projections

The implementation of the ACA is expected to increase the portion of home care cost covered by Medicaid and/or individual insurance. A large portion of this population is over age 65 and thus the home care provided to this group is not affected by ACA.

Milliman projected two scenarios, one which does not take into account the waiting lists and service limitations and another which takes these factors into consideration.

As can be expected, the scenario that does not consider the waiting lists predicts a slight decline in the costs of this service and a subsequent increase in public health functions while the scenario which considers the waiting lists predicts a general increase in costs as the individuals on the waiting list fill in the vacancies created by the individuals who gain Medicaid or insurance coverage. However, this decision to absorb the waiting lists or to increase the reduced benefits may occur on a county by county basis and the actual cost may be somewhere in between these two scenarios.

Figure 18
Home Care Aide and Nursing
Financial Projections w/o Waiting Lists Considered

	Actual			Projected	
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Nursing	$1,754,311	$988,463	$903,119	$830,581	$784,128
Home Care Aide	$4,470,246	$5,520,583	$5,234,853	$5,234,853	$5,234,853
Public Health Functions*	$2,237,213	$1,952,724	$2,323,798	$2,396,336	$2,442,789
Total	**$8,461,770**	**$8,461,770**	**$8,461,770**	**$8,461,770**	**$8,461,770**

**Examples of Public Health Functions include immunizations, health education, community health needs assessments, etc.*

Figure 19
Home Care Aide and Nursing
Financial Projections Eliminating Waiting Lists and Providing Full Services

	Actual			Projected	
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Nursing	$1,754,311	$988,463	$903,119	$1,050,145	$991,412
Home Care Aide	$4,470,246	$5,520,583	$5,234,853	$7,166,656	$7,166,656
Public Health Functions*	$2,237,213	$1,952,724	$2,323,798	$2,396,336	$2,442,789
Total	**$8,461,770**	**$8,461,770**	**$8,461,770**	**$10,613,137**	**$10,600,857**

**Examples of Public Health Functions include immunizations, health education, community health needs assessments, etc.*

D. Discussion of ACA Related Changes to Funding and Population Served

Due to the ACA, the Home Care Aide and Nursing program can expect to see a shift in the population being covered as the younger adults move to at least partial insurance coverage of the benefits. As indicated above, a large portion of the population served, over 75% according to the data that was provided to Milliman, is age 65 or older and their services will not be impacted by ACA. Even among those that do obtain health insurance coverage under ACA, not all of the home health services provided by IDPH are covered by IHAWP or Marketplace plans.

As openings in available services are created by those individuals who do find other sources of coverage, some counties will reduce existing waiting lists for services and/or increase services that have been reduced.

IX. TOBACCO QUITLINE

A. Program Background, Historical Eligibility and Covered Services

In addition to regulatory and surveillance duties for tobacco use, IDPH provides a broad range of tobacco use education, prevention, treatment, and support services. *This analysis focuses solely on the potential change in demand for the IDPH-funded Tobacco Quitline Program.*

The mission of IDPH's, Division of Tobacco Use Prevention and Control (TUPC) is to reduce tobacco use and exposure to secondhand smoke by promoting partnerships among state governments, local communities, and the people of Iowa in order to foster a social and legal climate in which tobacco use becomes undesirable and socially unacceptable. Quitline Iowa is part of a larger comprehensive program funded by the TUPC Division. Since the creation of the TUPC Division in 2000, state funding has been allocated at the local level to community partnership coalitions. The primary goal of the community partnerships is to educate the community about tobacco use and its impact and promote and support the implementation of community interventions and policies to address the goal areas established by the Centers for Disease Control and Prevention. The four goal areas are:

- Prevent initiation among youth and young adults.
- Promote quitting among adults and youth.
- Eliminate exposure to secondhand smoke.
- Identify and eliminate tobacco-related disparities among population groups.

This analysis focuses solely on cessation services utilizing Quitline Iowa.

IDPH tobacco control funding is a combination of State General Fund appropriations and CDC Federal dollars. There is not an insurance requirement to utilize Quitline Iowa services. Quitline Iowa serves any Iowans wanting to quit using tobacco products aged 13 and up.

Since 2001 the TUPC Division has contracted for Quitline Iowa services to assist Iowans in quitting their tobacco use. The funds to pay for Quitline Iowa are both state and federal funds. In addition to Quitline Iowa, the funded local community partnerships that serve 96 of Iowa's 99 counties also work on promoting cessation by adults and youth. The funds that the community partnerships receive are state appropriations.

The Quitline program covers all Iowa residents 13 and older. A breakdown of the population by age and type of tobacco cessation service is shown below. The number of tobacco users shown below was estimated using a combination of US census data and CDC tobacco usage percentages.

B. Projective Change in Demand for Program Services

Using the Center for Disease Control's tobacco usage statistics, the number of smokers in Iowa was estimated and projected to 2017. Combining this data with the previously modeled increase in the IHAWP population, Milliman arrived with the projected usage of both the telephone and web interface cessation services. This is shown below in Figure 20. Special consideration was taken in estimating the FY 2015 usage. Due to a funded temporary increase in the available nicotine replacement therapies, FY 2014 saw a boost in usage.

Figure 20
Tobacco Usage Projections and Medicaid User Projections

	Actual		Projected		
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Tobacco Users in Iowa	564,660	559,013	553,423	547,889	542,410
Telephone Service Usage	10,085	8,512	8,704	8,891	9,073
Web Service Usage	2,158	1,962	2,303	2,636	2,963
Total Services Used	**12,243**	**10,474**	**11,007**	**11,527**	**12,036**
Total IHAWP population	403,836	480,791	491,847	502,577	513,174
Estimated IHAWP population that will seek Tobacco Cessation Services	2,933	3,492	3,519	3,543	3,564

IHAWP enrollment was also included in Figure 20 to demonstrate the changing proportion of the tobacco cessation telephone service users (IHAWP enrollees may only use telephone services) that are paid for through Medicaid. The number of enrollees that are covered through IHAWP will play a role in the financial projections in the following subsection.

C. Financial Projections

The population accessing the tobacco cessation Quitline and website is projected to increase as population increases but the only change in funding is the result of a movement of a portion of the population to Medicaid which is a joint State/Federal funded cost. Legislated State and Federal funding was assumed to remain consistent.

Figure 21 Tobacco Cessation Financial Projections					
	Actual		Projected		
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Medicaid Federal Reimbursement	$162,204	$192,907	$191,285	$189,043	$187,000
Medicaid State Reimbursement	$117,796	$140,093	$144,715	$148,957	$153,000
Federal	$165,857	$165,857	$165,857	$165,857	$165,857
State	$1,950,000	$1,897,000	$1,894,000	$1,892,000	$1,890,000
Total Funding	$2,395,857	$2,395,857	$2,395,857	$2,395,857	$2,395,857
Total State Funding	**$2,067,796**	**$2,037,093**	**$2,038,715**	**$2,040,957**	**$2,043,000**
Total Federal Funding	**$328,061**	**$358,764**	**$357,142**	**$354,900**	**$352,857**

D. Discussion of ACA Related Changes to Funding and Population Served

In the above cost model Milliman assumed that the total funding for the tobacco cessation program remained constant and that the state's direct funding for the program decreased as other Medicaid funding increased. However, the Medicaid funding is split between the state and the Federal Government resulting in slight increases in the state's portion of the Medicaid funding but ultimately a slight decrease in the total state funding of the program. Although some Iowans may be able to access other tobacco cessation services through their newly obtained insurance coverage, Milliman anticipates that the state services will be more readily accessible. In addition any decrease in the newly insured population accessing the state's hotline and website has been assumed to be offset by the state's recent offering of an eight week Nicotine Replacement Therapy.

X. CERVICAL CANCER SCREENING AND OTHER PREVENTATIVE SERVICES

A. Program Background, Historical Eligibility and Covered Services

In addition to general health promotion and education, IDPH provides a broad range of chronic disease screening and management services. *This analysis focuses solely on the potential change in demand for IDPH-funded cervical cancer screening.*

IDPH has provided cervical cancer screening with state funding beginning in 2013 through two distinct, but related existing service delivery structures. The first program, the Care for Yourself Breast and Cervical Cancer Early Detection Program, provides cervical cancer screening services to low-income, uninsured and under-insured women age 40 to 64 years across the state. The primary support for this program is a cooperative agreement with the CDC. The federal funding has paid for cervical cancer screening services, necessary cervical cancer-related diagnostic services, data collection, outreach, and case management services for the women enrolled in the program. Covered services include Pap tests, office visits for cervical cancer screening, Human Papilloma (HPV) testing, colposcopy, cervical biopsy, pathology for Pap test and biopsy specimens. The second program structure used for cervical cancer screening is the Title X Family Planning Program. State funding, in the amount of $500,000, has provided the opportunity to expand the cervical cancer screening to a broader range of women with incomes of up to 300% of FPL, and provide cervical cancer prevention services include provision of the HPV vaccine to low-income, underinsured and uninsured women and men age 19 to 26.

The Care for Yourself Program's usual mechanism for administration of screening services is through contracts with local boards of health, some of whom contract the outreach, data collection and case management to an external agency. Screening services are delivered by licensed health care providers across the state through a health care provider agreement between the IDPH and the provider or the provider facility. Reimbursement for the screening and diagnostic services is paid at the Medicare Part B Participating Provider Rate for Iowa, which is the rate allowed by the federally-funded screening program. Women from across the state are eligible for the program's cervical cancer screening services.

The appropriation of the state funds in 2012 not only provided for screening to expand and cover additional women in the Care for Yourself Program, but it caused a new cervical cancer project to be developed. The newer project provides reimbursement for screening and preventative services in the younger population served by the state's Title X agencies. Cervical cancer screening and diagnostic services, as well as HPV immunization, are provided to eligible participants served by participating Title X family planning agencies across the state.

Since the state appropriation for the cervical cancer screening and preventive services was made available for IDPH use in July 2012, delivery of services under the cervical cancer project has been operational for less than two years. The data shown in subsequent tables within this section show the growth in the provision of services during that time.

B. Projective Change in Demand for Program's Services

Figure 22 below shows the projected drop in the program's covered uninsured female population under 300% FPL. Milliman has focused on the female population who receive the great majority of the services provided under this program.

Figure 22
Cervical Cancer Screening
Projection of Female Uninsured Population under 300% FPL in Iowa

	Actual	Projected			
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Uninsured Females Aged 19-64	92,236	36,988	32,454	30,311	28,408

C. Financial Projections

This is the one program where Milliman anticipates a clear drop in the services provided as the previously served population obtains health insurance. Pap smear tests are included in Essential Health Benefits and thus required in IHAWP coverage and all qualified health plans.

However, as shown in Figure 23, a shift in use of funds over the past two years has taken place. Due to the nature of this cervical cancer appropriation being new in 2012, and the program still growing and adapting to service delivery patterns related to cervical cancer screening and HPV vaccination, IDPH has shifted a portion of its use of funding from screening and preventive service-related use to outreach and education purposes. As the population to be served becomes increasingly harder to reach and smaller in number, additional efforts are being funded in local communities to educate women and men on the need for routine cervical cancer screening and vaccinations to prevent cervical cancer from developing.

Figure 23
Cervical Cancer Screening and Related Services
Financial Projections

	Actual			Projected	
	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Outreach/Education	$121,465	$147,190	$293,060	$300,112	$306,388
Screening/HPV Vaccination Services	$299,330	$237,307	$106,800	$99,748	$93,472
Administration	$79,205	$115,503	$100,140	$100,140	$100,140
Total	**$500,000**	**$500,000**	**$500,000**	**$500,000**	**$500,000**

D. Discussion of ACA Related Changes to Funding and Population Served

While Figure 22 shows a downward projection in the overall number of women eligible for the offered cervical cancer screening and preventive services, the remaining eligible population's size is significant.

Due to the recently changed guidelines for cervical cancer screening, it is known that many women will not receive annual cervical screenings. The recently revised screening recommendations guide women to receive cervical screening on an every three-year basis if the most recent Pap smear test was negative. That timeline can be further lengthened to every five years if the cervical cancer screening was coupled with HPV testing that was also negative.

This state funding for cervical cancer and preventive services can continue to be focused for use with populations that have opted out of available health insurance coverage. Those populations may include those that don't wish to be covered under the Marketplace or persons who are eligible for Medicaid but have decided not to apply. In addition, there are other populations including certain religious groups that have been exempted from the requirement to obtain coverage that includes screening services. A recent congressional report estimates that more than 25 million Americans may be without health coverage due to ACA exemptions.[5]

[5] CBO Report: Payments of Penalties for Being Uninsured Under the Affordable Care Act: 2014 Update http://cbo.gov/sites/default/files/cbofiles/attachments/45397-IndividualMandate.pdf

XI. ACKNOWLEDGEMENTS

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- Jill Myers-Geadelmann- Bureau Chief, Bureau of Chronic Disease Prevention and Management, Iowa Department of Public Health
- Jerilyn Oshel- Interim Division Director, Division of Tobacco Use Prevention and Control, Iowa Department of Public Health
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- Abby Less- Office of Health Care Transformation, Iowa Department of Public
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- Berdette Ogden- Local Public Health Regional Community Health Consultant, Iowa Department of Public Health

We would also like to acknowledge the participation of the group of local public health agencies who were surveyed to collect data used in this report.

XII. QUALIFICATIONS

This report was created by Timothy F. Harris. Mr. Harris is a principal and consulting actuary in the St. Louis office of Milliman and author of "Health Care Coverage and Financing in the United States." He is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. As such, he meets the qualification standards for performing the analyses contained in this report.

Appendix A
Technical details on population modeling

This appendix provides information on some of the key data sources, tools, and assumptions used to develop the projections presented in this report.

CURRENT POPULATION SURVEY (CPS) / AMERICAN COMMUNITY SURVEY (ACS) DATA

The initial census data was developed using the Current Population Survey (CPS). To mitigate the risk of population fluctuation that is due to the relatively small sample size responding to this self-reported survey, Milliman used CPS data for the Iowa market for both 2012 and 2013. Milliman used the CPS data to determine the composition of the Iowa population by age, gender, income level, insurance coverage type (e.g., individual, employer, Medicaid, Medicare disabled), and family status.

While Milliman used 2013 CPS data to determine population distribution by factors such as age, gender, and income level, the small sample size of certain subsections of the population may cause some irregularity in the results.

MEDICAL EXPENDITURE PANEL SURVEY (MEPS) DATA

Milliman used Medical Expenditure Panel Survey (MEPS) data to supplement the census data and to distribute the employer insurance data into small group, large group, self-insured, or fully insured.

UNDOCUMENTED UNINSURED MODELING

Milliman used 2010 ACS data to determine that approximately 18% of the uninsured population under age 65 would be undocumented and then allocated 18% of the uninsured population to an undocumented uninsured bucket. This bucket does not allow for new entry (since Milliman assumes no further net immigration) or exit to other insured markets such as Medicare, Medicaid, or the Marketplace (as undocumented uninsureds will be ineligible for such movement). However, the standard mortality assumption (described in further detail under the "Births and Mortality" section) is applied to the undocumented uninsureds. Any births to this population are considered documented and will enter other markets as modeled.

MEDICAL COSTS

Medical cost curves by age and gender were developed using an assumed set of benefits and research that underlies Milliman's *Health Cost Guidelines*™ (HCGs). To calibrate the costs to Iowa experience, Milliman used benefit designs consistent with those offered by carriers in Iowa (based on information provided by key insurer stakeholders) and geographic area adjustments from Milliman's HCGs. Milliman assumed that the majority of individual policies do not currently cover uncomplicated maternity care. Effective January 1, 2014, Milliman assumed that all individual policies would cover all maternity care.

Appendix A
Technical details on population modeling

BIRTHS AND MORTALITY

Milliman applied a population growth of 1.5% per year after 2014.

TAKE-UP RATES

Take-up rates describe the probability of people changing from uninsured to insured, or from one market to another (e.g., from the individual non-Marketplace market to the individual Marketplace). Milliman has conducted research to determine what percentage of people (for each combination of representative age, gender, and health status) will tend to switch markets, based on the ACA provisions and the modeled individual's expected healthcare costs, subsidies, and premium rate choices. Using that research, Milliman modeled the projected population's movements between the various insurance coverage types.

TAKE-UP RATE DISTRIBUTION FOR THE THREE MARKET SCENARIOS (BEST ESTIMATE, HIGH TAKE-UP, AND LOW TAKE-UP)

In order to model the three different scenarios underlying Milliman's Iowa reform projections (best estimate, high take-up rate, and low take-up rate), Milliman estimated take-up rates for three key market-to-market movements. Using the research Milliman developed to estimate the percentage of people who will move from one market to another based on their demographics, costs, subsidies, etc. (which is described above), Milliman modeled a variety of possible movements, including the movement from uninsured to individual Marketplace coverage; the movement from uninsured to individual non-Marketplace coverage; the movement from individual coverage to individual Marketplace coverage, etc.

In creating the three scenarios, Milliman was most interested in investigating the affordability of healthcare and, thus, the likelihood that people would need some form of coverage to meet their healthcare needs in the future. The three movements Milliman focused on when creating Milliman's projection scenarios are described in further detail below:

1. The movement from employer coverage (individual, small group, large group) to the Marketplace in 2014. The high take-up rate scenario assumes more people would go to the Marketplace in these earlier years as they lose coverage and the low take-up rate scenario assumes fewer people go to the Marketplace in 2014 with the best-estimate scenario approximately in the center.

2. The movement from an uninsured status to employer coverage in 2014 and thereafter. This movement was reflected in years 2014 through 2017 and again the high take-up rate scenario shows the largest percentage of people moving to employer coverage with the best estimate scenario to follow and the low take-up rate scenario with the smallest percentage movement. The take up rate varied from year to year to reflect the initial

wave of enrollees in 2014, but also the effect of the increasing individual mandate tax penalty.

3. The movement from an uninsured status to individual Marketplace coverage in 2014 and thereafter. This movement was reflected in years 2014 through 2017 and again the high take-up rate scenario shows the largest percentage of people moving to individual Marketplace coverage with the best estimate scenario to follow and the low take-up rate scenario with the smallest percentage movement. Also, Milliman assumed that the first year of eligibility (2014) would result in a far larger percentage movement, which would then taper off in subsequent years.

Figure A-1 summarizes the estimated percentage take-up rates in each market for the 2015 - 2017 modeling period in the scenarios described above.

Figure A -1
Take-Up Rate Comparison among Scenarios

Scenario	**Best Estimate**
Average Annual Take-Up from Uninsured to Medicaid (2015 - 2017)	1.5%
Average Annual Take-Up from Uninsured to Iowa's Marketplace (2015 - 2017)	2.4%
Scenario	**High Take-Up**
Average Annual Take-Up from Uninsured to Medicaid (2015 - 2017)	2.4%
Average Annual Take-Up from Uninsured to Iowa's Marketplace (2015 - 2017)	5.8%
Scenario	**Low Take-Up**
Average Annual Take-Up from Uninsured to Medicaid (2015 - 2017)	1.0%
Average Annual Take-Up from Uninsured to Iowa's Marketplace (2015 - 2017)	1.4%

MOVEMENT BETWEEN MARKETS THAT IS DUE TO AGING

The causes of age-related movements between markets include formerly dependent children who reach an age where they are emancipated to other markets, adults who reach age 65 and join the Medicare market (Milliman assumed 100% of documented individuals who are not already enrolled in the Medicare disabled market join the Medicare market at age 65), and individuals in other markets who lapse to the uninsured market because of premium rate increases.

Appendix B
Terminology Used in Actuarial Study

LIST OF ACRONYMS

ACA – Affordable Care Act
ACS – American Community Survey
CCIIO – Center for Consumer Information and Insurance Oversight
CHIP – Children's Health Insurance Program
CMS – Center for Medicare and Medicaid Services
CO-OPs – Consumer Operated and Oriented Plans
CPS – Current Population Survey
EHB – Essential Health Benefits
ESI – Employer-sponsored insurance
FPL – Federal poverty level
FY – Fiscal Year. In this report, State Fiscal Year
HCGs – Milliman's *Health Cost Guidelines*
HHS – Department of Health and Human Services
HIPAA – Health Insurance Portability and Accountability Act
HMO – Health Maintenance Organization
IDPH – Iowa Department of Public Health
IHAWP – Iowa Health and Wellness Plan
IT – Information Technology
MAGI – Modified Adjusted Gross Income
MEPS – Medical Expenditure Panel Survey
PMPM – Per member per month
PMPY – Per member per year
PPACA – Patient Protection and Affordable Care Act of 2010

ADDITIONAL DEFINITIONS

Qualified Health Plan: A plan that meets the following criteria:

- Has been certified that the plan meets certain criteria issued or recognized by the Marketplace through which the plan is offered;
- Provides the "Essential Health Benefits package"; and
- Is offered by a health insurance issuer that:

    - Is licensed and in good standing to offer health insurance coverage in each state in which the issuer offers health insurance coverage under the Act;
    - Agrees to offer at least one qualified health plan at the silver level, and at least one plan at the gold level;
    - Agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an exchange, or whether the plan is offered directly from the issuer, or through an agent; and

- Complies with the regulations that apply to exchanges, and any other requirements that an applicable exchange may establish.

Essential Health Benefits: All private health insurance plans offered in the Marketplace will offer the same set of essential health benefits. These are services all plans must cover.

The essential health benefits include at least the following items and services:

- Ambulatory patient services (outpatient care you get without being admitted to a hospital)
- Emergency services
- Hospitalization (such as surgery)
- Maternity and newborn care (care before and after your baby is born)
- Mental health and substance use disorder services, including behavioral health treatment (this includes counseling and psychotherapy)
- Prescription drugs
- Rehabilitative and habilitative services and devices (services and devices to help people with injuries, disabilities, or chronic conditions gain or recover mental and physical skills)
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services

Essential health benefits are minimum requirements for all plans in the Marketplace. Plans may offer additional coverage.

Appendix C
HHS Enrollment Data Summary for Iowa

PROFILE OF AFFORDABLE CARE ACT COVERAGE EXPANSION ENROLLMENT FOR MEDICAID / CHIP AND THE HEALTH INSURANCE MARKETPLACE

10-1-2013 to 3-31-2014

Iowa

GENERAL INFORMATION:

Marketplace Type:	FFM - Partnership
Medicaid Expansion Status:	Expanding Medicaid

AFFORDABLE CARE ACT ENROLLMENT TOTALS:

Marketplace Plan Selections:*	**29,163**
Change in Medicaid/CHIP Enrollment:**	**78,860**

CHARACTERISTICS OF MARKETPLACE PLAN SELECTIONS:

By Gender:	Number	% of Total
Female	15,853	54%
Male	13,306	46%
Subtotal With Known Data	*29,159*	*100%*
Unknown	*N/A*	*N/A*

By Financial Assistance Status:	Number	% of Total
With Financial Assistance	24,485	84%
Without Financial Assistance	4,678	16%
Subtotal With Known Data	*29,163*	*100%*
Unknown	*N/A*	*N/A*

By Age:	Number	% of Total
Age < 18	1,252	4%
Age 18-25	2,490	9%
Age 26-34	5,391	18%
Age 35-44	4,688	16%
Age 45-54	6,353	22%
Age 55-64	8,895	31%
Age ≥65	94	0%
Subtotal With Known Data	*29,163*	100%
Unknown	*N/A*	N/A
Ages 18 to 34	**7,881**	**27%**
Ages 0 to 34	9,133	31%

By Metal Level:	Number	% of Total
Bronze	7,511	26%
Silver	16,528	57%
Gold	3,460	12%
Platinum	1,139	4%
Catastrophic	619	2%
Subtotal With Known Data	*29,163*	*100%*
Standalone Dental	*5,634*	*N/A*
Unknown	*N/A*	*N/A*

Notes: * Marketplace data represent the cumulative number of Individuals Determined Eligible to Enroll in a plan Through the Marketplace who have selected a plan from 10-1-13 to 3-31-14, including Special Enrollment Period-related activity through 4-19-14 (with or without the first premium payment having been received directly by the Marketplace or the issuer), excluding plan selections with unknown data for a given metric.

** Medicaid/CHIP data are state reported and represent the difference between March 2014 enrollment and Pre-ACA Monthly Average Medicaid and CHIP Enrollment (July-Sept 2013). Not all changes in enrollment may be related to the Affordable Care Act. Because these data are state-reported, detailed questions about the Medicaid/CHIP data should be directed to the states.

Sources: ASPE Marketplace Summary Enrollment Report and CMS March Medicaid/CHIP Enrollment Report

Appendix D
Detailed Projections of Uninsured Population and Marketplace Enrollment

Figure E -1
Estimated Uninsured Population Breakdown by Age/Gender/FPL - 2014

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	**Male**	3,039	2,324	3,846	1,940	3,094	**14,243**
	Female	1,739	5,376	2,275	3,227	2,406	**15,023**
18-25	**Male**	4,365	7,571	5,937	8,255	4,795	**30,923**
	Female	3,742	4,250	2,412	1,386	3,560	**15,350**
26-34	**Male**	2,866	5,155	11,665	1,224	8,467	**29,377**
	Female	3,101	5,538	6,148	4,169	5,400	**24,356**
35-44	**Male**	3,578	2,973	8,998	7,497	7,024	**30,070**
	Female	6,435	4,986	3,094	3,578	2,539	**20,632**
45-54	**Male**	2,040	6,767	2,661	3,215	7,298	**21,981**
	Female	1,656	5,985	3,495	1,308	7,009	**19,453**
55-64	**Male**	1,467	813	1,743	2,686	0*	**6,709**
	Female	1,458	3,540	4,464	1,557	3,554	**14,573**
Total	**Male**	**17,355**	**25,603**	**34,850**	**24,817**	**30,678**	**133,306**
	Female	**18,131**	**29,675**	**21,888**	**15,225**	**24,468**	**109,385**
Grand Total		**35,486**	**55,278**	**56,738**	**40,042**	**55,146**	**242,1**

Source: Milliman projected the latest available US Census Data to estimate the future uninsured population.
** - When splitting US Census Data into increasingly smaller/more specific subsets, some zeroes occur. These occurrences should be considered data anomalies and should not influence the reader's conclusions.*

Figure E -2
Estimated Uninsured Population Breakdown by Age/Gender/FPL - 2015

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	**Male**	2,778	1,901	3,450	1,751	2,757	**12,637**
	Female	1,589	4,399	2,041	2,913	2,145	**13,087**
18-25	**Male**	3,991	6,195	5,326	7,452	4,273	**27,237**
	Female	3,421	3,477	2,164	1,251	3,173	**13,486**
26-34	**Male**	2,620	4,218	10,465	1,105	7,546	**25,954**
	Female	2,835	4,532	5,515	3,763	4,813	**21,458**
35-44	**Male**	3,271	2,433	8,072	6,767	6,259	**26,802**
	Female	5,882	4,080	2,776	3,229	2,262	**18,229**
45-54	**Male**	1,865	5,538	2,387	2,902	6,504	**19,196**
	Female	1,514	4,898	3,136	1,181	6,247	**16,976**
55-64	**Male**	1,341	665	1,563	2,425	0*	**5,994**
	Female	1,332	2,897	4,004	1,406	3,167	**12,806**
Total	**Male**	**15,866**	**20,950**	**31,263**	**22,402**	**27,339**	**117,823**
	Female	**16,573**	**24,283**	**19,636**	**13,743**	**21,807**	**96,039**
Grand Total		**32,439**	**45,233**	**50,899**	**36,145**	**49,146**	**213,862**

Source: Milliman projected the latest available US Census Data to estimate the future uninsured population.
** - When splitting US Census Data into increasingly smaller/more specific subsets, some zeroes occur. These occurrences should be considered data anomalies and should not influence the reader's conclusions.*

Appendix D
Detailed Projections of Uninsured Population and Marketplace Enrollment

Figure E -3
Estimated Uninsured Population Breakdown by Age/Gender/FPL – 2016

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	2,546	1,722	3,396	1,668	2,566	**11,898**
	Female	1,456	3,984	2,009	2,774	1,996	**12,219**
18-25	Male	3,657	5,611	5,242	7,097	3,977	**25,584**
	Female	3,135	3,149	2,129	1,191	2,952	**12,556**
26-34	Male	2,401	3,820	10,300	1,053	7,022	**24,596**
	Female	2,597	4,104	5,428	3,584	4,479	**20,192**
35-44	Male	2,997	2,203	7,945	6,445	5,825	**25,415**
	Female	5,390	3,695	2,732	3,076	2,105	**16,998**
45-54	Male	1,709	5,015	2,349	2,764	6,053	**17,890**
	Female	1,387	4,436	3,086	1,125	5,813	**15,847**
55-64	Male	1,229	602	1,539	2,309	0*	**5,679**
	Female	1,221	2,623	3,941	1,339	2,948	**12,071**
Total	**Male**	**14,539**	**18,973**	**30,771**	**21,336**	**25,443**	**111,062**
	Female	**15,186**	**21,991**	**19,325**	**13,089**	**20,293**	**89,884**
Grand Total		**29,725**	**40,964**	**50,096**	**34,425**	**45,736**	**200,946**

Source: Milliman projected the latest available US Census Data to estimate the future uninsured population.

** - When splitting US Census Data into increasingly smaller/more specific subsets, some zeroes occur. These occurrences should be considered data anomalies and should not influence the reader's conclusions.*

Figure E -4
Estimated Uninsured Population Breakdown by Age/Gender/FPL – 2017

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	2,339	1,565	3,344	1,592	2,395	**11,235**
	Female	1,338	3,621	1,978	2,648	1,863	**11,448**
18-25	Male	3,359	5,099	5,162	6,775	3,712	**24,107**
	Female	2,880	2,862	2,097	1,137	2,756	**11,732**
26-34	Male	2,206	3,472	10,143	1,005	6,554	**23,380**
	Female	2,386	3,730	5,346	3,421	4,180	**19,063**
35-44	Male	2,754	2,003	7,824	6,153	5,437	**24,171**
	Female	4,952	3,358	2,690	2,936	1,965	**15,901**
45-54	Male	1,570	4,558	2,314	2,638	5,649	**16,729**
	Female	1,275	4,031	3,039	1,074	5,426	**14,845**
55-64	Male	1,129	547	1,515	2,204	0*	**5,395**
	Female	1,122	2,384	3,881	1,278	2,751	**11,416**
Total	**Male**	**13,357**	**17,244**	**30,302**	**20,367**	**23,747**	**105,017**
	Female	**13,953**	**19,986**	**19,031**	**12,494**	**18,941**	**84,405**
Grand Total		**27,310**	**37,230**	**49,333**	**32,861**	**42,688**	**189,422**

Source: Milliman projected the latest available US Census Data to estimate the future uninsured population.

** - When splitting US Census Data into increasingly smaller/more specific subsets, some zeroes occur. These occurrences should be considered data anomalies and should not influence the reader's conclusions.*

Appendix D
Detailed Projections of Uninsured Population and Marketplace Enrollment

Figure E-5
Estimated Marketplace Population Breakdown by Age/Gender/FPL - 2014

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	0	230	263	98	92	**683**
	Female	0	193	221	82	77	**573**
18-25	Male	0	457	524	195	182	**1,358**
	Female	0	384	440	164	153	**1,141**
26-34	Male	0	989	1,134	422	395	**2,940**
	Female	0	830	952	354	332	**2,468**
35-44	Male	0	860	986	367	343	**2,556**
	Female	0	722	828	308	288	**2,146**
45-54	Male	0	1,165	1,337	497	465	**3,464**
	Female	0	979	1,122	417	391	**2,909**
55-64	Male	0	1,632	1,872	696	652	**4,852**
	Female	0	1,370	1,571	584	547	**4,072**
Total	**Male**	**0**	**5,333**	**6,116**	**2,275**	**2,129**	**15,853**
	Female	**0**	**4,478**	**5,134**	**1,909**	**1,788**	**13,309**
Grand Total		**0**	**9,811**	**11,250**	**4,184**	**3,917**	**29,162**

Figure E-6
Estimated Marketplace Population Breakdown by Age/Gender/FPL - 2015

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	0	473	499	244	304	**1,520**
	Female	0	397	419	205	255	**1,276**
18-25	Male	0	941	993	486	604	**3,024**
	Female	0	791	834	408	508	**2,541**
26-34	Male	0	2,037	2,150	1,052	1,309	**6,548**
	Female	0	1,710	1,805	883	1,100	**5,498**
35-44	Male	0	1,772	1,870	915	1,138	**5,695**
	Female	0	1,487	1,570	768	956	**4,781**
45-54	Male	0	2,401	2,534	1,239	1,543	**7,717**
	Female	0	2,016	2,127	1,040	1,296	**6,479**
55-64	Male	0	3,362	3,549	1,735	2,161	**10,807**
	Female	0	2,822	2,979	1,456	1,814	**9,071**
Total	**Male**	**0**	**10,986**	**11,595**	**5,671**	**7,059**	**35,311**
	Female	**0**	**9,223**	**9,734**	**4,760**	**5,929**	**29,646**
Grand Total		**0**	**20,209**	**21,329**	**10,431**	**12,988**	**64,957**

Appendix D
Detailed Projections of Uninsured Population and Marketplace Enrollment

Figure E-7
Estimated Marketplace Population Breakdown by Age/Gender/FPL - 2016

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	0	801	830	477	637	**2,745**
	Female	0	672	696	401	535	**2,304**
18-25	Male	0	1,593	1,649	950	1,265	**5,457**
	Female	0	1,339	1,385	797	1,063	**4,584**
26-34	Male	0	3,450	3,572	2,056	2,741	**11,819**
	Female	0	2,896	2,999	1,726	2,303	**9,924**
35-44	Male	0	3,000	3,106	1,788	2,384	**10,278**
	Female	0	2,519	2,607	1,501	2,002	**8,629**
45-54	Male	0	4,066	4,209	2,422	3,231	**13,928**
	Female	0	3,414	3,533	2,033	2,714	**11,694**
55-64	Male	0	5,693	5,894	3,391	4,526	**19,504**
	Female	0	4,778	4,949	2,846	3,799	**16,372**
Total	**Male**	**0**	**18,603**	**19,260**	**11,084**	**14,784**	**63,731**
	Female	**0**	**15,618**	**16,169**	**9,304**	**12,416**	**53,507**
Grand Total		**0**	**34,221**	**35,429**	**20,388**	**27,200**	**117,238**

Figure E-8
Estimated Marketplace Population Breakdown by Age/Gender/FPL - 2017

		Under 100%	100% to 199%	200% to 299%	300% to 399%	Over 400%	Total
0-17	Male	0	230	263	98	92	**683**
	Female	0	193	221	82	77	**573**
18-25	Male	0	457	524	195	182	**1,358**
	Female	0	384	440	164	153	**1,141**
26-34	Male	0	989	1,134	422	395	**2,940**
	Female	0	830	952	354	332	**2,468**
35-44	Male	0	860	986	367	343	**2,556**
	Female	0	722	828	308	288	**2,146**
45-54	Male	0	1,165	1,337	497	465	**3,464**
	Female	0	979	1,122	417	391	**2,909**
55-64	Male	0	1,632	1,872	696	652	**4,852**
	Female	0	1,370	1,571	584	547	**4,072**
Total	**Male**	**0**	**5,333**	**6,116**	**2,275**	**2,129**	**15,853**
	Female	**0**	**4,478**	**5,134**	**1,909**	**1,788**	**13,309**
Grand Total		**0**	**9,811**	**11,250**	**4,184**	**3,917**	**29,162**