Washington State Health Benefit Exchange: Report to the Governor and Legislature as Required by Substitute Senate Bill 5445

March 2012

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In 2010, President Obama signed the Patient Protection and Affordable Care Act (ACA) into law. Section 1311 of this law requires states to establish health benefit exchanges to facilitate the purchase of health insurance, and provides states with substantial flexibility regarding the establishment of the exchange. The health benefit exchange is an online marketplace that will allow individuals and small businesses to apply for and enroll in health insurance.

In 2011, the legislature passed SSB 5445, which created the Washington Health Benefit Exchange (Exchange) as a public-private partnership. On December 15, 2011, Governor Gregoire appointed nine Washingtonians to the governing board of the Exchange. Eight of the members were chosen from the nominees put forward by the two largest caucuses from each the House and the Senate. The Board takes over governing authority on March 15, 2012.Until that time, the Washington State Health Care Authority (HCA) is charged with planning and developing the Exchange.

The HCA has made considerable progress in designing the Exchange. In May 2011, the HCA was awarded a $22.9 million grant from the U.S. Department of Health and Human Services (HHS) to fund the Exchange work through May 2012. Another grant will be sought from HHS in March 2012 to fund the Exchange through December 31, 2014.

The HCA and the Joint Legislative Select Committee on Health Reform Implementation conducted eight public meetings around the state to incorporate public feedback into the Exchange design. Furthermore, the HCA has produced several issue briefs and reports, which have been incorporated into this report. These publications focus on specific areas that need to be addressed as a comprehensive operational and business plan for the exchange are built.

State law requires the HCA to report analysis and recommendations on several key areas to the Governor and Legislature. Below are requirements as directed by statute and the HCA's response:

1. The goals and principles of the exchange

The Washington State Health Benefit Exchange is being developed to improve access to health insurance coverage for individuals and small employers. The Exchange acts as an online marketplace where people can make apples-to-apples comparison of the private health insurance plans available to them. They will be able to search for plans based on factors that are important to them, such as whether their doctors are covered in a plan's network and how much of a deductible the plan has. The Exchange offers tax credits and cost-sharing reductions for those with incomes between 134 percent and 400 percent of the federal poverty level (FPL) to make the cost of coverage more affordable. The Exchange will also help people enroll in Medicaid, which expands to populations up to 133 percent FPL.

With a standard set of benefits and a level playing field with the outside insurance market, the Exchange has more of an ability to compete on the basis of price, quality, service and other innovative efforts that consumers may find attractive when searching for coverage.

The Exchange continues to engage with key stakeholders to ensure that the Exchange is built to work best for individuals, small businesses, the plans offering through the Exchange, as well as others.

The Exchange also draws on the goals the legislature outlined in Section 1 of SSB 5445:

"Increase access to quality affordable health care coverage, reduce the number of uninsured in Washington State, and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers.

Provide consumer choice and portability of health insurance regardless of employment status;

Create an organized transparent, and affordable health insurance marketplace for Washingtonians to purchase affordable quality health care coverage, to claim available federal refundable premium tax credits and cost-sharing subsidies, and to meet with personal responsibility requirements for minimum essential coverage as provided under the federal affordable care act;

Promote consumer literacy and empower consumers to compare plans and make informed decisions about their health care and coverage;

Effectively and efficiently administer health care subsidies and determination of eligibility for participation in publicly subsidized health care programs, including the exchange;

Create a health insurance market that competes on the basis of price, quality, service, and other innovative efforts;

Operate in a manner compatible with efforts to improve quality, contain costs and promote innovation;

Recognize the need for a private health insurance market to exist outside of the exchange; and

Recognize that the regulation of the health insurance market, both inside and outside the exchange, should continue to be performed by the insurance commissioner."

2. The creation and implementation of a single state-administered exchange for all geographic areas in the state that operates as the exchange for both the individual and small employer markets by January 1, 2014

This is addressed in the "Resources and Needs Assessment" document enclosed in this report.

3. Whether and under what circumstances the state should consider establishment of, or participation in, a regionally administered multistate exchange

The HCA has not examined the possibility of the establishment of or participating in a regionally administered multistate exchange. That is, however, an area that could be revisited at a later date, if there is interest.

The Washington Health Benefit Exchange regularly consults with exchange officials from other states. Specifically, the Exchange discusses issues with Oregon on a regular basis.

4. Whether the role of an exchange includes serving as an aggregator of funds that comprise the premium for a health plan offered through the exchange

The Small Business Health Options Program (SHOP) exchange will provide premium aggregation services to ease the burden to small businesses offering health insurance. The SHOP exchange will combine contributions from the small business and, employee for distribution to the health insurance plan. The HCA is currently evaluating the premium aggregation function for individuals, taking into consideration the ease for consumers and health carriers, but weighing the cost of offering the aggregation service as an operational expense to the exchange.

5. The administrative, fiduciary, accounting, contracting, and other services to be provided by the exchange

This is addressed in the "Resources and Needs Assessment" document enclosed in this report.

6. Coordination of the exchange with other state programs

A substantial effort has been made to coordinate the exchange with other state programs. The Exchange has created several workgroups comprised of individuals from the HCA, Medicaid, the Office of the Insurance Commissioner and the Department of Social and Health Services. These workgroups will ensure alignment of priorities and a seamless experience for individuals seeking insurance through the Exchange, regardless of their eventual enrollment in a qualified health plan, Medicaid, Apple Health for Kids plan or the federal basic health program.

The State's National Health Reform Steering Committee serves in an advisory role for the Exchange and the Medicaid expansion. It is made up of executive-level representatives from the Governor's Office, OFM, HCA, DSHS, and OIC. Given its unique role of coordinating health reform efforts in both programs, the Steering Committee is able to find solutions that best serve both programs.

In recognition of the role the Office of the Insurance Commissioner (OIC) plays in regulating the health insurance market, the Exchange regularly consults and coordinates on issues related to regulation of insurance inside the Exchange. Additional coordination is occurring between the Exchange and OIC to ensure there are not duplicative processes for offering plans in the marketplace.

7. Development of sustainable funding for administration of the exchange as of January 1, 2015

This is addressed in the report, entitled "Five-Year Administrative Budget Projections and Self Sustainability Analysis," which will be available in Spring 2012.

8. Recognizing the need for expedience in determining the structure of needed information technology, the necessary information technology to support implementation of exchange activities

This is addressed in the "IT Infrastructure Review and Assessment" report and the "Health Benefit Exchange Systems Integrator Services" RFP document enclosed in this report. Responses to the RFP have been received and are currently being evaluated. A formal announcement is anticipated in early 2012.

9. Whether to adopt and implement a federal basic health plan option as authorized in the affordable care act, whether the federal basic health plan option should be administered by the entity that administers the exchange or by a state agency, and whether the federal basic health plan option should merge risk pools for rating with any portion of the state's Medicaid program

This is addressed in the "Basic Health Plan" issue brief and the "Milliman Market Impact Analysis" document enclosed in this report.

10. Individual and small group market impacts, including whether to:

Merge the risk pools for rating the individual and small group markets in the exchange and the private health insurance markets; and

This is addressed in the "Milliman Market Impact Analysis" document enclosed in this report.

Increase the small group market to firms with up to one hundred employees

This is addressed in the "Milliman Market Impact Analysis" document enclosed in this report.

11. Creation of uniform requirements, standards, and criteria for the creation of qualified health plans offered through the exchange, including promoting participation by carriers and enrollees in the exchange to a level sufficient to provide sustainable funding for the exchange

This is addressed in the "Criteria for Qualified Health Plan" and "Market Rules to Avoid Unstable Risk Pools" briefs enclosed in this report.

12. Certifying, selecting, and facilitating the offer of individual and small group plans through an exchange, to include designation of qualified health plans and the levels of coverage for the plans

This is addressed in the "Criteria for Qualified Health Plan" brief enclosed in this report.

13. The role and services provided by producers and navigators, including the option to use private insurance market brokers as navigators

This is addressed in the "Navigators" brief enclosed in this report.

14. Effective implementation of risk management methods, including: Reinsurance, risk corridors, risk adjustment, to include the entity designated to operate reinsurance and risk adjustment, and the continuing role of the Washington state health insurance pool

The Exchange has begun exploring these issues in the brief "Risk Leveling and the State's High Risk Pool," which is due to be released in Spring 2012.

15. Participation in innovative efforts to contain costs in Washington's markets for public and private health care coverage

An issue brief on delivery system reforms will be issued in 2012.

16. Providing federal refundable premium tax credits and reduced cost-sharing subsidies through the exchange, including the processes and entity responsible for determining eligibility to participate in the exchange and the cost-sharing subsidies provided through the exchange

A single exchange portal will be used to determine eligibility for tax credits, cost-sharing reductions, and Medicaid and CHIP. This portal will provide an online application. Once an individual enters income and personal identifying information, eligibility data will be obtained electronically from state systems and the Internal Revenue Service, U.S. Department of Homeland Security and the Social Security Administration via a federal hub.

The Exchange will also facilitate enrollment into the health plan an individual chooses. The exchange will provide the capability for individuals to report changes in income, household composition, and other factors affecting eligibility..

Also see the "Health Benefit Exchange Systems Integrator Services" RFP document enclosed in this report for additional details.

17. The staff, resources, and revenues necessary to operate and administer an exchange for the first two years of operation

This is addressed in the "Resources and Needs Assessment" document enclosed in this report.

18. The extent and circumstances under which benefits for spiritual care services that are deductible under section 213(d) of the internal revenue code as of January 1, 2010, will be made available under the exchange

The Washington Health Benefit Exchange will not be requiring nor prohibiting specific spiritual care services from qualified health plans. Consistent with the legislature's intentions articulated in SSB 5445, the Health Benefit Exchange will work to "increase access to quality affordable health care coverage, reduce the number of uninsured persons in Washington State, and increase the availability of health care coverage through the private health insurance market to qualified individuals and small employers."

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Criteria for Qualified Health Plan

(Draft)

October 15, 2011

Final report anticipated in Spring 2012

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Criteria for Qualified Health Plans: An Analysis of Options for Washington State

This issue brief is intended to support a dialogue about certification of the qualified health plans in the Washington State Health Benefit Exchange. The brief presents a framework that could assist the state in adopting the criteria provided in federal law or guide the development of additional criteria for certifying qualified health plans.

The Patient Protection and Affordable Care Act (ACA) established the Exchange as another health insurance market for individuals and small businesses. The ACA provides states with the flexibility to distinguish the Exchange from the private health insurance markets that will continue to exist outside of the Exchange. How qualified health plans are certified will begin to shape the type of Exchange the state wants to develop and how it might be similar or different from the outside markets.

The ACA directs the Exchange to certify and offer only qualified health plans. In the process of certifying those plans, the Exchange could attempt to introduce changes to the insurance or delivery systems in Washington State. This issue brief presents ways in which the Legislature and Governor could establish guiding principles for the Exchange Board to use in its certification process. The criteria will help to define the Exchange and its role in the private health insurance market.

Background

Section 1301 of the ACA defines a qualified health plan (QHP) as a health plan that is certified by the Exchange, provides the essential benefits package,[1] and complies with other requirements established by HHS and the Exchange. In order to be certified as QHPs, the ACA requires plans to:

(1) Meet certain marketing requirements
(2) Meet certain network adequacy requirements
(3) Include in their networks essential community providers that serve low-income, underserved communities
(4) Be accredited by an entity that HHS recognizes for accreditation of health plans

[1] The essential health benefits package must cover the following general categories of services: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; pediatric services, including oral and vision care. The scope of benefits is to be determined by the Secretary of HHS, to equal to the scope of benefits under a typical employer-based plan. The ACA also imposes a maximum deductible (limited to $2,000 individual/$4,000 family, indexed to average premium growth) and cost sharing limits (equal to that for high-deductible health plans in 2014, indexed to the rate of average premium growth). QHPs may provide benefits in excess of the essential benefits package.

(5) Implement a quality improvement strategy to increase reimbursement or offer other incentives to improve health outcomes, prevent hospital readmissions, improve patient safety, implement health promotion, and reduce disparities
(6) Use a standard enrollment form
(7) Use a standard format for presenting health benefits plan options
(8) Provide information to the Exchange and enrollees on quality measures for health plan performance
(9) Submit justifications of any premium increase prior to implementation and post it on its website
(10) Submit and publicly disclose certain information, including claims payment policies and practices; periodic financial disclosures; data on enrollment, disenrollment, the number of claims denied, rating practices, cost-sharing and payments with respect to any out-of-network coverage, and enrollee rights; and other information that HHS may specify
(11) Allow individuals to learn, upon request or through a website, cost-sharing for specific items or services furnished by a participating provider
(12) Contract with any hospital with more than 50 beds only if it utilizes a patient safety evaluation system and provides education and counseling upon discharge, comprehensive discharge planning, and post-discharge reinforcement by a health care professional
(13) Contract with only health care providers that implement quality improvement strategies as required by HHS

Finally, issuers must meet a number of criteria in order to offer a QHP.[2] Specifically, the issuer must be licensed and in good standing in the state, agree to offer at least one silver plan and one gold plan in the Exchange, and agree to charge the same premium whether the plan is sold in the Exchange or outside the Exchange.

Beyond those criteria, the Exchange may establish additional standards that plans or issuers must meet "in the interest of individuals and employers in the state." This brief reviews the private market health insurance landscape in 2014 and explores the advantages and disadvantages to requiring additional criteria beyond what is laid out in the ACA.

Policy Options for QHP Criteria

The following are the options laid out for discussion in this brief.

Option 1: The Exchange would certify all health plans that meet and agree to comply with the minimum requirements specified in the ACA.

Option 2: The Exchange would certify selected plans with the intent of improving quality and/or access to care in underserved areas or for underserved populations. Additional selection criteria

[2] As used in the ACA, "issuer" is a term that refers to any entity that issues coverage. Issuers include insurers—a term that refers specifically to organizations licensed to sell insurance.

might include the issuer's past performance on key quality measures, quality improvement activities, and/or enhancement of provider networks to serve new patients.

Option 3: The Exchange would certify selected plans with the intent of better managing the cost of health plans available through the Exchange. Additional selection criteria might include the reasonableness of the plan's premium and cost-sharing levels, past premium increases, and proposed rate increases.

The Role of the Exchange Board

The criteria for QHPs will shape the identity of the Exchange. The criteria chosen for 2014 will have a significant impact on the operations, sustainability and health plans offered through the Exchange. However, it is unlikely that standards determined for 2014 will be stagnant. Innovations in health care delivery (e.g., medical homes), payment methodologies (e.g., bundled or global payments), and networks (e.g., tiered networks, accountable care organizations) continue to strive for increases in efficiency, access, and quality to consumers. It is likely that to continue to offer the best value to consumers, the exchange will have to be nimble in adopting or incorporating such innovations to continue to drive towards maximum efficiency. These innovations can be incorporated in the exchange through the criteria for QHPs.

As a result, it is critical that the Exchange contribute a unique perspective and adjust to the changing private health insurance markets. To lead in this role, the Exchange Board of Directors (Board) will have to be intimately involved in addressing key issues, such as the criteria for QHPs within the guiding principles established by the Legislature.

The Board's expertise will allow it to evaluate and select Exchange plans. The Board is well positioned to compare Exchange offerings to the outside market and assess the tolerance of consumers and issuers for change necessary to drive longer-term goals of the Exchange.

This issue brief presents the following themes that the Legislature might choose to consider as guiding principles for the Board to choose criteria when selecting QHPs. These themes encompass the critical issues for plans and consumers as they consider purchasing health insurance coverage through the Exchange. This would provide a framework for the Board to maximize the effectiveness of the Exchange as a significant participant in the private health insurance marketplace.

Major Themes for Considering QHP Criteria

The following are major themes that should be considered when creating the criteria for qualified health plans.

Maximizing Plan Participation

To be successful, the Exchange will need to attract a wide range of plans to participate. Without plan variety, limited choice might make the Exchange less attractive to individuals and small businesses.

Limiting requirements on QHPs should maximize plan participation during initial implementation of the Exchange. An unrestricted approach will likely encourage plans that might otherwise interpret the Exchange as risky to compete in the Exchange. They will have to distinguish themselves from other plans to get consumers' business. This could result, however, in more choices for consumers.

Maximizing plan participation in the Exchange could likely increase the reach of provider networks throughout the state. Issuers could have more incentive to widen their networks if the Exchange does not place additional criteria on how issuers contract with health care providers. Expanding networks is one way for issuers to attract more enrollees and could help, to reach consumers in more rural areas of Washington.

Additionally, the thirteen criteria outlined in section 1301 of the ACA may be substantial enough to require QHPs to meet sufficient quality and access standards. Not adding additional criteria should help contain administrative costs for the Exchange and potentially for the Office of the Insurance Commissioner, who manages several of the functions related to offering plans in the state, such as rate review.

However, fewer criteria may not be considered beneficial for the Exchange if the goal is to raise the bar for innovation for participating plans. QHPs may excel under more criteria and maximize enrollment in under those additional criteria. It would be important during initial implementation, however, that a sufficient number of plans meet those higher standards to ensure a choice of affordable QHPs in the Exchange.

Because the Exchange, along with other insurance regulations created by ACA, creates a new marketplace in 2014, it remains to be seen how many carriers might participate in the Exchange. Without prior experience, it might be beneficial for the Exchange to use the minimum criteria for QHPs in 2014. This would maximize initial participation while allowing the Exchange to find its stride. After a robust Exchange has been established in the individual and small group markets, additional criteria for QHPs may benefit the Exchange to further its efforts to focus on quality, affordable care.

Maximizing Consumer Participation

Maximizing the number of consumers participating is a critical aspect of the Exchange since it must be self-sustaining by 2015 and a potential option for funding the Exchange is to charge a fee per-enrollee. A major goal of the Exchange must be to attract, and maintain, consumers.

When considering the criteria for QHPs, the Exchange will need to consider the services and factors that will attract consumers and retain enrollees. In order to enhance participation, it is important to determine the factors that are most important to individuals using the Exchange. Those factors may vary depending on the mix of consumers needed to sustain the Exchange. Consequently, a critical factor in determining criteria will be enrolling a mix of consumers into Exchange plans to diversify the risk and types of plans offered to consumers.

Low-Income Individuals. For consumers with incomes below 400 percent of the federal poverty level (FPL), the plans that are paired with the tax credits and cost-sharing subsidies will be

important and likely to attract a significant number of Exchange participants. The affordability of these plans may be a critical factor for people to use the tax credits and cost-sharing subsidies and the accompanying health plans.

If no additional criteria for QHPs are used, affordability will be left to traditional competition methods among the plans participating in the Exchange. If quality or access criteria are expanded, it might drive up the price of products, which might make the Exchange plans less affordable. However, if the criteria attempt to address the rising cost of premiums, this may make coverage more affordable for individuals, especially if paired with subsidies. This delicate balance between the administrative cost of implementing additional criteria, and their potential effectiveness, is important to issuers who want to offer an affordable health plan and individuals who, with help of subsidies, will be able to purchase health insurance.

Attracting low-income participants can create additional insurance challenges: generally low-income participants have poorer health than their higher income counterparts, particularly those who have not been insured previously. If the Exchange were to have a majority of low-income individuals with high health utilization, this could drive up the cost of premiums in the market. This makes attracting a diverse consumer mix a critical aspect of the Exchange.

Populations with Difficulties Accessing Care. While Exchange QHPs must meet network adequacy standards, HHS' proposed rules for QHPs do not enhance coverage for rural residents or individuals whose coverage options are limited for other reasons. While competition in the Exchange may naturally address the need for wider geographic plan areas, that outcome is not guaranteed and has not played out in the insurance market thus far.

Therefore, policy-makers might prefer to add criteria that increases access to care and maximizes the participation of hard-to-reach consumers. This could be addressed, for example, by encouraging additional primary care options or incentives to provide specialty mobile health units in provider networks, assuming these methods are proven to be effective.

QHPs could also be required to cover wider networks of providers to help address access issues and attract new individuals. Wider provider networks, however, may increase premiums. Providing ways to increase access to the Exchange in hard-to-reach areas may increase enrollment in the Exchange, but would have to be done in a way to not limit access to others by creating undue premium increases.

As is the case with low-income individuals, those in hard-to-reach areas who have not been previously insured are likely to have higher health care costs than those with regular access to care. Thus, it is important for the Exchange to simultaneously reach out to these groups, while continuing to attract consumers who will have regular access to health care.

Higher Income Individuals and Small Businesses. It will be more difficult to attract those not qualifying for low-income subsidies – higher income individuals and small business owners. One potential attraction may be the plans offered through the Exchange. All individuals, regardless of income, may look to the Exchange as a source of unbiased, reliable information. The issue is whether additional requirements on QHPs can translate to a positive impression of

the Exchange – enough to drive more people to purchase their health insurance through it. Important factors, such as a focus on health needs, engaging people in the purchase of health insurance, and isolating personal preferences should be considered when the Exchange determines how to meet the needs of consumers.

Price will likely be a driving factor in individuals' and small businesses' decision-making processes. Because similar products may be offered in the outside market, it will be crucial for the Exchange to offer competitive prices to entice these groups. They will also likely prefer a range of plan options to choose from, so choice of plans will be another important factor in attracting this needed group of consumers.

Maximizing the diversity of consumers participating in the Exchange should be an important factor considered in developing criteria. Small business, individuals, low and higher income families all have a range of preferences. The criteria cannot ignore their needs and expect to enroll a broad mix of enrollees.

Competitive Marketplace

Keeping a competitive marketplace in the Exchange is a crucial factor in the success of the Exchange – both competition within the Exchange and between the Exchange and the outside market. The Exchange must offer competitive choices compared to the outside market to attract individuals and small businesses. There are many factors that help define a competitive marketplace and many of them are based on consumers' behavior.

Quality. Additional criteria for QHPs that require them to meet higher quality standards may be an appealing option to separate the Exchange from the outside market. Setting quality criteria assures consumers that the Exchange establishes a higher bar for their health plans and therefore a higher level of care will be delivered from those plans in the Exchange. Because of the low-income subsidies coming in through the Exchange, substantial enrollment will likely be assumed in the Exchange. If this is the case, the higher quality standards may start a trend in the market and spread to other markets as well.

Higher quality standards on QHPs may also assist in requiring higher quality outcomes for providers. Plans may create incentives for those providers with whom they have contracts to ensure the highest outcomes are achieved. This may drive toward a more efficient system with better health outcomes for consumers and create competition among providers. The existing health care system is not administered in a way that currently rewards better health outcomes and cost-effective care. Improvement will likely be incremental and difficult to recognize – meaning the Exchange will likely need to adopt quality improvement as a long-term goal for cost containment.

On the other hand, quality criteria could inadvertently turn consumers away from the Exchange. If higher quality plans are not valued by individuals and small businesses, and instead they are more interested in traditional plan comparison methods, it could have an adverse effect on the Exchange. This could drive consumers to the outside market where they may experience lower prices and a more convenient atmosphere.

Additionally, higher quality criteria are not necessarily associated with lower costs and could potentially add additional costs to health plans because of the administration workload associated with collecting and reporting on quality measures. If additional criteria were used, it may be important to address efficiency and cost alongside quality measures. This could be done by providing incentives to issuers whose plans and providers meet or exceed quality measurement standards.

Traditional Competition among Plans. Without additional criteria, plans inside and outside of the Exchange would compete on aspects of plans that they feel would be most valuable to consumers. Because there will be a standard set of benefits within cost-sharing ranges in each plan inside the Exchange, plans will have to compete on other factors besides standard benefits.

This may include traditional avenues, such as additional benefits and slight differences in cost sharing. However, this may also drive more creative competition in areas such as customer service, disease management programs, and incentives for healthier living. This approach may create a competitive marketplace without additional standards, and may drive further participation in the Exchange. This, in turn, may also result in competitive premiums to also attract individuals to certain products.

Because of the low-income tax credits and cost-sharing reductions, there is likely to be natural competition among plans for that population, as they are a guaranteed source of premium dollars through the Exchange. Because of the volume of the individuals likely to qualify, many plan features will likely be aimed at this population. Plans will have to differentiate themselves in order to engage with this group.

Alternatively, if carriers are not given additional criteria, there may be a lack of creative competition for enrollment in the Exchange. Because there will be many enrollees who were previously uninsured, plans may want to avoid new competitive measures that may attract new enrollees with poorer health, thus creating a sicker risk pool.

There are many unknown factors with the Exchange, and carriers may be hesitant to engage without more information on enrollees. Given these factors, it might be better to initiate the Exchange with the minimal criteria for QHPs as laid out by the ACA. Traditional competitive methods will be used by the QHPs and the Exchange can determine whether that is an effective method for increasing competition among plans in a way that is beneficial for the Exchange. If, in later years, the Exchange moves toward more standards for QHPs, there is an opportunity to move toward more focused competition and an emphasis on a different approach to the Exchange.

Offering Meaningful Choice to Consumers

The Exchange should strive to offer a range of plans that meet the needs of consumers. The question then becomes, how much choice is too much? Is it possible to offer too much choice and what does that look like? Having a robust Exchange would mean many plans participating to meet the needs of many enrollees. If a robust Exchange can be developed from applying the federal QHP criteria, then the Exchange may have substantial plan choices which are also similar to options in the outside individual or small group market. On the other hand, if the criteria for

QHPs are further defined, meaningful choices may be created but also limited compared to the outside individual and small group markets.

It is important to note that in 2014, due to the new marketplace created by the Exchange, as well as insurance regulations that will go into effect at the same time as the Exchange, that the willingness to offer plans and the number of individuals and small businesses willing to initially participate in the Exchange is unknown. It is possible that there will be few issuers willing to participate, and therefore, the Exchange will have limited plan choices available. On the other hand, if there is a rush of plans to participate, there may be numerous choices.

Beyond discussing the number of plan choices, the definition of "meaningful choice" may vary among consumers. To some, meaningful choice is having the ability to choose a plan that covers a person's doctor and nearby hospital. For others, it may mean paying lower premiums and higher out-of-pocket costs. These choices will be available through the ACA standards for QHPs. However, if consumers are interested in added choice that goes beyond traditional factors, criteria would need to be established as part of the QHP certification program. For instance, if it is determined that requiring medical home assignments for all Exchange users was a criteria or that particular performance measures would be weighed against premium costs, this may constitute a more meaningful choice for some consumers when choosing their health plan.

The balance between a robust and functional marketplace and meaningful choices for consumers will be important factors in determining the criteria for QHPs. Without additional information about potential plan participation, it might be reasonable to consider limited or no additional QHP criteria in 2014. It is possible to increase the criteria as the Exchange settles into the new landscape to insert or modify criteria in later years. The Exchange could foster short-term and long-term success by starting with basic criteria and responding to consumer behavior to determine how to enhance them in the future.

Summary

Framing the process and specifying the criteria for the selection of qualified health plans is a key decision in the development of the Exchange. Balancing the needs of consumers and issuers will be a critical factor as the analysis of QHP criteria evolves.

Policymakers are aware that the selection of criteria must be considered in a new landscape where previous risks and opportunities might no longer hold true. A different set of unknowns will exist in 2014. Without a better understanding of the outcome of this process, the state may need to consider a phased-in approach that begins with the minimum requirements for QHPs. Under this scenario, the Exchange could become a sustainable organization and then potentially grow to take a leadership role in the Washington State health care market. Others might believe that the Exchange should pursue additional criteria to address different, more comprehensive goals.

No matter how someone perceives this decision, the selection of the QHP criteria will define the available coverage in the Exchange and help shape the role of the Exchange in the private health

insurance market. The Governor and Legislature will need to weigh these considerations as they consider this issue.

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Market Rules to Avoid Unstable Risk Pools

(Draft)

December 6, 2011

Final report anticipated in Spring 2012

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Washington State Market Rules to Avoid Unstable Risk Pools: An Analysis of Policy Options

Purpose of this Issue Brief

Beginning in 2014, tens of thousands of consumers will become insured through Washington State's Health Benefit Exchange (Exchange). Stable risk pools will help to offer these enrollees an affordable Exchange.

Enrolling individuals with a balance of high and low health care needs will help the Exchange to offer coverage in stable risk pools in the Exchange. If the Exchange does not maintain a balance, and enrolls too many individuals with high health care needs, then premiums will rise. Risk pools will become unstable and enrollees in the Exchange will have difficulty retaining affordable coverage.

The Affordable Care Act (ACA) designed ways to increase the availability of private health care coverage, maintain risk pools with a balanced mix of enrollees, and aid the creation of a health insurance market that competes on the basis of price, quality, service, and other innovative efforts. The purpose of this issue brief is to discuss whether Washington State needs to adopt regulations in addition to those in federal law to further stabilize risk pools inside the Exchange.

Definitions

There are four terms from the ACA that are relevant and help to clarify explanations in this issue brief.

Issuer: Issuers are otherwise referred to as: health insurance companies, insurers, managed care organizations, or carriers. An issuer is the company that issues a health insurance plan. The full definition of "health insurance issuer" is in subsection 2791 of Public Law 104-191.

Health plan: Plans are referred to as: the health policy, contract, or "the product." The health plan is the product that offers specific benefits, cost-sharing, provider networks, and coverage limits. A health plan can be offered by an issuer, and also offered by an employer or trust. The use of the term "health plan" is defined in subsection 1301 of the ACA.

Risk pool: All of the enrollees whose medical costs are combined for rating premiums form a risk pool. All enrollees in an individual plan offered by an issuer are said to be in the same risk pool. The same points hold true for enrollees in small group plans.

Grandfathered plan: A grandfathered plan is exempt from many of the ACA requirements on plans and must have been in existence prior to March 23, 2010. To keep their grandfathered status, they cannot make major changes to the plan. Once major changes are made, for example changes in benefits or cost-sharing, then the plan loses its grandfathered status and must comply with additional ACA health plan requirements.

Background: How Adverse Selection Makes Risk Pools Unstable

An increase in less healthy consumers can cause large premium increases and signal the beginning of an unstable risk pool. Healthier enrollees respond by disenrolling. These healthy enrollees typically find less expensive coverage, bringing more stability to the risk pools they join.

Because the value of their benefits still exceeds their premium, less healthy enrollees select to remain in the risk pool. Issuers increase premiums to cover costs; healthier enrollees again disenroll. The risk pool, consequently, has been "adversely selected" by too many unhealthy, high-cost enrollees, and is now unstable.

Extreme adverse selection leads to a spiral of escalating premiums and disenrollment that is difficult to stop. At its worst, adverse selection severely impacts one or a few issuers and can have unintended consequences. Entire markets can become destabilized and cause issuers to pull out of that market. The spillover from those markets can impact healthy markets in unforeseen ways.

Both enrollees and issuers have incentives that can make their risk pools unstable. The ACA recognized that enrollees have a financial incentive to become insured only when they are sick. The ACA also recognized that issuers have a financial incentive to avoid potentially high-cost enrollees. First, this brief will describe how the ACA responded to these adverse incentives with a set of policies that have become well known to the public and a set of "risk leveling" programs well known to industry experts. Then the issue brief will discuss if Washington State needs to consider any additional market rules that could reduce adverse selection and allow for the Exchange to offer plans in stable risk pools.

How the ACA Reverses Financial Incentives that Encourage Consumers Not to Enroll

Health care coverage is expensive, and consumers have a financial incentive to wait to enroll in insurance until they are sick and in need of services. Without coverage, people receive care and cannot afford to pay for it. As a result, premiums increase to cover the cost of this otherwise "uncompensated" care, and this has a destabilizing effect on risk pools as higher premiums price enrollees out of the market.

In 2014, the ACA will apply three new policies to reverse the financial incentive that encourages consumers to wait before signing up for coverage: (1) Issuers may no longer turn away applicants with costly medical conditions or make enrollees wait to receive coverage for a specific medical condition; (2) adults who can afford insurance under the "individual mandate" will face financial penalties if they do not enroll; and (3) federal subsidies will help people pay for private insurance. Because the Exchange would still be vulnerable to people waiting to enroll until they are sick, consumers will not be able to choose when to enter individual plans purchased in the Exchange. The Exchange's annual open enrollment period will give consumers a specific time within the year to enroll in an individual plan.

Concerns persist that the initial penalties for ignoring the individual mandate are too small. However, ever-increasing penalties and new policies that encourage enrollment remove many of the lingering financial incentives that might cause people to wait to enroll in coverage.

How the ACA Deals With Financial Incentives That Encourage Issuers to Avoid Unhealthy Populations

Issuers also face financial incentives that distort the type of consumers they enroll. These incentives encourage them to isolate less healthy populations in certain plans. The ACA addressed, but did not eliminate, this financial incentive. For example, the ACA requires issuers to determine premiums by

pooling together the total community of enrollees from their individual market plans. The same "community rating" requirement holds true for plans in the small group market.

Under the new community rating requirements, however, issuers still have the financial incentive to offer plans that steer clear of benefits that might attract unhealthy, high-cost enrollees. The ACA reduced the incentive to avoid certain benefits by establishing a set of "essential health benefits" that issuers must include in health plans offered inside and outside of the Exchange.

The ACA reduced some inappropriate financial incentives, but also opened up the Exchange to adverse selection. The ACA separates the individual and small group markets in the Exchange from the markets that currently cover individuals and small employer groups in the private health insurance market. Two markets, one inside of the Exchange and one outside of the Exchange, will now comprise the private health insurance markets for individuals and small employers. Whenever two markets serve the same consumers, one market will attract a less healthy segment of that population. The Exchange will likely attract enrollees with greater health care needs than their counterparts outside the Exchange for the following reasons:

- Low-income families can receive federal health care subsidies only through the Exchange and will likely be attracted to the Exchange's comprehensive coverage with minimal cost-sharing.
- Previously uninsured consumers, many of them low-income and without regular health care, will likely turn to the Exchange for coverage.
- Washington State covers people with high-cost medical conditions in two different high-risk pool plans. If either plan is disbanded, or the enrollees voluntarily leave a plan, they might turn predominantly to the Exchange for coverage.

The ACA also created incentives that might cause healthier populations to turn to the outside market for coverage. For example, "grandfathered plans" cannot be offered in the Exchange, and these plans can retain their higher cost-sharing levels when the ACA sets limits for cost-sharing in 2014. Issuers will find it difficult, however, to rely upon grandfathered plans to attract healthier consumers to the markets outside of the Exchange. New consumers in the individual market cannot enroll in grandfathered plans. New employees, however, can enroll in small group grandfathered plans. Of greater concern to issuers is losing a plan's grandfathered status, which ends if significant plan changes reduce benefits or increase costs to consumers. Consumers gain new protections, but lose the higher cost-sharing they might have preferred.

Issuers might also attract healthier enrollees by offering a greater variety of less comprehensive and catastrophic plans in the outside market. If the Exchange, however, offers a wide variety of plans, issuers might have limited means to offer an even greater variety of plans that could attract healthier consumers.

Refinements to community rating will reduce some of the adverse selection toward the Exchange. First, the ACA pulls together into the same risk pool an issuer's individual plans from the markets inside and outside of the Exchange. The same rating refinement will be applied to the small group market. Second, the ACA requires that issuers charge the same premium for the same plan offered both inside and outside of the Exchange.

The ACA, however, does not require issuers to offer plans in the Exchange. Yet, the potential to serve a new market might be attractive. Issuers, especially when entering a market that covers low-income consumers, will want to reduce the risk of becoming burdened with a disproportionate number of high-cost enrollees. To address these concerns, the ACA established three "risk-leveling" programs that are designed to help issuer's manage the expenses of covering high-cost populations.

Two of these programs are temporary. The first is a temporary reinsurance program for the state's individual plans offered inside and outside of the Exchange. The transitional reinsurance program shares the cost of covering extraordinarily high-cost enrollees in individual market plans. Reinsurance will help pay the unknown costs of thousands of previously uninsured consumers entering the private health insurance market.

The second is a temporary "risk corridor program." The risk corridor program applies to plans offered in the Exchange ("qualified health plans"). It is difficult to estimate the premium of a new plan, especially when it is introduced in a new market like the Exchange. The risk corridor program will help limit the losses and gains of those plans.

The ACA also implements a permanent risk adjustment program. This program applies to all individual and small group plans offered inside and outside of the Exchange. The goal of risk adjustment is to stop rewarding or penalizing issuers based on the risk of the population they enroll. This program will reimburse issuers that attract more risk. Issuers who enroll more consumers with medical conditions known to be expensive to treat, such as diabetes, will be compensated. The program requires issuers to compensate others when the risk of their enrolled population is lower than average.

It is unknown how well the risk-leveling programs will equitably redistribute risk among issuers. The three programs might not perform well enough in either the individual or small group markets to help persuade issuers to participate in the Exchange. Conversely, issuers in the Exchange will likely enroll a less-healthy, higher-cost population. Enrollees with greater health needs will be attracted to the Exchange by the subsidies and comprehensive coverage of plans required to offer minimal cost-sharing. The concern remains that some issuers could concentrate enrollment in the Exchange and the medical needs of their enrollees could increase premiums to the point where their risk pools become unstable.

Options for Potential Market Rules

The question for the remainder of this issue brief is whether the risk pools in the Exchange could become unstable unless Washington State establishes additional rules for the private individual and small group health insurance markets. Reducing adverse selection is a key ingredient to developing stable risk pools. The potential options discussed below, however, will not guarantee stable risk pools or a sustainable Exchange. Those results will rely upon many implementation and operational efforts.

The HCA is also taking into account that these options will likely be considered along with additional priority policy decisions, such as setting standards for plans offered in the Exchange, whether to retain a high risk pool, or opting for a federal Basic Health program (please refer to the policy briefs on these topics). Any decision on these additional priority policy decisions will not erase the incentives for adverse selection in the Exchange.

The potential options would not create a competitive advantage for any issuer based on the risk of the enrolled population. Rather, the options are designed to promote a mix of healthy and unhealthy enrollees in the markets both inside and outside of the Exchange.

The HCA recognizes the significance of drafting an issue brief that might lead to imposing new regulations on the private health insurance market. The intent of these options is to avoid establishing markets that are designed, from the beginning, to produce unstable risk pools:

A. Require an issuer participating in the individual or small group markets outside of the Exchange to offer at least one plan at the silver and gold levels.

The Exchange categorizes health plans into four levels: platinum, gold, silver, and bronze. Platinum plans are the most comprehensive, followed by gold then silver and bronze. (Issuers can also offer catastrophic plans for consumers under 30 years of age or who cannot afford coverage.) An issuer participating in the Exchange must offer at least one silver and one gold plan. This option calls for issuers in the market outside of the Exchange to participate in a similar fashion by requiring that they offer at least one plan that would fall within the silver and gold levels.

The intent of this option is to make it more difficult for issuers to avoid unhealthy consumers by only offering less comprehensive plans in the outside market. An issuer that offers less comprehensive plans (i.e., bronze/catastrophic plans) along with more comprehensive plans (i.e., gold plans) will likely enroll a population of healthy and unhealthy consumers in its risk pool. Additionally, this option provides an incentive that will help distribute the enrollment of unhealthy consumers between the Exchange and the outside market.

Directing an issuer to offer silver and gold plans in the outside market, however, might not compel unhealthy consumers to enroll in a plan outside of the Exchange. Unhealthy consumers might purchase silver and gold level plans predominantly in the Exchange because they need the federal subsidies. In that case, an issuer could decide not to participate in the Exchange, offer silver and gold plans in the outside market, and still enroll a relatively healthy population.

An unstable market could create uncertainty and confusion that extends beyond the borders of the Exchange. Rising premiums in the Exchange might disrupt the market as too many consumers transition to other markets or remain uninsured without a penalty. The unintended consequences of allowing a market to become adversely selected can be difficult to predict and contain. If the risk pools in the Exchange become unstable, then an issuer might decide to pull out of the entire individual and small group markets.

B. Permit an issuer to offer catastrophic or bronze-level plans in the outside market only when that issuer offers those *same* plans inside the Exchange.

Under this option, the only way an issuer could offer catastrophic or bronze-level plans in the outside market would be to offer the same catastrophic or bronze-level plans in the Exchange. Because of the standards laid out in the ACA, an issuer would also have to offer one silver and one gold plan in the Exchange under this option.

The intent of this option is to attract more issuers to the Exchange. The option addresses the concern that an issuer could remain out of the Exchange and concentrate on attracting healthy consumers by offering less comprehensive plans in the outside market.

This option provides an incentive for an issuer to participate in the Exchange. Only by participating in the Exchange can an issuer offer catastrophic and bronze-level plans in the outside market. Opportunities for issuers to compete over favorable risk would be diminished throughout the individual and small group markets, and they would have more incentive to compete on the basis of price, quality, service, and other innovative efforts. More issuers in the Exchange could also increase enrollment, drive down administrative expenses, and help achieve sustainability.

An issuer might not look favorably on an option that requires them to offer catastrophic, bronze, silver, and gold plans in the Exchange to permit the offering of a variety of less comprehensive plans in the outside market. An issuer might also resist having the criteria for qualified health plans apply to all catastrophic and bronze-level plans offered in the outside market.

Initially, staying out of the Exchange might depend largely on whether an issuer has grandfathered plans in its portfolio of individual and small group plans that provide less coverage than catastrophic or bronze-level plans. Grandfathered plans cannot retain their status indefinitely, and eventually, an issuer would have to decide to enter the Exchange so that it may offer less comprehensive plans in the outside market.

This option provides the framework for a more stable marketplace. An issuer would have to enter the Exchange so that it may offer less comprehensive plans in the outside market. This option could form a stable risk pool by distributing the enrollment of healthy and unhealthy consumers across the markets inside and outside of the Exchange.

C. Only an issuer that participates in the Exchange will be permitted to offer plans outside the Exchange.

Only an issuer selected to offer plans inside the Exchange can also offer individual and small group plans outside of the Exchange. The plans offered in the outside market would not have to be the same plans offered by the issuer inside the Exchange.

The intent of this option is to create a population of healthy and unhealthy consumers in an issuer's risk pool. This option achieves that intent by compelling an issuer to participate in the Exchange so that they will be permitted to participate in the outside market. By combining the less healthy enrollees of the Exchange with the healthier enrollees of the outside market, issuers can form stable risk pools that bridge the markets. This option could also increase the number of issuers participating in the Exchange.

Under this option, an issuer must offer silver and gold plans in the Exchange. Once in the Exchange, an issuer will have an incentive to offer catastrophic and bronze plans in the Exchange to attract healthier enrollees. This option could result in an issuer offering the same Exchange plans as under Option B. Also, similar to Option B, staying out of the Exchange might initially depend largely on whether an issuer has grandfathered plans in its portfolio of individual and small group plans.

This option does not favor participation from an issuer that wants to enroll a smaller pool of healthy consumers. It likely compels an issuer to offer plans that enroll a population of healthy and unhealthy consumers. Similar to Option B, opportunities for issuers to compete over favorable risk under this option could be diminished throughout the individual and small group markets. Issuers would then have more incentive to compete on the basis of price, quality, service, and other innovative efforts.

This option, however, imposes a greater requirement on issuers because they must participate in the Exchange to gain entry to the outside market. Accordingly, this option creates the possibility that issuers might opt to not participate in the Exchange and may consider pulling out of the individual and small group markets outside of the Exchange.

D. Require that health plans offered inside and outside of the Exchange must all meet the criteria for Qualified Health Plans.

Any health plan offered inside or outside of the Exchange in the individual or small group market would have to meet, at a minimum, the thirteen criteria for a qualified health plan required by the ACA (see issue brief on "Criteria for Qualified Health Plans).

This option establishes a minimum standard for offering plans. An issuer could still attempt to offer a greater variety of catastrophic or less comprehensive plans in the outside market. Those plans would now, however, have to meet the standards of a qualified health plan in the Exchange.

This option simplifies offerings in the market by creating a set of plans that adhere to a common standard. That common approach could provide transparency and support plan comparisons between the markets inside and outside of the Exchange.

This option creates a potential for increases in administrative workload for the Exchange and issuers. All of the plans, except grandfathered plans, would have to be developed, reviewed, and verified to meet the criteria for a qualified health plan. The Office of Insurance Commissioner and the Exchange would have a greater need to coordinate to make certain that these plans adhere to the same requirements.

The option would not require an issuer to participate in the Exchange. An issuer choosing to participate solely in the outside market would still have to offer plans that meet the criteria for qualified health plans but could limit plans offered to those below the silver and gold levels required by issuers participating in the Exchange.

It is not likely that the added transparency of this option will reduce adverse selection in the Exchange. The additional burden of the new requirements could nudge some issuers to consider pulling out of the individual and small group markets.

This option applies a new minimum standard, the criteria for selecting qualified health plans, to every plan in the individual and small group markets, which could raise the transparency and standards for plans offered in the market. This could also increase competition among plans on the basis of price, quality and service.

Summary

Policymakers have an incentive to reduce the kind of adverse selection that can lead to unstable risk pools in the private health insurance market. Separately or in combination, these options could help the Exchange avoid offering plans through unstable risk pools.

The options promote the enrollment of healthy and unhealthy populations through both the Exchange and outside markets, and could help to avoid the large premium increases and shedding of enrollees that occur when risk pools become unstable. Each option, to a different degree, imposes new requirements upon an issuer, and policymakers will likely want to consider how the market will respond. The following is a summary of the main points for each option.

Option A: Requiring issuers to offer gold and silver plans outside of the Exchange.

- Promotes a mix of healthy and unhealthy individuals inside and outside of the Exchange.
- Does not require issuers to offer plans in the Exchange.
- Modest burden on issuers.

Option B: Only catastrophic and bronze plans offered inside the Exchange can be offered outside of the Exchange.

- Promotes a mix of healthy and unhealthy individuals inside and outside of the Exchange.
- Encourages additional young, healthy individuals to participate in the Exchange.
- Requires issuers to offer gold, silver, along with bronze and/or catastrophic plans in the Exchange to be able to offer bronze and catastrophic plans in the individual and small group markets.
- Requires all bronze and catastrophic plans in the market to meet qualified health plan criteria.
- Promotes a more viable Exchange with more issuers and individuals participating.
- Adds considerable requirements for issuers that want to offer catastrophic and bronze plans in the individual or small group market.

Option C: To offer a plan in the individual and small group markets, issuers must participate in the Exchange.

- Promotes a mix of healthy and unhealthy individuals inside and outside of the Exchange.
- Requires issuers to offer at least gold and silver plans in the Exchange to participate in the outside markets.
- Promotes a more viable Exchange with more issuers and individuals participating.
- Adds considerable requirements for issuers in the individual and small group markets.

Option D: All plans offered inside and outside of the Exchange must meet qualified health plan criteria.

- Promotes uniform standards across all plans inside and outside of the Exchange.
- Increases transparency.
- Does not require plans to be offered in the Exchange.
- Adds administrative burden to issuers and necessitates additional coordination between the Office of Insurance Commissioner and the Exchange.

The options in the issue brief attempt to address the concern that issuers have an incentive to concentrate on offering less comprehensive plans to healthier enrollees in the outside market. Any option selected needs to reduce adverse selection and promote competition on the basis of price, quality, service, and other innovative efforts in the individual and small group markets.

Risk Leveling and the State's High Risk Pool

This report is scheduled to be released in Spring 2012

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Federal Basic Health Plan

December 22, 2011

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The Federal Basic Health Program: An Analysis of Options for Washington State

I. Introduction

The Patient Protection and Affordable Care Act (ACA) offers states the option to implement a Federal Basic Health Program to citizen adults with incomes between 134 and 200[1] percent of the Federal Poverty Level (FPL) ($15,000 to $21,800) and legally resident immigrants with incomes no greater than 133 percent FPL whose immigration status disqualifies them from Federally-matched Medicaid. The Federal government will give states 95 percent of what they would have spent on premium tax credits and cost-sharing reductions[2] to eligible individuals enrolled in standard health plans in the state if such eligible individuals had been enrolled in a qualified health plan through an Exchange.

The Federal Basic Health Program must include at least the Essential Health Benefits[3] under the ACA and consumers may not be charged more than what they would have paid in premiums in the Exchange. In addition, cost sharing must be no greater than a platinum plan (90 percent actuarial value)[4] for individuals with incomes less than 150 percent FPL or gold (80 percent actuarial value) for individuals with incomes between 150 and 200 percent FPL.

Per the ACA, states selecting to implement a Federal Basic Health Program would need to establish a competitive process for entering into contracts with plans, including negotiation of premiums and cost-sharing and negotiation of benefits in addition to Essential Health Benefits.[5] Contracts must be with a "managed care system" or a "system that offer(s) as many of the attributes of managed care as are feasible in its local health care market."[6] In addition, plans must report on selected performance measures[7] and must also maintain medical loss ratios of 85 percent or higher. The plans must also include care coordination and case management, incentives for preventive services, maximize patient involvement in health care decision-making and provide incentives for appropriate utilization of health care services.[8]

If states choose to implement a Federal Basic Health Program, eligible individuals cannot receive tax credits through the State's Health Benefit Exchange. According to the ACA, Health and Human Services will make a single payment to the State at the start of the fiscal year based on best available estimates and will make corrections (if the amount was too high or low) in the next year's payment.[9] Since the Federal government has not released its guidance on the Federal Basic Health Program, there remain many unanswered questions about how this payment to states will occur. For example, what estimates about enrollment will be used by the Federal government and if states incorrectly estimate the risk of this population, will they be responsible for under or overpayments?

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1 The ACA expands Medicaid eligibility to 133 percent of the federal poverty line. In addition, S2002(a)(14)(I)(i) adds a five percentage point income disregard which effectively increases Medicaid eligibility to 138 percent FPL. The increased Medicaid eligibility results in eligibility for a Federal Basic Health Program would begin at incomes greater than 138 percent FPL.

2 It is unclear whether the "95 percent" qualifier in ACA applies to the cost sharing subsidies as well as the premium tax credits.

3 Essential Health Benefits will be determined by HHS, guidance is expected in 2012.

4 Actuarial value is the ratio of benefit costs to allowed cost (i.e., the cost of covered services, prior to member cost-sharing). In other words, the actuarial value represents the portion of the total cost of covered benefits that are paid by a health insurance plan.

5 ACA S1331(c)(1)

6 ACA S1331(c)(2)(C)

7 ACA S1331(c)(2)(D)

8 ACA S1331(b)(2)(A)

9 ACA S1331(b)(3)(A)

Because Washington State already has a State Basic Health Plan in place that can be used as a platform from which to establish the Federal Basic Health Program, the considerations about whether or not to implement this option are somewhat different from other states.

This issue brief presents a background assessment of Washington State's current programs and eligibility and projections for the population eligible for the Federal Basic Health Program from 134 - 200 percent FPL. A financing and cost estimate for the Federal Basic Health Program is provided here as well as a discussion of the advantages and disadvantages of such a program in Washington State. Where appropriate, insights into the perspective of or the impact upon consumers, employers, insurers, and health care providers in the private and public health insurance markets are discussed. A framework for considering these issues and a recommendation for moving forward is also provided.

This issue brief discusses the following three options for Washington State:

> Option 1: Under this option, adults with income less than 134 percent FPL will be eligible for Medicaid, and a standalone Federal Basic Health Program will be established for adults 134 - 200 percent FPL. Children and pregnant women will remain eligible for Apple Health and Medicaid, respectively. Adults with incomes above 200 percent to 400 percent FPL will be eligible for premium tax credits and cost-sharing subsidies in the Exchange.
>
> Option 2: Under this option, adults between 0 - 200 percent FPL will be eligible for coverage through a rebranded Medicaid + Federal Basic Health Program. This new re-branded low-income program will have consistent plans and benefits across income groups but different risk pools. Children and pregnant women would be included in this re-branded program but their cost sharing and benefits would remain unchanged from Apple Health and Medicaid, respectively.
>
> Option 3: Adults with income less than 134 percent FPL will be eligible for Medicaid, and premium tax credits and cost-sharing subsidies will be available in the Exchange for adults 134 - 400 percent FPL (Essential Health Benefits). Children and pregnant women will remain eligible for Apple Health and Medicaid, respectively.

It is important to note that this brief is preliminary in nature because the Federal government has not yet released its guidance for states on the establishment of a Federal Basic Health Program. Nonetheless, it is still important to consider a framework for thinking about these issues now as the timeframe for implementation is very ambitious. If Washington State policymakers were to decide to implement a Federal Basic Health program by January 1, 2014, work would need to be underway by the beginning of 2012.

II. Background

Access to health care for disadvantaged citizens has long been a policy concern among Washington State policymakers. Washington State also has had a relatively long history of support for the use of managed care to control health care expenditures. These two interests came together with the development of the State's Basic Health Plan established in 1987. The legislation creating the State Basic Health Plan also included expansion of Medicaid eligibility, expansion of a State-funded prenatal care program, and creation of a high-risk pool, the Washington State Health Insurance Pool (WSHIP) for the uninsurable. In addition, Washington State children up to 300 percent FPL are

eligible for subsidized coverage regardless of their citizenship status through the State's Apple Health program. Together, these programs comprise the patchwork of access programs in Washington State before the implementation of the ACA.

Table 1 presents Washington State eligibility for public programs before and after the ACA's implementation. In addition, several smaller programs are not listed in Table 1. Washington State implemented the Federal temporary high-risk pool for people who have been uninsured for six months or more and who have a pre-existing condition (PCIP-WA). A Health Insurance Partnership (HIP) program, which subsidizes low-income employees (less than 200 percent FPL) who work for small employers (fewer than 50), and a newly launched unsubsidized program called Washington Health, which provides a limited benefits plan for low-income individuals were also established.

Although Washington State has had a history of innovative coverage programs, the State has been hard hit by the most recent recession and consistent funding for these programs has been difficult to sustain. The 2011 Supplemental Budget reduced the State Basic Health Plan's funding and limited eligibility guidelines. Effective January 4, 2011, the state received a CMS 1115 Medicaid Demonstration Waiver that provided federal matching funds for only those Basic Health enrollees who were determined to be Transition Eligible under the waiver or who are foster parents licensed under chapter 74.15 RCW. Thus, people with incomes above 133 percent FPL and/or without legal residence in Washington State were terminated from the program. The State disenrolled approximately 17,000 members from the State Basic Health Plan effective March 1, 2011 and transitioned about 1,700 children to Apple Health effective April 1, 2011. In addition, the HIP program recently closed its doors to new membership due to the termination of Federal funds.

Table 1: Approximate Eligibility for Washington State Health Insurance Programs for <u>Non-Disabled</u> People < 65, Pre and Post ACA Implementation

Eligibility Group	Current Eligibility	ACA Eligibility
Citizen or legally present non-citizen adults, no children	Countable income[10]: < 133% FPL and not categorically eligible for Medicaid – State Basic Health Plan (capped enrollment) Legally present non-citizens must serve 5-year wait period.	Countable income: <134% FPL - Medicaid 134-200% FPL - Federal Basic Health Program or Exchange with subsidies 200-400% FPL- Exchange with subsidies Legally present non-citizens can be in a federally-subsidized program like the Exchange while serving 5-year wait period.
Citizen or legally present non-citizen adults with children	Countable income: < 75% FPL – Medicaid 75%-133% FPL – State Basic Health Plan Legally present non-citizens must serve 5-year wait period for Medicaid.	Countable income: <134% FPL - Medicaid 134-200% FPL- Federal Basic Health Program or Exchange with subsidies 200-400% FPL- Exchange with subsidies Legally present non-citizens can be in a federally-subsidized program like the

[10] Countable income has a different meaning under the ACA (i.e. MAGI) than under the traditional Medicaid standard.

		Exchange while serving 5-year wait period.
Pregnant Women	Countable income: < 185% FPL Medicaid >185% FPL Medically Needy 185-200% FPL – State Basic Health Plan	Countable income: <185% FPL - Medicaid 185-200% FPL – Federal Basic Health Program or Exchange with subsidies 200-400% FPL - Exchange with subsidies
Children	Countable income: < 300% Apple Health (above 200% FPL maximum $30 per child, $60 per family per month)	Countable income: <300% FPL – Apple Health 300-400% FPL – Exchange with subsidies

The current State Basic Health Plan in Washington is similar in its broad framework to the Federal Basic Health Program outlined in the ACA. That comes as no surprise since Senator Cantwell and her staff were involved in drafting that section of the law. However, there are some distinct differences in the two plans that are discussed below and highlighted in Table 2.

Eligibility

Eligibility for Washington's Basic Health Plan is currently limited to Washington State resident adults under 134 percent FPL (plus pregnant women when eligible) due to requirements limiting eligibility in order to receive federal matching funds. The Federal Basic Health Program is for citizens and federally-qualified immigrant adults with incomes between 134 and 200 percent FPL and non-qualified but lawfully present immigrants with incomes below 133 percent FPL whose immigration status disqualifies them from Federally-matched Medicaid. Washington's State Basic Health Plan was, however, originally designed for people up to 200 percent FPL and only recently was pared back due to a new eligibility requirement, as part of the federal waiver, and budget shortfalls.

Premiums and Cost Sharing

Premiums for Washington's Basic Health Plan are based on income, age, county of residence, and product choice,[11] whereas the premiums for the Federal Basic Health Program vary by income only. Prior to the recent cutbacks, the range of premiums for people with incomes between 134 and 200 percent FPL was $71.08-$155.49/month in Washington's Basic Health Plan while the maximum premiums allowed in the Federal Basic Health Program are somewhat lower ranging from $37.02 - $116.05 (the expected participant premiums in the Exchange are the maximum allowed in the Federal Basic Health Program).

The State's Basic Health Plan includes incentives for appropriate utilization of health care services with a deductible of $250 and 20 percent co-insurance for some services. Some services require modest co-payments instead of the co-insurance, as noted in the table below, and out-of-pocket costs

[11] Currently there is no distinction in premiums by plan type but managed care organizations are allowed to offer plans at a higher rate than the negotiated premium and the subscriber who enrolls in those plans pays the additional premium.

(OOP) are capped at $1500. Generic prescriptions are $10 and name- brand prescriptions require 50 percent cost sharing. Cost sharing in the Federal Basic Health Program is dependent on income with cost sharing equal or less than that required of a platinum plan in the Exchange for people between 134 - 150 percent FPL and of a gold plan for people with incomes between 151 - 200 percent FPL. The cost-sharing features and amounts will be determined by the qualified health plans but could include a mix of deductibles, co-payments, and coinsurance. OOP costs are capped at $1983 for both income groups. Examples of possible cost sharing for these plans can be found in Table 2.

Table 2: Comparison of Washington's State Basic Health Plan and the Federal Basic Health Program

Feature	**Washington Basic Health Plan**[12]	**Federal Basic Health Program**
Income Eligibility	< 200% FPL (enrollment capped at 84,000)	134-200% FPL (not eligible if access to affordable employer plan meeting coverage minimums)
Participant Premium	Based on income, age, and insurance product: Between 133-149% FPL - $71.08 - $88.85 Between 150-200% FPL - $108.85 - $155.49	Premiums can be no greater than what eligible individuals would have paid in the Exchange and are based on % of income only: Between 134-149% FPL- $37.02-$54.89 Between 150-200% FPL – $55.63 - $116.05
Participant Cost sharing	Deductible of $250, No co-payments for preventive services or maternity care. $15 co-payment for office visits, $100 co-payment for emergency room visits, $10 copayment for generic Rx and 50% co-payment for brand-name Rx in formulary, 20% coinsurance (inpatient capped at $300) for other services. OOP capped at $1500	Cost sharing must be equal or less than that required of a platinum plan in the Exchange (134-150% FPL) or gold plan (151-200%FPL). OOP capped at $1983. According to one source[13] a sample platinum plan would not have a deductible but would include $20 office visit co-payments, $250 co-payment for inpatient stays and Rx co-payments of $10/$24/$45. A gold plan could include a modest deductible of $250, $15 co-payments, 25% of Rx costs and 10% of other costs.
Funding	Fully state funded until 2010. ACA provided opportunity for federal/state shared funding for citizens with incomes <133% FPL.	State will receive 95% of (second lowest cost silver plan premium + cost sharing subsidies)

[12] In order to show a comparison of program eligibility, benefits and cost sharing are displayed with descriptions prior to 2011 cutbacks
[13] Peterson, C. Setting and Valuing Health Insurance Benefits, Congressional Research Service, April 6, 2009.

Enrollment	Capped at 84,000, 74% were below 133% FPL (before cutbacks) and will be offered Medicaid in 2014.	Unlimited, as many as 398,000[14] estimated between 134-200% FPL
Benefits	Similar to Medicaid but no vision or dental	Essential Health Benefits [15]
Plan Choice	Currently choice of 4 Managed Care plans (not offered in every county): Molina, Community Health Plan of WA, Group Health Cooperative and Columbia United Providers.	Managed Care, at least 2 plan choices, if possible
Provider Reimbursement	Similar to Medicaid rates (enhanced when necessary to ensure access to particular providers)	To be determined

III. Description of Implementation Options Under Consideration

This brief considers three policy options for implementing the ACA to low-income populations up to 200 percent FPL in Washington State. It is important to understand that the options presented here are only part of a wider range of options that could be considered for the Federal Basic Health Program. There are a number of interchangeable elements from each option that can be combined in any number of ways. However, it was necessary to define the specific options being considered here so that cost estimates and advantages and disadvantages across options could be made. Below is a brief summary of each option.

Option 1: This option would establish a Federal Basic Health Program for citizen adults between 134 and 200 percent FPL who are not income or categorically eligible for Medicaid, as well as for legally resident adults with incomes no greater than 133 percent FPL who are not eligible for Medicaid. Children below 300 percent FPL and pregnant women below 185 percent FPL remain eligible for Apple Health and Medicaid, respectively. The eligibility process will be streamlined via the new eligibility system, making transitions across programs easier. The goal of this option would be to establish a Federal Basic Health Program so that the plans, providers, and program benefits for enrollees would be similar to the Medicaid expansion and Apple Health. As part of implementing the Federal Basic Health Program option, no changes to Apple Health or Medicaid benefits or cost sharing would be made. Premiums and cost-sharing responsibilities would be established on a sliding scale in the Federal Basic Health Program so that transitions to/from Medicaid and to/from the Exchange would be smoother than what is envisioned if people transitioned from Medicaid programs to the Exchange. Plan procurement and provider reimbursement for the Federal Basic Health Program also would be coordinated with Medicaid and Apple Health, although premium and provider rates for each of the programs could be different under this option.

[14] Planning Washington's Health Benefit Exchange: The potential impact of three key decisions, January 27, 2011, Milliman Client Report

[15] States are required to include Essential Health Benefits but are permitted to include other benefits important to this low-income population

This option is similar to the model implemented in Massachusetts under its 2006 reform. While Commonwealth Care (the subsidized program within the Massachusetts Connector Authority) shares an eligibility portal with the Medicaid agency, procurement of plans, enrollment, and customer service are all separate functions operating within the Connector.

Option 2: This option would establish a Federal Basic Health Program as a newly branded program for all low-income legally resident individuals 0 - 200 percent FPL. This rebranded program would include children and pregnant women although their benefits and cost sharing would remain at current levels. In this new program, plan procurement would be done jointly for Medicaid, Apple Health, and the Federal Basic Health Program. Plan and provider rates would be synchronized as much as feasible and allowed by the Federal government as would benefits and cost sharing. Importantly, from the consumer's perspective, everyone up to 200 percent FPL would apply for a single program and would have the same choice of health plan. The risk pool of the Federal Basic Health program enrollees would remain separate from Medicaid and Apple Health

Option 3: This option would not establish a Federal Basic Health Program and would instead assume Medicaid coverage for adults under 134 percent FPL (pregnant women up to 185 percent FPL), Apple Health coverage for children up to 300 percent FPL (below the CHIP cap) and premium tax credits and cost-sharing subsidies in the Exchange for adults 134 - 400 percent FPL (Essential Health Benefits) and children and pregnant women not eligible for Apple Health and Medicaid, respectively. The goal of this option would be to retain coverage for current populations and to enroll new populations into private coverage via the Exchange. Options for smoothing transitions between current public programs and the Exchange are discussed below.

IV. Policy Discussion

There are a number of issues to consider regarding the options described above. This brief will discuss some of the key issues and challenges with each of the options within the following broad categories: 1) coordination with Medicaid and the Exchange; 2) cost comparison; 3) administration issues; 4) health benefit exchange and provider issues; and 5) issues for beneficiaries.

1) Coordination with Medicaid and Exchange

The ACA requires states choosing to establish a Federal Basic Health Program to coordinate the administration of and provision of benefits across its Federal Basic Health, Medicaid, and CHIP programs to maximize the efficiency for such programs and improve continuity of care.[16] Continuity of care is dependent upon continuity of coverage and leads to better health care for most people. Retention of coverage permits continuous relationships between patients and their health care providers and is a fundamental characteristic of "patient-centered medical homes." People experiencing coverage gaps of any length face substantial barriers to accessing affordable, quality care and disruptions in coverage are associated with the underuse of preventive care. [17] [18]

[16] S. 1331(c) (4)
[17] Rosenbach, M et al. National Evaluation of the State Children's Health Insurance Program: A Decade of Expanding Coverage and Improving Access. Mathematica Policy Research, Inc. 2007
[18] Shoer, PF. et al. Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem. Commonwealth Fund, pub no. 288. November 2003.

There are a number of reasons why people transition off and on to public programs and experience disruptions in coverage, including income fluctuations, changes in employment, inability to pay premiums, and failure to return paperwork or other necessary documentation. An important issue regarding the policy options under consideration is how, and to what extent, each policy option could be implemented to mitigate coverage discontinuities and churn particularly associated with changes in income.

Not all movement on and off of public programs should be considered churning and therefore a "problem;" some enrollment and disenrollment is a natural consequence of a program where eligibility is based on income. Ensuring that only people eligible for the programs are enrolled is an important component of a program's integrity, demonstrating appropriate use of State and Federal tax dollars. However, to the extent possible, reducing unnecessary churning can reduce administrative costs and improve the health of enrolled populations.

This issue may be partially addressed by implementing a Federal Basic Health Program, as Washington State could establish the program ensuring similar provider networks, benefits, and cost sharing for the 134-200 percent FPL income group as Medicaid.[19] Although such a strategy addresses transitions due to income fluctuations up to 200 percent FPL, it may create more difficulties for transitions between the Federal Basic Health Program and the Exchange when incomes increase above 200 percent FPL. There are a few specific questions to consider here:

1) Where does most of the income fluctuation In Washington State occur?
2) Could the Federal Basic Health Program be established in a manner that addresses income fluctuations and transitions between it and the Exchange?
3) Are there other options for mitigating the potential harm of income fluctuations and transitions between Medicaid and the Exchange?

While Washington-specific data have not been analyzed for this brief, two recent studies assessing income fluctuations and public program eligibility using national data provide some empirical data that can help policymakers better understand this issue. A study using national survey data found that nearly 40 percent of adults experienced a change in income that would have resulted in a disruption in Medicaid eligibility within the first six months of enrollment.[20] In this study, people with incomes at the Medicaid-Exchange income divide (between 100-150 percent FPL) were more likely to experience income fluctuations when compared both with people with incomes below poverty, or above 150 percent FPL. Importantly, this study did not assess fluctuations that would occur specifically in a Basic Health program. A more recent study, using national longitudinal income and health insurance data from the U.S. Census Bureau, found that: "operating separate BH, Medicaid, and Exchange programs substantially increases churning."[21] This study also found greater churning overall under an integrated program similar to that proposed under Option 2 (compared to Option 3).

If a Federal Basic Health Program were to be established in Washington State, it would be helpful if it also could be designed to provide a smooth transition between it and the Exchange. The ACA did consider these transitions and the Department of Health and Human Services (HHS) continues to provide guidance to states on how to streamline the eligibility process for these programs. For

[19] Dorn, S; The Basic Health Program Option under Federal Health Reform: Issues for Consumers and States. March 2011.
[20] Sommers, B. and Rosenbaum, S. Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges; Health Affairs, 30:2, February 2011
[21] Graves, J.A., Curtis, R, and Gruber, J.; N Engl J Med 2011; 365:e44 December 15, 2011.

example, recent guidance from HHS confirmed that Modified Adjusted Gross Income (MAGI) will be used as the unified income guideline to ensure a system of streamlined and coordinated eligibility and enrollment through which an individual may apply for enrollment in a Qualified Health Plan (QHP) in the Exchange or any insurance affordability programs (including CHIP, Medicaid, and the Federal Basic Health Program).[22] These guidelines also require the Exchange to be the entity that determines all eligibility.

It seems very important that no matter which option Washington State policymakers choose, they will need to consider the alignment of markets and provider networks across all insurance affordability programs. Washington State has begun to make progress towards this goal through its Joint Procurement Project. This seems to be the most critical element for continuity and quality of care for individuals and their families as income changes. Ideally, at least some of the same plans with the same provider networks would participate in the Exchange, CHIP and Medicaid markets whether a Federal Basic Health Program were established or not. This is not only important for transitions between programs but may allow families to be enrolled in the same plans in situations where program eligibility differs. Because program eligibility is different for children and adults, having the same plans available across all insurance affordability programs will allow families to stay together on the same plan. While it may not be possible or desirable to ensure that all of the plans are participating in all of the markets, if there are at least a few plans that cross all markets, continuity of care can be improved for populations susceptible to income volatility.

A number of strategies also could be employed under any of the options to mitigate the problems associated with frequent fluctuations in income. In addition to ensuring an alignment of markets and provider networks, Washington State could consider establishing a minimum guaranteed eligibility period with annual redeterminations ensuring a person has continuity of coverage for at least a year. Washington State also could require enrollment in plans through the Exchange to be retroactive to the date of first eligibility for people transitioning from Medicaid, or extend Medicaid coverage until Exchange coverage takes effect. Insuring that beneficiaries have appropriate support for transitions and that these transitions are as seamless as possible for beneficiaries is extremely important.

Navigators also could help educate people who have income that suggests future fluctuations to consider plans that are available across all programs. While establishing a Federal Basic Health Program may seem like the ideal choice to address the issue of coordination among insurance affordability programs, the ACA envisions more coordinated coverage no matter which option a state chooses.

2) Cost Comparison

One of the more fundamental questions for Washington State policymakers to consider is whether the funding the State will receive from the Federal government will be sufficient to cover beneficiaries in a Federal Basic Health Program. Although some national estimates exist, they are not based on Washington-specific data. This section will provide estimates both for the revenues that will be provided to the State and the cost of running the program using Washington-specific data. The analysis that follows includes a number of steps, each of which will be described in some detail. In addition, a number of assumptions are made which will be noted when appropriate.

[22] 45 CFR Parts 155 and 157{CMS-9974-P} RIN 0938-AR25

Step 1. Estimating the number of participants

To determine revenue and cost estimates for the Federal Basic Health program it is important to understand who could be enrolling in the program. A recent report estimated that as many as 398,000 Washington State residents were income eligible for the Federal Basic Health Program. However, once access to employer-sponsored coverage and take-up was taken into account, the estimate ranged from 80,000 – 140,000.[23] Another recent estimate found 104,266 would be potentially eligible in the State.[24] For the analysis that follows, people uninsured, per the 2010 Washington State household survey, who are income-eligible for a Federal Basic Health Program under the ACA, are included as shown in Table 3 below. Because this estimate does not take into account access to affordable employer-sponsored health insurance or changes in employers' offer of insurance, the actual number may be smaller or larger.

Table 3: Washington State's Population Potentially Eligible for the Federal Basic Health Program by Income

Income Range	Uninsured
134%-150% [25]FPL	37,438
150% - 200%[26] FPL	96,229
Total	133,667

Step 2: Assessing ACA Provisions for Premium Tax Credits in the Exchange

Table 4 displays the ACA requirements by income of people receiving premium tax credits and cost-sharing subsidies in the Exchange. For each income group there is a range of premiums. For people with incomes between 134-150 percent FPL, the range is between 3 and 4 percent of income or participant premiums ranging from $37.02 -$54.89. For people with incomes between 151 and 200 percent FPL, the range is between 4 and 6 percent of income or participant premiums range from $55.63 to $116.05. There is also an OOP maximum of $1983 for people under 200 percent FPL.

[23] Planning Washington's Health Benefit Exchange: The potential impact of three key decisions, January 27, 2011, Milliman Client Report
[24] Estimate from Stan Dorn's draft report
[25] For Basic Health Plan enrollment and disenrollment this category is 140-154% FPL
[26] For Basic Health Plan enrollment and disenrollment this category is 155-200%FPL

Table 4: ACA Provisions for Premiums, Actuarial Value and OOP Maximums in the Exchange

Income Range	Premium Range	Est. Income	Est. Premium % of income	[monthly] Income (1 Person)	[monthly] Participant Premium	AV	OOP Max
134-150%	3-4%	134%	3.00%	$1,234.14	**$37.02**	94%	$1,983
134-150%	3-4%	142.5%	3.50%	$1,312.43	**$45.93**	94%	$1,983
134-150%	3-4%	149.0%	4.00%	$1,372.29	**$54.89**	94%	$1,983
151-200%	4-6.3%	151.0%	4.00%	$1,390.71	**$55.63**	87%	$1,983
151-200%	4-6.3%	175%	5.15%	$1,611.75	**$83.01**	87%	$1,983
151-200%	4-6.3%	200%	6.30%	$1,842.00	**$116.05**	87%	$1,983

Note: AV = actuarial rate, OOP = Out-of-pocket maximum

Step 3: Estimating Private Market Premiums for the Second Lowest Cost Silver Plan in the Exchange

It is necessary to estimate the premium of the second-lowest cost silver plan in the Exchange to determine how much revenue Washington State will receive from the Federal government for people enrolled in the Federal Basic Health Program. States will receive 95 percent of the premium tax credits and cost-sharing subsidies that people would have otherwise received had they purchased coverage through the Exchange. Guidance from the Federal government regarding the definition of Essential Health Benefits and actuarial requirements has not yet been released and therefore this part of the analysis will need to be revisited at a later date.

Two strategies for estimating the second lowest cost silver plan premium are used here. The first estimate begins with a base premium from the current State's Basic Health Plan and the second estimate begins with a base premium from the current average premium in the individual market. Each of these approaches makes numerous assumptions. Because this part of the analysis is critical, it was decided to use two different methods for deriving the silver premium from which Federal revenues will be based.

Method 1: Starting with the Basic Health Plan Premium

Using the premium from Washington's State Basic Health Plan as a baseline is reasonable since the population served by the State's Basic Health Plan will be similar to the one served by the Federal Basic Health program (i.e. low income without access to employer-sponsored insurance). Accounting for differences in health status among populations and the affect on premiums is a difficult task. By using State Basic Health premiums as a baseline, it is not as important to adjust the premiums for health status differences.

However, the following adjustments will need to be made to account for differences in premium between the State's Basic Health Plan and a silver plan in the Exchange.

1) Carrier administrative costs: The current State Basic Health Plan's administrative costs are assumed to be lower than what would be expected in a commercial plan in the Exchange. For this analysis, it is estimated that the difference in administrative load between the State

Basic Health Plan and a commercial plan in the Exchange is 5% (State Basic Health Plan has an estimated administrative load of 10 percent while commercial loads are estimated to be 15 percent).[27]

2) Provider rates: Provider rates are lower in plans contracting for services for State Basic Health Plan beneficiaries versus the privately insured. For this analysis, an adjustment of 25 percent is added to claims cost to account for these differences in provider rates.[28]
3) Actuarial value: It is assumed that the actuarial value of the State Basic Health Plan is richer than a future silver plan in the Exchange. The State Basic Health Plan is estimated to have an actuarial value of between 78 – 80 percent so a small decrease in the premium is made to account for differences in actuarial value. (Silver plans will have actuarial values of 70%)

In addition to the above adjustments, several other assumptions are made in this analysis. First, the benefits covered by the existing State's Basic Health Plan are similar to what would be covered by a silver plan in the Exchange in 2014. In addition, premiums are not inflated from their 2011 base for any of the calculations presented here.

The most recent data available from the Washington Health Care Authority (HCA) notes that premiums in the State's Basic Health Plan program are $251.99/month for the period January – June 2011. Taking the baseline premium and rounding up to $252/month, of which 10 percent is assumed to be carrier administrative costs, a claims premium of $227/month is determined. This premium is increased by 25 percent (to account for provider rate differences) to arrive at a claims premium of $284. Out-of-pocket cost sharing is then estimated at $71 for a plan with an actuarial value of 80 percent. The premium is then adjusted down to account for the difference in actuarial values (from 80% to 70%) and administrative costs of 15 percent are added back in. The final premium derived by this method is $285.52/month or $3426/year**.**

This is somewhat higher than the $231/month Washington State average individual market premium for 2011.[29] However, there are several explanations for this difference. First, the actuarial value of the current average individual plan is likely lower than a silver-level plan. Second, the health status of people currently enrolled in the individual market is better than the health status of people enrolled in the State's Basic Health Plan.

Method 2: Starting with the Individual Market Premium

The individual market premium is also used as the baseline to estimate the value of a silver plan in the Exchange. The following adjustments will need to be made to account for differences between the average individual plan premium and a silver plan in the Exchange.

1) Health Status Adjustment: Milliman recently reported that the average healthcare expenditure index for people purchasing individual coverage was .79 compared to 1.03 for the uninsured.[30] Since both populations will be enrolling in silver plans in the Exchange, some average of these two populations must be used here. The current individual plan premium is adjusted up by a factor of 15 percent to adjust for an estimated sicker population enrolling in coverage in 2014 versus now.

[27] Conversations with Washington HCA staff.
[28] Ibid.
[29] Mapping Premium Variation in the Individual Market, Kaiser Family Foundation issue brief, August 2011.
[30] Milliman Client Report. Planning Washington's Health Benefit Exchange: The potential impact of three key decisions. January 27, 2011

2) Actuarial Value: It is assumed that the actuarial value of an average individual plan in Washington State is closer to a bronze level plan (60%) so a small adjustment is made to increase the premium reflecting this difference in actuarial value.

Beginning with a premium of $231, administrative costs of 15 percent are subtracted to arrive at a claims premium of $196.35. An increase of 15 percent is made to adjust for health status. The actuarial value is adjusted and then administrative costs of 15 percent are added back to arrive at a monthly premium of $302.95/month or $3635.40/year. No adjustments to benefits (from existing benefits) or annual inflation are accounted for.

The two estimates presented above both contain numerous assumptions but both arrive at similar premiums for a silver plan in the Exchange of $285.52 - $302.95. As guidance from the Federal government becomes available, in particular regarding the definition of Essential Health Benefits, these analyses may need to be revisited.

Step 4: Estimate Cost-Sharing Subsidies

It is somewhat unclear from the ACA language whether states will receive 95 or 100 percent of the cost-sharing subsidy amount; for this analysis 95 percent is used. To calculate the amount of cost-sharing subsidy Washington State will receive from the Federal government in lieu of people receiving cost-sharing subsidies in the Exchange, the average amount of cost sharing in a typical silver plan is first estimated. The average cost sharing in a silver plan with an actuarial value of 70 percent is estimated here to be 30 percent of the current claims cost. The ACA requires that cost sharing be reduced for people with incomes between 134 and 150 percent to a platinum plan (94% actuarial value) and to a gold plan (87% actuarial value) for people with incomes between 151 and 200 percent FPL. It is therefore estimated that annual cost-sharing reductions to out-of-pocket costs are approximately $798/year for people under 151 percent FPL and $558/year for people between 151-200 percent FPL for the estimate beginning with State Basic Health Plan premiums. ($873/year and $618/year for the estimate beginning with individual plan premiums).

Tables 5a and 5b provide a summary of the estimated total revenue that would be provided to Washington State per person enrolled in a Federal Basic Health Program based on the two methods for calculating a silver-level premium. It is clear from these tables that as the income of the enrollee increases, the amount of revenue provided by the Federal government decreases. The estimated revenue amounts provided in Tables 6a and 6b do not account for the age of the enrollees. Premiums also will vary based on the age of the enrollee, and so will the revenue provided by the Federal government. Thus, it is important to not only consider the average income of the population but also the age of the population expected to enroll in the Federal Basic Health Program, when assessing the overall revenue that will be available.

Table 5a: Estimated Premium and Cost Sharing Revenue/Month for People Enrolled in a Federal Basic Health Program -- Starting with the Basic Health Plan Premium

Point estimate Income %FPL	Participant Premium	Premium for Silver plan[31]	Premium Subsidy	Cost Sharing Subsidy	Total Monthly Subsidy @100%	Total Monthly Subsidy @95%
	(a)	(b)	(b – a)	d	(b – a) + d	.95 (b – a) + d
138%	**$37.02**	$285.52	$248.50	$66.53	$315.03	**$299.28**
142.5%	**$45.93**	$285.52	$239.59	$66.53	$306.12	**$290.81**
149%	**$54.89**	$285.52	$230.63	$66.53	$297.16	**$282.30**
151%	**$55.63**	$285.52	$229.89	$46.54	$276.43	**$262.61**
175%	**$83.01**	$285.52	$202.51	$46.54	$249.05	**$236.60**
200%	**$116.05**	$285.52	$169.47	$46.54	$216.01	**$205.21**

Table 5b: Estimated Premium and Cost Sharing Revenue/Month for People Enrolled in a Federal Basic Health Program – Starting with the Individual Market Premium

Point estimate Income %FPL	Participant Premium	Premium for Silver plan[32]	Premium Subsidy	Cost Sharing Subsidy	Total Monthly Subsidy @100%	Total Monthly Subsidy @95%
	(a)	(b)	(b – a)	d	(b – a) + d	.95 (b – a) + d
138%	**$37.02**	$302.95	$265.93	$72.71	$338.64	**$321.71**
142.5%	**$45.93**	$302.95	$257.02	$72.71	$329.73	**$313.24**
149%	**$54.89**	$302.95	$248.06	$72.71	$320.77	**$304.73**
151%	**$55.63**	$302.95	$247.32	$51.51	$298.83	**$283.89**
175%	**$83.01**	$302.95	$219.94	$51.51	$271.45	**$257.88**
200%	**$116.05**	$302.95	$186.90	$51.51	$238.41	**$226.49**

Step 5: Costs of Operating the Federal Basic Health Program

In 2011, per member per month (pmpm) costs for the State's Basic Health Plan are $251.93. This rate includes a 10 percent administrative load and has an actuarial value of 78-80% percent. Provider rates are reportedly similar to Medicaid except in some cases where small increases are made to assure access to certain providers. Under the Federal Basic Health Program, it is assumed that plans would be required to do more care management, patient engagement and reporting and therefore plan administrative costs will likely be higher than the 10 percent included here. It is estimated that these

[31] This estimate began with the current State Basic Health Plan premium
[32] This estimate began with the current average individual plan premium

additional responsibilities will add 5% to the administrative costs. In addition, actuarial values must be no lower than that of a platinum plan (actuarial value = 90 percent) for people 150 percent FPL and below, and a gold plan (actuarial value = 80 percent) for people between 151 - 200 percent FPL. Therefore, a plan's base premium cost will increase for people in the lower income category to account for this actuarial difference. Since many of the people eligible for the Federal Basic Health Program will be in the higher income category an adjustment of 5% is made to the claims premium. The total minimum Federal Basic Health Program premium is therefore estimated to be $277.12/month.

In addition, there is a cost to the State for establishing and operating a Federal Basic Health Program. Current State administrative costs for the State's Basic Health Plan provide a reasonable starting point for estimating the on-going costs of operating a Federal Basic Health Program. According to the Health Care Authority, State costs for operating the State Basic Health Plan were $7.2 million and $6.7 million in 2010 and 2011 respectively. This is an average per member per month administrative fee of approximately $8.83.

Estimates for establishing a Federal Basic Health Program are difficult to predict as they somewhat depend on guidance that has yet to be provided by the Federal government. However, it is important to keep in mind that start-up costs are not supported by Federal Exchange Establishment grant funds. It is also unclear whether the Federal government will allow states to use any Federal reimbursement to operate the program.[33] Probably the largest start-up costs of a Federal Basic Health Program would be the procurement of new IT systems. To the extent the IT system from the Exchange could be used for the Basic Health Program, these costs would be reduced.

Although the Federal government requires that a single eligibility portal be established and that all of the insurance affordability programs be coordinated, there will still be allocation costs for determining eligibility for the Federal Basic Health Program. To the extent that Option 2 could be achieved, resources dedicated to operating the Medicaid program potentially could be redirected to run this rebranded program. This arrangement would require approval from the Federal government and would likely present challenges for the State regarding accounting of costs and other reporting for the different populations.

Step 6: Determining the Breakeven Point for the Federal Basic Health Program

The estimate of Federal revenue that will be received by Washington State ranges from $205.21–$299.28 pmpm dependent on enrollee's income using the State Basic Health Plan premium as the base for the silver-level premium and $226.49 - $321.71 using the current average individual plan premium in Washington State as the base.

The cost of the State Basic Health Plan averages between $13 and $36 pmpm lower than the average revenue that would be provided by the Federal government (see yellow highlighted boxes in Tables 5a and 5b) for lower income people. However, for people at the highest income level the cost of covering the enrollee is greater than what would be provided by between $20 and $41 pmpm. It is estimated that nearly three quarters (71%) of the expected population who would enroll in the Federal Basic Health Program in Washington State are in the higher income categories (Table 3).

However, the figures provided in Tables 5a and 5b do not include any payment of premiums by the enrollee. It is expected that Washington State would charge participants premiums for the Federal

[33] S1331 (d)(2) states that "amounts in the trust fund shall only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within the State."

Basic Health Program, although it is not yet known what these premiums would be. Tables 6a and 6b below incorporate participant premiums at the highest level allowed (the same level as required in the Exchange) as an example. Although policymakers may want to consider lower premiums, the maximum allowed premiums are used here to allow for discussion of the breakeven points for managing a Federal Basic Health Program in Washington State. The columns labeled "Difference" in Table 6a and 6b provide the estimated amount of total revenue Washington State would have per enrollee for coverage in a Federal Basic Health Program if enrollees paid premiums equal to those they would have paid in the Exchange.

The small estimated difference could be used to incorporate one or more of the following enhancements although the available funding is likely not sufficient to significantly improve the program in all three areas.

- Reduce premiums and/or cost sharing below what is expected in the Exchange
- Increase provider rates from their near Medicaid-levels,
- Cover any additional benefits not included in the definition of Essential Health Benefits

Table 6a: Maximum Estimated Revenues Available to Cover People Eligible for Exchange Subsidies Under 200% FPL in the Federal Basic Health Program -- Starting with the State Basic Health Plan Premium

Point estimate income %FPL	Total ACA Subsidy Method 1	Maximum Premiums Allowed	Total Maximum Basic Health Revenue	Minimum Basic Health Cost (from above)	Difference
	(a)	**(b)**	(a + b)	(d)	(a + b) - d
138%	**$299.28**	**$37.02**	$336.30	$277.12	$59.18
142.5%	**$290.81**	**$45.93**	$336.74	$277.12	$59.62
149%	**$282.30**	**$54.89**	$337.19	$277.12	$60.07
151%	**$262.61**	**$55.63**	$318.24	$277.12	$41.12
175%	**$236.60**	**$83.01**	$319.61	$277.12	$42.49
200%	**$205.21**	**$116.05**	$321.26	$277.12	$44.14

Table 6b: Maximum Estimated Revenues Available to Cover People Eligible for Exchange Subsidies Under 200% FPL in the Federal Basic Health Program – Starting with the Individual Market Premium

Point estimate income %FPL	Total ACA Subsidy Method 2	Maximum Premiums Allowed	Basic Health Revenue	Minimum Basic Health Cost (from above)	Difference
	(a)	**(b)**	(a + b)	(d)	(a + b) - d
138%	**$321.71**	**$37.02**	$358.73	$277.12	$81.61
142.5%	**$313.24**	**$45.93**	$359.17	$277.12	$82.05
149%	**$304.73**	**$54.89**	$359.62	$277.12	$82.50
151%	**$283.89**	**$55.63**	$339.52	$277.12	$62.40
175%	**$257.88**	**$83.01**	$340.89	$277.12	$63.77
200%	**$226.49**	**$116.05**	$342.54	$277.12	$65.42

Summary of Analysis

The analysis provided here finds that Washington State may be able to cover its enrollee costs under a Federal Basic Health Program option if premiums were kept at levels similar to what is required by people in the Exchange. These estimates suggest some small savings that could be used to lower participant cost sharing, add benefits, or increase provider rates. There are, however, significant assumptions made throughout this analysis. Importantly, the risk profile of those who enroll in program is not known, and Essential Health Benefits are not yet defined. It is also unclear how Washington State would find the revenue to cover the start up or development costs of this program, which could be significant.

Another recent financial analysis of the Federal Basic Health Program found that average Federal payments to Washington State would exceed the costs of furnishing CHIP-like coverage in a Federal Basic Health Program by 11.4 percent.[34] Although the methodology, assumptions, and conclusions differ from those provided here, the revenue-cost differential of 11.4 percent is one of the smallest across all states, and significantly lower than the US average. This result suggests that Washington State would have less revenue and flexibility to increase benefits, reduce cost sharing, or enhance provider rates than would other states.

3) Administration Issues

A number of administrative issues arise with each of the options under consideration. Options 1 and 2 involve establishing and administering a new Federal Basic Health program that would require significant infrastructure and on-going operational costs.

Option 1 assumes a different operating infrastructure from both the Exchange and Medicaid and one that is similar to what is in existence today within the Health Care Authority. Some operational tasks

[34] Dorn, S, Burgess, M and Carroll, C; Using the Basic Health Program to Make Coverage More Affordable to Low-income Households: A Promising Approach for Many States. September 2011.

could be coordinated with Medicaid for efficiencies and to ensure coordination across all programs. If the program were housed in the Health Care Authority, certainly building off of the current infrastructure and sharing some of the administrative functions with Apple Health and Medicaid would be recommended. However, the programs would still remain distinct under this option and some redundancy in functions across the various programs and the Exchange would likely persist. In addition, the administrative costs of running this wholly separate program would need an on-going revenue source. The Federal government's guidance on the Federal Basic Health Program has indicated that user fees can be used as a revenue source.[35]

Option 2 envisions a new, single branded program for low-income individuals that would incorporate Medicaid and the Federal Basic Health program and likely would be operated within the Medicaid office. Procurement of plans, enrollment, customer service, etc. could be streamlined within the Medicaid program. The Federal government is unlikely to allow the merging of risk pools so some disaggregation of the programs would be necessary. In addition, a cost allocation system for the administrative functions that could be streamlined would be necessary, as the Federal government will want these costs separated out from Medicaid's administrative costs. This option would certainly reduce administrative costs from that of Option 1, although there would remain some obvious redundancy in functions between the Federal Basic Health program and the Exchange. Unfortunately, this is an issue that is not easily remedied as states will continue to manage CHIP and Medicaid programs, and the ACA requires states to establish Exchanges.

Option 2 would, however, require greater start-up costs than Option 1. The complexity of merging these programs and determining which features could be synchronized is not straightforward. Moreover, there are likely some features that would require approval from the Federal government particularly if any changes in benefits or cost sharing are desired. Funding of the initial start-up costs for Options 1 or 2 could prove problematic in this tight State fiscal environment especially since the Federal government is not allowing the use of Exchange Establishment grant funds to finance the development costs of the Federal Basic Health program. Moreover, it is unclear what level of risk the State is responsible for regarding costs exceeding Federal reimbursement on a year-to-year basis for this program (The ACA states that the Federal government will adjust rates for subsequent years if the rates were too high or too low).

Option 3 would not require any new infrastructure (beyond the establishment of an Exchange) and would maintain Apple Health and Medicaid as distinct programs. As with the other options, duplication of certain administrative tasks already handled by the Health Care Authority for Apple Health and Medicaid such as customer service, Federal reporting, plan procurement and certification, quality monitoring, etc. and the Exchange is unavoidable.

The administrative issues discussed here provide little guidance regarding whether Washington State should pursue one option over another. Option 2 reduces duplication of functions compared to Option 1 by integrating most of the existing public programs, however, even with this option some duplication of functions remains across the Health Care Authority and the Exchange and this option may prove too complex to implement in the necessary timeframe.

[35] Centers for Medicare & Medicaid Services, "State Exchange Implementation Questions and Answers." November 29, 2011.

4) Health Benefit Exchange and Provider Issues

In considering the options discussed above, Washington State policymakers will want to assess the potential impact each option would have on the private insurance market, the Exchange, and providers. The following issues related to the private insurance market and providers are discussed here: 1) the impact on the size of the Exchange; 2) the impact on the risk pool of the Exchange; and 3) the impact on provider reimbursement and cost shifting.

One of the more significant concerns regarding establishing a Federal Basic Health program under Option 1 or 2 is the resultant size of the Exchange. The size of the Exchange is important for at least two reasons. First, the larger the Exchange, the greater the number of insured lives over which to spread administrative costs. Second, a larger Exchange will likely have a better chance of attracting and engaging plans to its distribution channel, as well as greater opportunity to move the market regarding quality improvement efforts. A recent report estimated the range of the number of individuals in Washington State who could enroll in health insurance through the Exchange as 140,000 – 410,000. If all individuals who would be eligible for the Federal Basic Health Program, if established, are removed the individual Exchange enrollment drops by at least a third. In Massachusetts, where individuals are subsidized to 300 percent FPL, most subsidized individuals currently covered through the Exchange are under 200 percent FPL (84 percent). Thus, establishing a Federal Basic Health program could reduce Exchange enrollment below a critical level that is required for the Exchange to be self-sustaining. A full discussion of this issue was provided in the report prepared earlier in the year by Milliman.[36]

Not a lot is understood about the difference in risk between people who will be eligible for the Federal Basic Health program with incomes between 134 and 200 percent FPL and those who will be eligible for premium tax credits and cost-sharing subsidies through the Exchange with incomes between 201 and 400 percent FPL. However, generally speaking, lower income is associated with poorer health status. There also is some evidence that Washington State's Basic Health Plan suffered from some risk selection in the past as the estimated HealthCare Expenditure Index for State Basic Health Plan members is 1.06 compared to the general individual market index of 0.79.[37]

The ACA addresses risk selection in the insurance market with several mechanisms; however, it is not clear how the Federal Basic Health Program will interact with these mechanisms. Risk will be pooled across the individual market inside and outside the Exchange in the commercial market, but the ACA and subsequent proposed regulations on risk adjustment are silent on whether the Federal Basic Health program could be included in this pooling mechanism. The primary concern is that the Federal Basic Health program's population risk is greater than the risk of the population in the Exchange. Because reimbursement is based on the premiums of those in the second lowest cost silver plan in the Exchange, if the risk was much lower in the Exchange, the premiums from which the Federal Basic Health reimbursement is based would be lower while the population actually requires more services. The cost analyses presented earlier does not adequately account for any potential differences in health status of the populations in the Federal Basic Health program and the Exchange. Guidance from the Federal government is forthcoming and may include information on how these risk adjustment mechanisms will interact with the Federal Basic Health program.

[36] Milliman Client Report. Planning Washington's Health Benefit Exchange: The potential impact of three key decisions. January 27, 2011

[37] ibid.

The ACA extends Medicaid coverage to all legal residents up to 133 percent FPL. In Washington State, the State Basic Health Program already extended coverage to a proportion of residents in that income group. However, according to one report an additional 189,463 previously uninsured Washington residents will become eligible for Medicaid coverage in 2014.[38] This will create added pressure on Medicaid provider rates in order to ensure access to providers for all the newly insured. It may be unrealistic to expect that providers can absorb all of these newly insured individuals at current Medicaid reimbursement rates. However, establishing a Federal Basic Health Program under Option 1 or 2 could exacerbate this problem. The State partially addresses the issue of low provider rates in its State Basic Health Plan by occasionally increasing provider rates when it is necessary to ensure adequate access. Washington State policymakers would likely need to use much of the potential surplus in revenue provided by the Federal government to increase rates to managed care organizations so that provider rates could be enhanced in the Federal Basic Health program, leaving little funding for decreasing beneficiary cost sharing or enhancing benefits.

If policymakers choose Option 3 and do not establish the Federal Basic Health program, then the population from 134 - 400 percent FPL receiving coverage through the Exchange would be covered by private insurance and providers would be reimbursed at commercial rates. This would likely be preferable to providers and it would be at the expense of the Federal government. This removes the State from the rate negotiations with providers for this sizeable population.

It is also logical to expect that some providers will see a decrease in uncompensated care and will be able to absorb lower reimbursement through a Federal Basic Health program. However, this is a difficult argument to make when these providers are fiscally quite vulnerable with slim financial margins. Moreover, in Massachusetts, providers experienced significantly less uncompensated care as an outcome of their reform, but provider reimbursement issues remain a problem.

5) Issues for beneficiaries

Washington State policymakers also will want to assess the potential impact each option would have on consumers. The following discussion covers several of the consumer issues that have been identified but it may be necessary to talk with potential consumers in order to ensure that their preferences are included in any decision making.

Three consumer concerns are discussed here: choice, access, and cost. The consumer would have the greatest choice if Option 3 were implemented. The Exchange will have more options available to consumers at the metallic tiers with varying levels of cost sharing and provider networks. In addition, consumers will have a choice of the same private health insurance plans and will not have the stigma of being enrolled in a public plan.

Consumers' access to providers would also be the best under Option 3 because provider reimbursement would be at commercial rates. Although policymakers could increase provider reimbursement above the Medicaid level, it is unlikely they will be able to increase rates to commercial levels. Consumer choice, however, must be balanced with cost.

One potential advantage to establishing a Federal Basic Health Program is that premiums and cost sharing could be lowered (from what is expected in the Exchange) for the population between 134 -

[38] Holahan, J and Headen, I. Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL, Kaiser Commission on Medicaid and the Uninsured. May 2010.

200 percent FPL. For people in this income category, the ACA requires them to pay between $37.02 and $116.05 per month in premiums in the Exchange. In addition, they will be responsible for some cost sharing typical of a platinum plan (if between 134-150 percent FPL) and a gold plan (if between 151-200 percent FPL) in the Exchange. While platinum plans likely will have no deductible, and gold plans only a modest one, they will be cost sharing in the form of co-payments or co-insurance similar to what is found in many employer plans.[39]

Washington State has some experience understanding what is affordable for its low-income population because of extensive experience operating its State Basic Health Plan. For people at similar income levels (as those who would be eligible for the Federal Basic Health program), recent premiums and cost sharing have been somewhat higher in Washington State's Basic Health Plan than what is expected in the Exchange. Washington State's experience suggests that these levels of premiums and cost sharing largely have not deterred people from enrolling in the State's Basic Health Plan or in seeking necessary care. In fact, there has always been a long waiting list for the State's Basic Health Plan. However, it should be noted that over time enrollment in Washington's State Basic Health Plan has declined in the higher-income categories as premiums increased.[40]

Therefore it is possible that the level of premiums and cost sharing expected in the Exchange will deter some people from enrolling in Exchange plans. If policymakers in Washington State are interested in lowering premiums and cost-sharing requirements to ensure greater take-up of coverage, they also need to be mindful that lowering premiums for this income group will create a larger increase in premiums and cost sharing when people transition from the Federal Basic Health Program to the Exchange above 200 percent FPL. There are also State cost considerations of reducing premiums from those required in the Exchange.

Policymakers should also consider the effects of cost on take-up rates. If cost sharing could be significantly reduced under a Federal Basic Health Program, then greater take-up of this insurance may be likely. However, it is difficult to assess what consumers value more, choice or affordability, and which option would ensure greater take-up of coverage. One issue related to take-up is that consumers are required to pay back the Federal government some portion of any overpayment of tax credits received via the Exchange. It is possible that this pay-back feature could dissuade eligible individuals from participating in the Exchange. Establishing a Federal Basic Health Program likely would be implemented without this pay-back feature. Choice, overall cost, and ease of enrollment will also be important factors to consider regarding the take-up rates of the various options.

V. Framework for Considering a Federal Basic Health Program in WA State

There are clearly many issues facing policymakers regarding whether they should establish a Federal Basic Health Program in lieu of Exchange subsidies for people with incomes up to 200 percent FPL. It may be difficult for policymakers to weigh the competing goals with the advantages and disadvantages of the options presented here. This section presents a table summarizing the issues discussed in this brief and provides a framework for policymakers to consider these issues moving forward. In Table 7, each of the policy options are presented and scored on their effectiveness in addressing the issues described in this paper. A score of A, B, and C are assigned to each of the three options (A is assigned to the options that can most easily address that particular "Issue for the State," B

[39] Peterson, C. Setting and Valuing Health Insurance Benefits, Congressional Research Service, April 6, 2009.
[40] 16% of BHP enrollees were in the 125-200%FPL range according to the most recent BHP report

is assigned to options where the issue is likely to remain, and a C is assigned to the options that exacerbate the issue). While these assignments are somewhat subjective, they may provide guidance in considering the issues in the context of each option.

Table 7: Framework for Assessing Issues Best Addressed by the Various Options

Issues for the State	*Option 1*	*Option 2*	*Option 3*
Exchange sustainability	C	C	A
Complexity of insurance affordability programs	B	C	A
Federal Funds to support establishment and on-going operation	C	C	A
Adequate take-up of insurance coverage	A	A	A
Issues for Consumers			
Affordability (premiums and cost sharing)	B	A	C
Access to providers	B	C	A
Choice of Plans and Providers	B	C	A
Complexity navigating the system	C	A	B
Issues for other stakeholders			
Provider stability and cost-shifting	B	C	A

VI. Summary

The Federal Basic Health Program option is one that Washington State policymakers are considering. This brief provides a discussion of two options for implementing this program and compares it to covering income-eligible people in the Exchange on a number of dimensions. The discussion was focused on issues related to: 1) coordination with Medicaid and the Exchange; 2) cost comparison; 3) administration issues; 4) health benefit exchange and provider issues; and 5) issues for beneficiaries. While all of these issues are important, there are a few questions that are critical and should be the primary focus of the policy discussion.

First, will the revenue provided by the Federal government be sufficient to cover individuals enrolled in a Federal Basic Health Program? The analysis provided here presented two estimates of revenue projections, both making numerous assumptions. While these estimates provide some level of

assurance that costs can be covered (particularly for people at lower incomes), the available revenue is likely not sufficient to address all of the issues of interest to policymakers such as cost-sharing levels, benefits, and provider rates. The second critical question is what is the risk that the establishment of a Federal Basic Health Program causes the resulting Exchange to be unsustainable? Preliminary estimates and experience from Massachusetts suggest that the establishment of a Federal Basic Health Program may indeed limit enrollment in the Exchange to a point where the Exchange is not sustainable. A third key question is the availability of State funds to develop and administer a new Federal Basic Health Program when the federal government has not, to date, indicated financial support for the program.

Additionally, a $2.0 billion deficit has been forecasted for Washington State. To help address this, the Governor has proposed eliminating the State Basic Health Plan. If the Legislature follows through and cuts the current program as part of budget reductions, the state would have to consider the Federal Basic Health Program without an existing program to build from.

The answers to these questions start with the estimates in Tables 6a and 6b. Whether starting with the State Basic Health Plan or individual market premium, the analysis arrives at similar estimates of total revenue: roughly $320-$360 per participant per month if Exchange-level premiums are charged to participants. That estimate of total revenue is roughly $40-$80 above the projected monthly premium of covering a participant in the Federal Basic Health Program. An important discussion for Washington State is whether that gap is large enough to alleviate the risks associated with implementing the Federal Basic Health Program.

That gap does not include the administrative expenses, which must be funded by the State, of operating the Federal Basic Health Program. This issue brief identifies additional administrative functions primarily in the area of coordination with other public programs and private markets that are not performed by the current State Basic Health Plan. Washington State would have to fund the development and operation of those administrative functions. Also, if the current State Basic Health Plan is eliminated, then Washington will lose some or all of the advantage of building the federal program upon an existing administrative base and attracting individuals back to a plan that had just been dissolved may also prove difficult.

The gap between estimated revenue and premiums in the Federal Basic Health Program could be overwhelmed by outcomes different than the assumptions in this issue brief. If the second lowest-cost silver plan has a lower premium than expected, then federal subsidies, and thus, total revenues will be lower. The health status of the participants could be worse than expected and drive up the cost of coverage compared to the second lowest-cost silver plan. If more participants from the lower end of the income scale enroll, then total participant premiums will be less than expected. Finally, health care providers will likely argue for higher reimbursement rates leaving less funding to lower premiums or enhance benefits. A difference in any of these assumptions could place the state at risk of funding coverage in the Federal Basic Health Program because the participants cannot be turned away or placed on a waiting list.

Adding to these concerns, HHS has not yet specified how the estimate of capped federal funding will be calculated for each state. To generate any interest in the Federal Basic Health Program, HHS will need to provide funding on a per participant basis. States also need to know if HHS intends to dynamically alter the funding estimate throughout the year based on, for example, the age or income of the program's population.

The final key question for policymakers to answer is what are the specific goals for this low-income population? As this brief presents, none of the issues discussed point to a particular policy choice but rather suggest that each option will have implementation and operational challenges that will need to be addressed in order to achieve the desired goals.

While states are awaiting further guidance from the federal government on the establishment of a Federal Basic Health Program, and the definition of Essential Health Benefits, this analysis can be used as a starting point for the 2012 legislative session discussion.

Milliman Market Impact Analysis

June 13, 2011

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Planning Washington's Health Benefit Exchange

The potential impact of three key decisions:

- **Whether to merge the Individual and Small Group markets**
- **Whether to establish a Federal Basic Health program**
- **How to define "small employer"**

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Thank you

We thank the many stakeholders and Washington State representatives who displayed an extraordinary spirit of cooperation, and who contributed extraordinary time and effort, to help make this report available under a challenging delivery schedule.

In particular, we thank the State's director for this project, Michael Arnis of the Washington State Health Care Authority, and representatives of:

- the Washington State Health Care Authority and Medicaid Purchasing Administration
- the Washington State Office of the Insurance Commissioner and the Commissioner's Health Care Realization Committee
- the Washington State Office of Financial Management
- the Washington State Joint Legislative Select Committee on Health Reform Implementation and its Advisory Group on the Exchange and Insurance Reforms
- Washington State health insurance companies, including the Community Health Plan of Washington, Group Health Cooperative, Kaiser Permanente, Premera Blue Cross, Regence Blue Shield of Washington, and UnitedHealth Group
- the Association of Washington Health Plans
- America's Health Insurance Plans
- Washington Association healthcare plans
- many other stakeholder organizations

Our hope is that, thanks to your efforts, this report will help stakeholders make policy decisions that will lead to better health care for all Washingtonians.

Contents

I. EXECUTIVE SUMMARY

The Washington State Health Care Authority engaged Milliman to analyze the potential impact of three key decisions Washington will make as it establishes its health benefit exchange ("Exchange"):

- Whether to merge the risk pools for the Individual and Small Group health insurance markets, or keep them separate (as they are now).
- Whether to establish a Federal Basic Health plan, or not.
- For the years 2014-2015, whether to define a "small employer" as one with 1-50 employees, or as one with 1-100 employees.[1]

As requested, Milliman analyzed the potential impact of these decisions on enrollment and relative healthcare plan cost levels as of 2014 (when the Exchange will first be operational) and as of an "ultimate year" (the year when the healthcare market reaches a steady state), for:

- Individual and Small Group healthcare plans, both inside and outside the Exchange
- A Federal Basic Health program, if one is established
- Association healthcare plans for small employers[2]

The purpose of this report is to help Washington's healthcare stakeholders understand the potential impact of the three key decisions. The purpose is *not* to precisely predict enrollment and relative plan cost levels, which – because of a lack of both data and knowledge about human behavior in the new healthcare environment, and because many critical regulatory and policy decisions have yet to be made – is impossible. Therefore, we encourage you to read Sections II-IV of this report, in order to better understand the potential dynamics of the new healthcare environment.

A. SUMMARY OF RESULTS

Table 1 on the following page summarizes our analytic results. The first column of the table gives "baseline" results as of 2010. The second and third columns give the potential changes in enrollment and plan cost levels after establishing an Exchange. These potential changes are measured relative to characteristics of the Washington healthcare market in 2010. As the table shows, we estimate that total Exchange enrollment in 2014 will be between 140,000 and 410,000 people and that plan cost levels[3] for Individual coverage will increase 10 to 15 percent.

The remaining columns of the table give potential changes for each of the three key decisions. These changes are measured relative to results after establishing an Exchange (corresponding to the table's first two columns). For example, in 2014 we estimate that merging the risk pools will decrease the level of plan costs for Individual coverage by 5 percent from the level after the Exchange is established. Similarly, in 2014 we estimate that merging the risk pools will increase the level of plan costs for Small Group coverage by 10 to 15 percent.

[1] These decisions are described in detail in Section III (Background) of the report.

[2] Because the regulatory status of Association healthcare plans under national healthcare reform is unclear, in this report we assume that the current status will continue to apply in 2014 and beyond. However, in Appendix 5 (Sensitivity analysis) we discuss the potential impact of a change in this regulatory status.

[3] Measured by the "Plan Cost Index", described in Section IV (Results) and Appendix 1 (Methodology) of the report.

Metric/ Coverage type	Baseline (2010)	Potential impact of: Establishing an Exchange in 2014 — 2014	Establishing an Exchange in 2014 — Ultimate year	Merging the risk pools in 2014 — 2014	Merging the risk pools in 2014 — Ultimate year	Establishing a Federal Basic Health Program in 2014 — 2014	Establishing a Federal Basic Health Program in 2014 — Ultimate year	Defining small employer as 1-100 employees for 2014 and 2015 — 2014	Defining small employer as 1-100 employees for 2014 and 2015 — Ultimate year
Enrollment (thousands)									
Individual (inside Exchange)	NA	↑ 140 - 380	↑ 170 - 430	↑ 10 - 20	↑ 0 - 10	↓ 60 - 140	↓ 80 - 140	↓ 0 - 20	NA
Small Group (inside Exchange)	NA	↑ 10 - 30	↑ 30 - 100	↓ 10	↓ 10 - 50	- 0	- 0	↑ 10 - 40	NA
Total Exchange	NA	↑ 140 - 410	↑ 200 - 520	↑ 0 - 10	↓ 10 - 40	↓ 60 - 140	↓ 80 - 140	↑ 10 - 20	NA
Individual (outside Exchange)	290	↓ 40 - 130	↓ 80 - 190	↑ 10 - 20	- 0	- 0	- 0	↓ 10 - 20	NA
Small Group (outside Exchange)	190	↓ 20 - 30	↑ 30 - 50	↓ 10	- 0	- 0	- 0	↑ 90	NA
Federal Basic Health program	NA	NA	NA	- 0	- 0	↑ 80 - 140	↑ 100 - 150	- 0	NA
Association healthcare plans	760	↓ 40 - 50	↓ 40 - 80	↓ 10	↑ 10 - 40	- 0	- 0	↑ 0 - 30	NA
Uninsured	820	↓ 350 - 530	↓ 500 - 670	↑ 0 - 10	- 0	↓ 0 - 20	↓ 10	↓ 10	NA
Plan Cost Index (percent)									
Individual	NA	↑ 10% - 15%	↑ 10% - 15%	↓ 5%	↓ 10%	↓ 5%	↓ 5%	- 0%	NA
Small Group	NA	- 0%	↓ 5%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	↓ 5%	NA
Association healthcare plans	NA	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	NA

Table 1: Summary of results

Notes:

1. The arrows (↑ and ↓) in the table indicate the direction of impact, either increasing (↑) or decreasing (↓).
2. In the table, enrollment changes are rounded to the nearest 10,000 people and plan cost changes are rounded to the nearest 5 percent.
3. The results for "Establishing an Exchange in 2014" (the first two columns) are without merged risk pools, without a Federal Basic Health Program, and without redefining small employer (for 2014 results). The ultimate year results reflect a redefinition of small employer.
4. The range of results shown in the table is a consequence of the range of assumptions we used corresponding to three scenarios of Exchange participation: Low, Medium, and High.
5. The last column of the table is NA (not applicable) because starting in 2016 "small employer" must be defined as employers with 1 – 100 employees. The "ultimate year" is assumed to be after 2016.
6. Because data about Association healthcare plans are scant, the estimate of enrollment in these plans is subject to significant uncertainty.

B. Discussion of results

Following are the salient results of our analysis:

Establishing an Exchange in 2014

- **Enrollment**. As Table 1 shows, in 2014 we estimate that Exchange enrollment will total 140,000 - 410,000 people, with 140,000 - 380,000 people covered under Individual insurance, and 10,000 - 30,000 people covered under Small Group insurance. Outside the Exchange, we estimate that the number of people covered by Individual insurance, Small Group insurance, and Association healthcare plans will all decrease, by 40,000 - 130,000, 20,000 - 30,000, and 40,000 - 50,000 people, respectively. We also estimate that the number of uninsured people will decrease by 350,000 - 530,000. Many of these will flow into the Exchange, but many will migrate to Medicaid and some will become covered under employer-sponsored plans.

  As the table shows, in the ultimate year, we estimate that Exchange enrollment will total 200,000 - 520,000 people, and that the number of uninsured people will drop by 500,000 - 670,000 people.

- **Plan cost level**. In 2014, for Individual coverage, the level of plan cost is expected to increase by 10 to 15 percent. After implementation of the Exchange, there will be an influx of relatively unhealthy people into Individual insurance (including formerly uninsured people and members of the Washington State Health Insurance Pool) which will increase the level of plan cost for Individual insurance. In 2014, plan costs for Small Group coverage and for Association plans are not expected to change. In the ultimate year, the increase in plan cost for Individual coverage is expected to be again 10 to 15 percent, while the level of plan cost for Small Group coverage is expected to decrease 5 percent as small employers with predominantly low-income employees drop coverage.

Merging the risk pools in 2014

- **Plan cost level**. For Individual coverage the level of plan cost is expected to decrease by 5 percent in 2014 and by 10 percent in the ultimate year, and for Small Group coverage it is expected to increase 10 to 15 percent. This inverse relationship is mainly due to the difference in average health status of people covered under Individual insurance versus people covered under Small Group insurance after implementation of the Exchange. With the advent of the Exchange, the average health status of those with Individual coverage is substantially less than the average health status of those with Small Group coverage. Consequently, if the risk pools were merged, plan costs for Individual insurance would decrease, and plan costs for Small Group insurance would increase.

Merging the risk pools in 2014 **continued**

- **Enrollment.** In 2014, because fully-insured Small Group plan costs would increase with merged risk pools, small employers would be more likely to drop coverage, self-insure, or migrate to Association healthcare plans, thus causing a decrease in Small Group enrollment both inside and outside of the Exchange. Based on similar reasoning, Individual enrollments inside and outside the Exchange would *increase*. In the ultimate year, the migration pattern for people in the Exchange is similar, whereas for Small Group enrollment outside the Exchange no significant change is expected.

Establishing a Federal Basic Health program in 2014

- **Enrollment.** With the establishment of a Federal Basic Health program in 2014, the number of people with Individual insurance in the Exchange would decrease by 60,000 – 140,000 and the number in the Federal Basic Health program would increase by a similar number. In the ultimate year, the pattern is similar.
- **Plan cost level**. Because people migrating to the Federal Basic Health program are lower-paid, and because lower-paid people generally have poorer health status (and thus incur higher healthcare expenditures) the level of plan cost for Individual coverage would decrease by about 5 percent in both 2014 and in the ultimate year.

Defining small employer as 1-100 employees for 2014 - 2015

- **Enrollment.** If "small employer" is redefined in 2014 as employers with 1-100 employees, rather than employers with 1-50 employees, then the number of people covered under the redefined Small Group would increase both inside and outside the Exchange.
- **Plan cost level**. Because people covered by insurance provided by employers with 51 - 100 employees are, on average, in better health than people covered by employers with 1 - 50 employees, combining the groups would slightly decrease plan costs for the Small Group category. Redefining small employer would also result in a slight plan cost increase on average for employers with 51 - 100 employees. However, these cost changes would be minimal.

  The last column of Table 1 is NA (not applicable) because starting in 2016 "small employer" must be defined as employers with 1 – 100 employees. The ultimate year is assumed to be after 2016.

C. POLICY CONSIDERATIONS

Following are potential impacts of the three key decisions in major policy areas:

1. **Number of uninsured people**: As Table 1 shows, the Exchange itself, together with expanded Medicaid eligibility, is expected to dramatically reduce the number of Washington's uninsured people. However, each of the three key decisions is expected to have only a relatively minor impact, with the changes in uninsured people expected to be at most 10,000 to 20,000.
2. **Healthcare expenditure trend**: Although the Exchange itself, if appropriately designed and implemented, could potentially help to mitigate the long-term rise in healthcare expenditures[4], it is unlikely that any of the three key decisions would materially impact the trend.
3. **Quality and outcomes**: Although the Exchange itself, if appropriately designed and implemented, could improve healthcare quality and health outcomes in Washington, it is unlikely that either merging the risk pools or redefining small employer would materially affect quality or outcomes. However, a Federal Basic Health program might be implemented in a way that could increase the continuity of care—and consequently healthcare quality and health outcomes—for low-income people.
4. **Consumer choice**: Although the Exchange itself may increase consumer choice of healthcare plans, it is unlikely that any of the three key decisions would increase consumer choice. In fact, implementing a Federal Basic Health program could *decrease* the available plan options for people eligible for the program, because they would likely be excluded from the Exchange.
5. **Administrative simplicity**: While the Exchange itself, if appropriately designed and implemented, may reduce healthcare administrative complexity for consumers, it is unlikely that either merely merging the risk pools (absent further elaboration, such as harmonizing Individual and Small Group products) or redefining small employer would add to the simplification. However, establishing a Federal Basic Health program might further reduce administrative complexity for the people eligible for it.
6. **Healthcare market stability**: Both merging the risk pools and redefining small employer could slightly destabilize the healthcare market, since employers might respond to both by moving to Association healthcare plans, self-insuring, or dropping coverage.
7. **Existing State healthcare plans**: None of the three key decisions would necessarily affect existing State-administered healthcare plans. However, the Federal Basic Health program could potentially replace the Washington Basic Health program.
8. **Exchange sustainability**: Establishing a separate Federal Basic Health program could remove a large number of people from the Exchange, and thus reduce the Exchange population below a critical mass necessary for its long-term sustainability. It is unlikely that the other two decisions would materially impact the Exchange's long-term sustainability.[5]

[4] To learn more about the potential impact of an Exchange on cost containment, see the HCA issue brief titled, "Cost containment opportunities", found at www.hca.wa.gov/hcr/exchange.html.

[5] For more information about the relationship between Exchange sustainability and the Exchange enrollment level, see the HCA issue brief titled "Exchange sustainability" at www.hca.wa.gov/hcr/exchange.html.

D. RECOMMENDATIONS

We make the following recommendations related to the three key decisions:

- **Defer making the decision about merging risk pools**. The risk pools can be merged at any time during or after 2014. A more-informed merger decision can be made after the State assesses the post-Exchange healthcare market, and the impact of Exchange subsidies on the affordability of health insurance. In particular, before adding another layer of complexity to the State's health insurance risk management system, it is important for the State and its health insurers to first determine how well the risk-adjustment mechanisms introduced by the health reform law work.[6]

  Another reason to defer the decision is to decouple the expected increase in Small Group plan costs from the establishment of the Exchange. Otherwise, in the business community the Exchange may become associated with excessive plan cost increases.

- **Defer the decision about establishing a Federal Basic Health program**. The decision about establishing a Federal Basic Health program depends on how the Exchange will be financed, marketed, and operated – considerations outside this report's scope. As Table 1 shows, establishing a separate Federal Basic Health program could potentially remove a large number of people from the Exchange, which in turn could reduce both the Exchange's ability to pay for itself and its leverage in the healthcare marketplace, and thus hinder its sustainability.[7] On the other hand, a Federal Basic Health program might be implemented in a way that could provide lower premiums and cost sharing for its members than they could obtain through the Exchange, as well as providing them greater continuity of care with Medicaid[8] – considerations that are also outside this report's scope. Before making the decision about establishing a Federal Basic Health program, it is important for the State to explore these additional considerations.

- **For redefining small employer, default to the required 2016 implementation**. Because redefinition of small employer will likely have an adverse impact on employers with 51 to 100 employees (by subjecting them to Small Group adjusted community rating regulations, and consequently increasing their plan costs) redefinition in 2014 could become a politically contentious issue and could cause disruption in the healthcare market, as employers with 51 to 100 employers either self-insure their healthcare plans or drop coverage. Further, as with the other two decisions, it may prove wise to observe the post-Exchange Washington healthcare environment before making this decision. Deferring the decision would also give the State time to further study the characteristics and potential behavior of employers with 51 to 100 employees.

[6] For more information about the law's risk adjustment mechanisms, see the HCA issue brief titled "Managing health insurance expenditure risks" at www.hca.wa.gov/hcr/exchange.html.

[7] For more information about the relationship between Exchange sustainability and the Exchange enrollment level, see the HCA issue brief titled "Exchange sustainability" at www.hca.wa.gov/hcr/exchange.html.

[8] For information about these topics, see the Milliman briefing paper titled "Healthcare reform and the basic health program option", at publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf.

II. INTRODUCTION

A. PURPOSE

The purpose of this report is to help Washington's healthcare stakeholders understand the potential impact of three key decisions the State will make as it establishes a Washington health benefit exchange ("Exchange"). The three key decisions are:

- Whether to merge the risk pools for the Individual and Small Group health insurance markets, or keep them separate (as they are now).
- Whether to establish a Federal Basic Health plan, or not.
- For the years 2014-2015, whether to define a "small employer" as one with 1-50 employees, or as one with 1-100 employees.

The report explores the potential impact of these decisions on enrollment and relative healthcare plan cost levels as of 2014 (when the Exchange will first be operational) and as of an "ultimate year" (the year when the market reaches a steady state), for:

- Individual and Small Group health plans, both inside and outside the Exchange
- A Federal Basic Health program, if one is established
- Association healthcare plans

B. EIGHT DECISION OPTIONS

In the report, we refer to the eight combinations of the three key decisions collectively as the "Eight Decision Options":

Decision Option	Risk pools	Federal Basic Health program?	Small employer definition
1	Separate	No	1-50
2	Merged	No	1-50
3	Separate	Yes	1-50
4	Merged	Yes	1-50
5	Separate	No	1-100
6	Merged	No	1-100
7	Separate	Yes	1-100
8	Merged	Yes	1-100

C. THREE SCENARIOS

For each of the Eight Decision Options, we present results under three scenarios:

- **Low participation**: In this scenario, we estimate that a relatively low percentage of eligible individuals and small employers will move from existing coverage to the Exchange.
- **High participation**: In this scenario, we estimate a high level of participation in the Exchange. It assumes the Exchange will employ extensive marketing, outreach, and education — as well as simple and efficient enrollment and consumer incentive processes — to encourage employers and individuals to participate.
- **Medium participation**: This scenario is mid-way between the Low and High scenarios.

Scenarios vs. Options

To keep this report's terminology straight, remember that the Eight Decision Options refer to the eight combinations of the three key decisions that the State will need to make about the Exchange.

To assess the potential impact under each of the Eight Decision Options, we present results for three scenarios.

D. UNDERSTANDING VS. PREDICTION

The goal of this report is to aid understanding, not to predict. Because of a lack of both (a) data and (b) knowledge about human behavior in the new healthcare environment, precisely predicting the impact of the State's three key decisions is impossible.

Although we can estimate the current distribution of Washington's population among the many employer types, income levels, and insurance coverage options necessary for performing an impact analysis (see the sidebar), precision is hindered by significant data gaps. As examples:

- Little is known about statewide enrollment in Association healthcare plans.
- Detailed information about enrollment under self-insured vs. commercially-insured plans is not available.
- An accurate headcount of people covered under health plans provided by employers with 51 to 100 employees is not available.

The crazy quilt of healthcare coverage

Healthcare coverage is a patchwork of public, commercial, and employer self-insured plans. In 2014, with an Exchange and perhaps a Federal Basic Health program, the number of patches in Washington may become even greater.

Where a person will end up on this crazy quilt of healthcare coverage depends on many factors, such as:

- Whether the person is employed
- The size of the person's employer
- Whether the employer self-insures, maintains a "grandfathered plan", joins an Association healthcare plan, has commercial coverage, or foregoes coverage altogether
- The amount of the person's household income
- The types of plans offered in and out of the Exchange
- Perhaps most importantly, individual decisions that each person will make

This complexity makes precise prediction all but impossible.

D. UNDERSTANDING VS. PREDICTION CONTINUED

But even if we had perfect data, our lack of knowledge about human behavior in the new healthcare environment would preclude precise prediction. For example, we do not know how Washington employers and consumers will react to the Exchange, to the federal mandate for all individuals to secure health insurance coverage, or even to the expanded rules for Medicaid eligibility.

But we *can* develop clear understanding about the dynamics of Washington's Exchange-based healthcare market and about the range of potential effects that the State's decisions might produce. We *can* make assumptions about the data gaps and how people will behave, and, through the three scenarios, explore the range of potential impact.

Our hope is that this report will help stakeholders deepen their understanding, so that they will have more informed and robust discussions about the three key decisions facing the State and its Exchange.

E. REPORT ORGANIZATION

The bulk of this report is divided into three sections and several appendices:

BACKGROUND: This section details the State's three key decisions, and describes the current state of Washington's healthcare environment.

RESULTS: This section shows the range of potential effects that may flow from the State's decisions, under varying assumptions regarding human behavior and unavailable data.

NEXT STEPS: This section describes what can be done in 2011 to more accurately assess where Washington will end up among the range of possibilities.

APPENDICES

1. **METHODOLOGY:** Describes the methodology used to produce the report's results.
2. **SMALL GROUP DATA PREPARATION:** Details the procedure to prepare Small Group data.
3. **DATA REASONABILITY TESTS:** Describes the tests employed to test the validity of baseline data.
4. **DETAILED RESULTS:** Provides the detailed analytic results.
5. **SENSITIVITY ANALYSIS:** Analyzes the sensitivity of assumptions for Association plan participation and self-insured plan participation, and discusses the potential impact of changing the regulatory status of some Association healthcare plans covering small employers (1-50).
6. **TAKE-UP RATES:** Presents the take-up rates used to model individual and employer behavior, as described in the Methodology appendix.

III. BACKGROUND

This section describes the State's three key Exchange decisions, and sketches the current state of the components of Washington's healthcare environment that are relevant to these decisions.

A. THREE KEY DECISIONS

The new Patient Protection and Affordable Care Act ("PPACA") presents Washington State with several decisions to make in order to establish an Exchange. (see the sidebar) Among these are the three key decisions that are the focus of this report:

- **Merge risk pools**. Instead of requiring insurance companies to maintain two separate risk pools, one for Individual and one for Small Group insurance, the State may require companies to merge them into one pool.[10] In Washington, these risk pools are also referred to as "adjusted rating communities".
- **Establish a Federal Basic Health program**. Washington can establish a Federal Basic Health program that offers one or more subsidized health plans providing at least the essential health benefits (see sidebar) to individuals with household income between 133 percent and 200 percent of the Federal Poverty Level (FPL), in lieu of offering such individuals coverage through the Exchange.[11]
- **Define small employer**. PPACA defines "small employer" as one that employs 1 to 100 employees.[12] However, for 2014 and 2015, States may elect to define small employer as one that employs only 1 to 50 employees (as it is currently defined in Washington).[13] As of 2016, all States must define "small employer" as one that employs 1 to 100 employees.

For each of these decisions, following is a more complete description.

The Exchange

PPACA requires Washington State to establish an American Health Benefit Exchange ("Exchange") no later than January 1, 2014, or else default to a federally-run exchange.

The primary purpose of the Exchange is to help certain individuals and small employers (so-called "qualified individuals" and "qualified small employers") purchase "qualified health insurance plans" that provide a minimum level of covered healthcare services (the so-called "essential benefits").[9]

Each qualified plan must belong to one of four "metallic tiers". A metallic tier is defined according to the percentage of full actuarial value for plan benefits that are covered by the plan's premium (with the remaining percentage being the responsibility of the covered person):

- Bronze: 60%
- Silver: 70%
- Gold: 80%
- Platinum: 90%

For more information about the Washington Exchange, including its potential goals, structure and governance, responsibilities, benefit levels, and issues, see the seven issue briefs prepared by the Washington Health Care Authority, located on their website at www.hca.wa.gov/hcr/exchange.html.

[9] PPACA § 1311(b)(1)
[10] PPACA § 1311(b)(2) and Section 1312(c)(3)
[11] PPACA § 1331
[12] PPACA § 1304(b)(2)
[13] PPACA § 1304(b)(3)

A. Three key decisions continued

Merge risk pools

PPACA provides that a State can, at any time, elect to merge the risk pools of its Individual and Small Group insurance markets.[14] Currently the Washington Individual and Small Group markets are separate community-rated pools: An insurer determines the amount of its Individual plan premiums based solely on members covered under Individual insurance plans, and similarly, Small Group premiums are determined based solely on members covered under Small Group plans. Under a merged market, with merged risk pools, premium amounts for Individual and Small Group coverage would be based upon a combined Individual and Small Group risk pool.

Under a merged market, because individuals who purchase Individual insurance often have different characteristics from those covered under Group insurance, the design of Individual and Small Group health insurance products may differ. Indeed, in this report we assume that they will be different. However, it should also be noted that the State could require all products under a merged risk pool arrangement to be the same for both the Individual and Small Group markets.

There are potential advantages and disadvantages to merging the risk pools:

Potential advantages

- By creating a larger population over which healthcare expenditure risks are spread, merging the risk pools could reduce premium volatility, insurer earnings volatility, administrative costs, and perceived inequities between Individual and Small Group products and pricing. It should be noted, however, that these advantages would not be expected to materially mitigate the rapid rise in the State's healthcare expenditures.
- Our analysis indicates that, in Washington State, merging the risk pools would decrease plan costs for Individual insurance coverage, thus at least partially offsetting the increase in such costs expected from establishing an Exchange.

Potential disadvantages

- Small employers might view a merged market as burdensome, especially if it causes their premiums to increase, and so be more inclined to self-insure, move to "defined contribution" coverage, or drop health insurance coverage.
- National insurers may also view a merged market as an added burden. As a consequence, they may be less willing to participate in the Exchange or even in the Washington health insurance market outside the Exchange.
- There may be significant practical obstacles to merging the risk pools, such as the costs involved in revising State and insurer administrative systems.

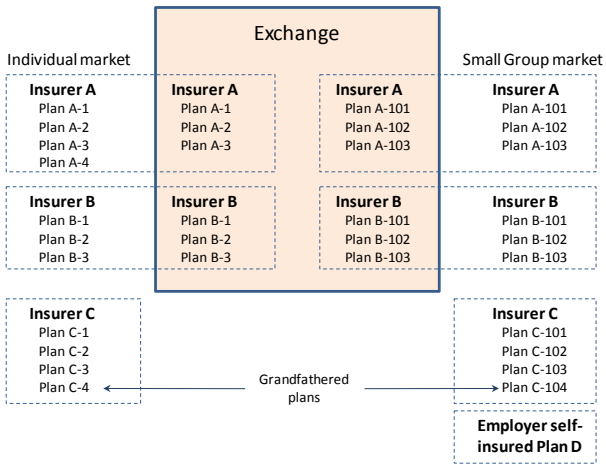
[14] PPACA § 1312(c)(3)

A. THREE KEY DECISIONS CONTINUED

Merge risk pools continued

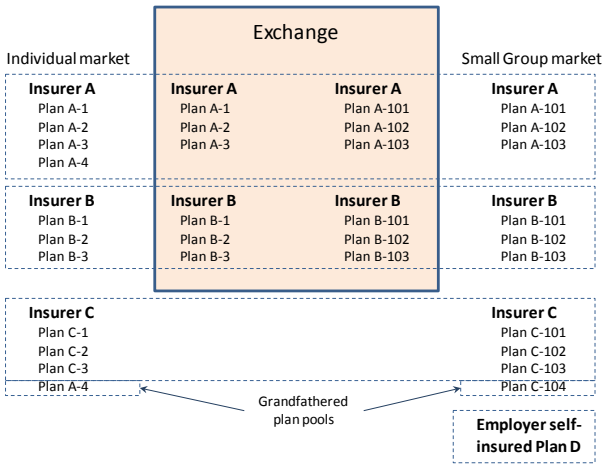
The following figures illustrate what it means to merge risk pools.

Figure 1: **Before** merger of Individual and Small Group markets



As Figure 1 shows, *before* merger of the Individual and Small Group markets (the current situation in Washington), each insurer pools its Individual market separately from its Small Group market. For example, as you see in Figure 1, Insurer A combines all its Individual market plans into one risk pool (indicated by a dotted box) and similarly for its Small Group plans.

Figure 2: **After** merger of Individual and Small Group markets



After merger of the risk pools, each insurer pools its Individual and Small Group plans together into one larger pool, with two exceptions: Grandfathered plans and self-insured plans are exempt.

A. THREE KEY DECISIONS CONTINUED

Establish a Federal Basic Health program

Drawing on the example of Washington State's Basic Health program, PPACA provides that each state can establish a Federal Basic Health program. Such a program offers one or more subsidized health plans that provide at least the essential health benefits to individuals with household income of 133% - 200% of the FPL, in lieu of offering such individuals coverage through the Exchange.

Under a Federal Basic Health program, the amount of monthly premium an eligible individual is required to pay for coverage would not exceed the amount that would have been required for the second lowest-cost Silver plan offered through the Exchange. Also, for an individual with household income not in excess of 150 percent of the FPL, the individual's cost sharing would not exceed the cost-sharing required under a Platinum plan; and for other individuals would not exceed the cost sharing required under a Gold plan.

For each individual enrolled in the Federal Basic Health program, each year the federal Department of Health and Human Services would transfer to the State an amount equal to 95 percent of the premium tax credits and cost-sharing reductions that would have been provided for the year if the eligible individual had been enrolled in a qualified health plan through the Exchange.

A Federal Basic Health program would give Washington State additional flexibility in providing benefits to low-income people. For example, because such people can migrate in and out of Medicaid coverage, in order to provide greater consistency in healthcare coverage the State could align benefits and provider networks of Federal Basic Health and Medicaid, to the extent possible.

On the other hand, because enrollment in a Federal Basic Health program could increase rapidly and swiftly draw a substantial number of people away from the Exchange, the program could reduce Exchange enrollment below a critical level that is required for the Exchange to be self-sustaining. This is one of the topics addressed in Section IV (Results).

A. THREE KEY DECISIONS CONTINUED

Define small employer

Currently in Washington State, for health insurance purposes "small employer" is defined as an employer with 1-50 employees. PPACA changes the definition: For a calendar year, PPACA defines "small employer" as an employer that employs at least one part-time or full-time employee on the first day of the year, and that employed an average of 1 to 100 full-time or part-time employees during the preceding year.[15] However, to ease the transition to this definition, for the calendar years 2014 and 2015 PPACA provides that a State may elect to define small employer as above, but substituting 50 for 100.[16]

The definition of small employer for 2014 and 2015 potentially affects enrollment and plan costs for the Small Group market both inside and outside the Exchange. In addition, the impact of the decision about merging the risk pools depends on how small employer is defined. This report addresses these issues.

B. CURRENT ENVIRONMENT

Table 1 on the following page summarizes the components of the current Washington State healthcare environment that are relevant for this report.

The table is in two major sections, one (on the left) that gives the current number of people in Washington's population broken down into relevant categories, and the other (on the right) that gives the "Healthcare Expenditure Index", or "HEI", for each population category. The HEI is a measure of the likely healthcare expenditure level of a population group under a standard health insurance plan, relative to a value of 1.00 for the population as a whole. For example, the HEI of Washington State Health Insurance Pool (WSHIP) members is 3.91. This means that the average healthcare expenditures of WSHIP members are likely to be 3.91 times greater than average expenditures for the Washington population as a whole, if everyone were covered under the same health insurance plan. How we developed the population counts and Healthcare Expenditure Indices is described in Appendix 1 (Methodology).

The table divides people into categories according to employment status and household income level (the rows of the table) and healthcare coverage (the columns).

[15] PPACA § 1304(b)(2)
[16] PPACA § 1304(b)(3)

B. CURRENT ENVIRONMENT CONTINUED

Household employment status and household income level	Number of people (thousands)									Healthcare Expenditure Index								
		Non-employer coverage									Non-employer coverage							
	Employer coverage	Individual insurance	Medicaid	CHIP	WA Basic Health	WSHIP	Medicare	Uninsured	Total	Employer coverage	Individual insurance	Medicaid	CHIP	WA Basic Health	WSHIP	Medicare and retiree medical	Uninsured	Total
A. Employed households																		
1. Small employer (1-50)																		
a. > 400% FPL 2	355	104	10	-	-	-	44	41	554	0.69	0.71	0.51	-	-	-	2.03	0.68	0.80
b. 200% - 400% FPL	233	54	41	4	-	-	44	94	470	0.73	0.71	0.56	0.43	-	-	2.37	0.96	0.91
c. 133% - 200% FPL	61	16	64	-	12	-	21	80	254	0.72	0.78	0.48	-	0.90	-	2.38	0.92	0.87
d. < 133% FPL	26	12	135	-	36	-	16	130	355	0.98	0.74	0.53	-	0.94	-	2.48	1.11	0.91
Total	675	186	250	4	48	-	125	345	1,633	0.72	0.72	0.52	0.43	0.93		2.27	0.97	0.87
2. Small employer (51-100)																		
a. > 400% FPL	123	4	3	-	-	-	6	6	142	0.66	0.73	0.52	-	-	-	2.15	0.65	0.72
b. 200% - 400% FPL	58	2	9	1	-	-	6	12	88	0.66	0.84	0.55	0.41	-	-	2.27	0.93	0.80
c. 133% - 200% FPL	10	-	9	-	1	-	1	7	28	0.76	-	0.48	-	0.83	-	2.56	0.99	0.79
d. < 133% FPL	8	1	21	-	2	-	3	14	49	0.70	0.72	0.56	-	0.78	-	2.51	1.05	0.85
Total	199	7	42	1	3	-	16	39	307	0.67	0.76	0.54	0.41	0.80		2.29	0.94	0.77
3. Large employer (> 100)																		
a. > 400% FPL	929	20	13	-	-	-	32	29	1,023	0.66	0.73	0.52	-	-	-	2.15	0.65	0.71
b. 200% - 400% FPL	434	11	44	4	-	-	28	63	584	0.66	0.84	0.55	0.41	-	-	2.27	0.93	0.76
c. 133% - 200% FPL	74	2	45	-	6	-	5	33	165	0.76	1.06	0.48	-	0.83	-	2.56	0.99	0.79
d. < 133% FPL	62	3	106	-	9	-	18	70	268	0.70	0.72	0.56	-	0.78	-	2.51	1.05	0.86
Total	1,499	36	208	4	15	-	83	195	2,040	0.67	0.78	0.54	0.41	0.80		2.29	0.94	0.75
4. Public employer																		
a. > 400% FPL	533	9	9	-	-	-	31	16	598	0.75	0.94	0.49	-	-	-	2.27	0.96	0.83
b. 200% - 400% FPL	271	8	14	1	-	-	15	17	326	0.68	0.73	0.33	0.59	-	-	2.17	0.97	0.75
c. 133% - 200% FPL	40	3	36	-	1	-	4	6	90	0.82	0.78	0.80	-	1.17	-	2.33	1.11	0.90
d. < 133% FPL	13	2	46	-	4	-	4	18	87	0.83	0.92	0.91	-	0.93	-	2.05	0.92	0.95
Total	857	22	105	1	5	-	54	57	1,101	0.73	0.84	0.76	0.59	0.98		2.23	0.97	0.82
Employed total	3,230	251	605	10	71	-	278	636	5,081	0.70	0.74	0.57	0.44	0.90		2.27	0.96	0.80
B. Unemployed households																		
a. > 400% FPL	55	17	3	-	-	2	131	19	227	1.17	0.82	0.59	-	-	3.76	2.09	1.12	1.69
b. 200% - 400% FPL	59	12	21	2	-	1	214	45	354	1.44	0.95	0.68	0.51	-	4.22	2.38	1.38	1.94
c. 133% - 200% FPL	12	5	36	-	2	-	104	40	199	1.57	1.56	1.05	-	3.42	-	2.67	1.29	2.01
d. < 133% FPL	13	9	212	-	13	-	112	77	436	1.26	1.97	1.12	-	1.79	-	2.93	1.48	1.69
Total	139	43	272	2	15	3	561	181	1,216	1.33	1.18	1.07	0.51	2.01	3.91	2.48	1.38	1.82
C. Grand total	3,369	294	877	12	86	3	839	817	6,297	0.72	0.80	0.73	0.45	1.09	3.91	2.41	1.05	1.00

Table 2: Current Washington State healthcare environment

B. CURRENT ENVIRONMENT CONTINUED

Because Table 2 by itself partially explains the potential impact of the three key decisions addressed by this report, it is worth spending a little time to understand it well. The implications of Table 2, together with more detailed analyses, are covered in Section III (Results).

The population in Table 2 encompasses all Washington State non-institutionalized, non-military, legal residents, as of 2010. A resident "A" is placed in a particular employment category in the table according to A's household employment status and household income level:

- **Employed households.** If A belongs to a household in which someone is employed, then A is in the "Employed households" category. A's subcategory depends on the type of employer and A's household income level. For example, if A has healthcare coverage from an employer with 1-50 employees, or if A does not have employer-based healthcare coverage and the highest earner in A's household works for an employer with 1-50 employees, then A is placed in one of the "Small employer (1-50)" categories, according to A's household income.
- **Unemployed households**. If A belongs to a household in which no one is employed, then A is in the "Unemployed households" category. A's subcategory depends on A's household income level.

As the table shows, there are 5,081,000 residents in the "Employed households" category. Of these, 3,230,000 have coverage through employers; 251,000 have Individual insurance; 605,000 are covered by Medicaid; 10,000 are covered under the Children's Health Insurance Program (CHIP); 71,000 are covered by the Washington Basic Health program; 278,000 are covered under Medicare, and 636,000 are uninsured.

Similarly, there are 1,216,000 residents in the "Unemployed households" category, producing a total population of 6,297,000. Of these, 139,000 have employer-provided coverage (such as retiree medical and COBRA coverage), 43,000 have Individual insurance, 272,000 are covered by Medicaid, 2,000 are covered under CHIP, 15,000 are covered by the Washington Basic Health program, 3,000 are covered under the Washington State Health Insurance Pool (WSHIP), 561,000 are covered under Medicare, and 181,000 are uninsured.

Of perhaps even more interest, there is wide variation in the Healthcare Expenditure Indices among the population groups. As an important example: The index for all people covered under Individual insurance is 0.80, whereas the index for people covered under insurance with small employers (1-50) is 0.72, and with small employers (51-100) is 0.67. These results have important implications regarding the decisions about merging the risk pools and defining small employer, as discussed in Section III (Results).

We tested the reasonableness of Table 2 data in a number of ways. These tests are described in Appendix 5 (Data reasonability tests).

C. ASSOCIATION HEALTHCARE PLANS

Conspicuously absent from Table 2 are categories for coverage of the Washington population under Association healthcare plans. (see the sidebar)

Washington State is one of the few States in which Association healthcare plans play a major role in the health insurance market. Although these plans are very important, the amount of data available about them is scant. For this reason, in this report we reflect the population under Association plans through the use of assumptions. For a more complete description of how we treat Association plans, see Appendix 1 (Methodology).

Small employers in Association healthcare plans are in a separate insurance regulatory class; their coverage is not regulated as Small Group insurance.[17] This allows these plans to determine premiums using pure experience rating. Because the regulatory status of Association healthcare plans under national healthcare reform is unclear, in this report we assume that the current status will continue to apply in 2014 and beyond. However, in Appendix 5 (Sensitivity analysis) we discuss the potential impact of a change in this regulatory status.

Association Healthcare Plans

Association healthcare plans are plans that cover individuals or employers that join together (or associate) for a common purpose. In Washington State, that common purpose can be merely to purchase health insurance.

Examples of Association healthcare plans in Washington State are plans that cover real estate agencies, schools (eg, the Washington State Education Association), and small businesses (Chambers of Commerce).

In Washington State, these plans are not regulated the same as Individual, Small Group, or Large Group plans. They are specifically excluded from such regulations, and follow a different rating structure.

As a result, Association plans for individuals and small groups are not subject to adjusted community rating rules for establishing their premiums, and so may choose to "medically underwrite" each group. This approach produces relatively favorable premium amounts for healthy groups and relatively unfavorable premiums for groups that are less healthy. The result is that — according to general reasoning, as well as our observations and professional assessment — healthier individuals and employers tend to join Washington's Association plans, leaving the less healthy to seek coverage under plans that must comply with adjusted community rating rules.

However, not all Association plans are alike. Although in aggregate they may draw away healthier individuals and employers, this will vary considerably by plan.

D. SELF-INSURED HEALTHCARE PLANS

Also absent from Table 2 are healthcare plans that employers self insure. We also have incomplete data about the people covered under these plans. Therefore, we also reflect the population under self-insured plans through assumptions. For information about the assumptions used, see Appendix 1 (Methodology).

E. REGULATORY ENVIRONMENT

Individual and Small Group plans in Washington are subject to separate adjusted community rating regulations. Carriers may rate based on age (with a rate compression band of 3.75:1), but not on health status or other factors. Small Group coverage is guaranteed issue, but Individual coverage is not.[18]

[17] Washington Revised Code RCW § 48.44.024(2)
[18] Washington Revised Code RCW § 48.20.028, § 48.21.045, and § 48.43.005

IV. RESULTS

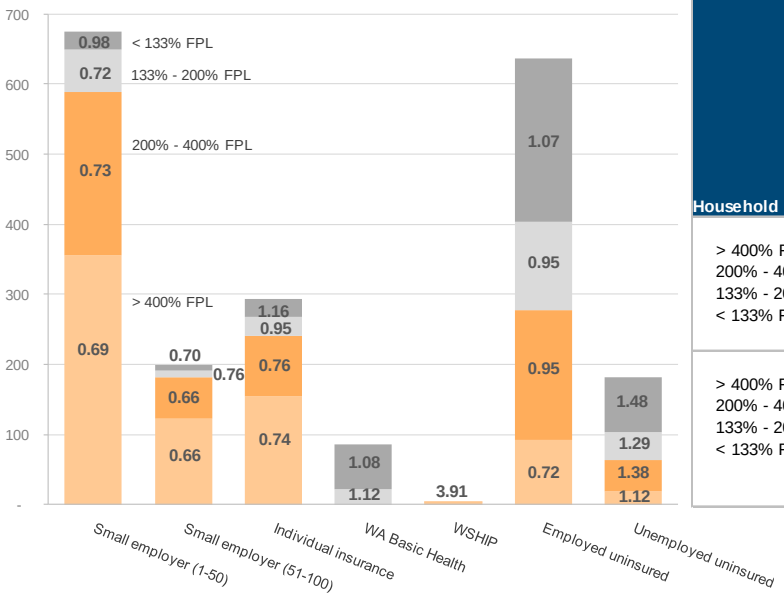
This section presents our analysis of the potential impact of the three key decisions. First we take a look at what one can infer about the potential impact from the baseline data presented in Table 2 of Section III (Background). This preliminary analysis also introduces the report's analytic approach.

Then we present the results of our more detailed analysis which incorporates assumptions about individual and employer behavior, Association healthcare plan participation, etc.

A. ANALYSIS OF BASELINE DATA

The chart and table below contain summarized results from the baseline data of Table 2 from Section III (Background). Merely from this data, one can make important observations about the potential impact of the State's three key decisions. However, for a more complete analysis, behavior rules and modeling assumptions must be introduced, as they are in the second part of this section.

Chart 1: Summary baseline data



Household income level	Employer coverage: Small employer (1-50)	Employer coverage: Small employer (51-100)	Individual insurance	WA Basic Health	WSHIP	Employed uninsured	Unemployed uninsured
	Number of people (thousands)						
> 400% FPL	355	123	154	-	2	92	19
200% - 400% FPL	233	58	87	-	1	186	45
133% - 200% FPL	61	10	26	22	-	126	40
< 133% FPL	26	8	27	64	-	232	77
	675	199	294	86	3	636	181
	Healthcare Expenditure Index						
> 400% FPL	0.69	0.66	0.74	-	3.76	0.72	1.12
200% - 400% FPL	0.73	0.66	0.76	-	4.22	0.95	1.38
133% - 200% FPL	0.72	0.76	0.95	1.12	-	0.95	1.29
< 133% FPL	0.98	0.70	1.16	1.08	-	1.07	1.48
	0.72	0.67	0.80	1.09	3.91	0.96	1.38

Table 2: Summary baseline data

The chart presents the same information as the table. Each bar of the chart represents an insurance coverage type, and each bar is subdivided into four household income levels. The height of each bar and segment represents the number of people in the coverage type or income level. Also indicated is the Healthcare Expenditure Index for each segment. For example, the bottom segment of the chart's first bar represents 355,000 people who are covered by insurance provided by small employers (1-50), whose household income level is greater than 400% of the FPL, and who have an average Healthcare Expenditure Index of 0.69.

A. ANALYSIS OF BASELINE DATA CONTINUED

Following are observations that one can make from Chart 1 and Table 2:

1. Merging the risk pools

If the risk pools were merged today

If the risk pools were merged today, with everyone covered under Individual insurance ("Individual insureds") merged into one risk pool together with everyone covered under Small Group insurance with small employers (1-50) (the "Small Group insureds"), then plan costs for the Small Group insureds would likely increase and plan costs for the Individual insureds would likely decrease. (see the sidebar)

"Plan cost" vs. Premium

In this report, rather than use the term "premium" to refer to the cost of a health insurance plan, we use the term "plan cost".

In our usage, "plan cost" is intended to include more than a plan's premium. It includes all consumer costs associated with a plan, no matter whether it is paid by an individual, an employer, or the government. In particular, it includes all consumer cost-sharing amounts (co-insurance, co-pays, etc.).

We use this broader concept because it is largely independent of a plan's cost-sharing design. In the new healthcare environment, there may be many plan design variations, both inside and outside the Exchange, and the premiums and cost-sharing for the various designs may vary widely. However, we are most interested in the impact of the three key decisions on aggregate plan cost, rather than merely the premium amount.

Our measure of relative plan costs under the Eight Decision Options is the "Plan Cost Index", introduced later in this section.

To understand this, observe that for each income band the healthcare expenditure indices (HEI) for Individual insureds are greater than the HEI for Small Group insureds. For example, the 87,000 Individual insureds in the 200% - 400% of the FPL band have an HEI of 0.76, whereas the 233,000 Small Group (1-50) insureds in the same band have a lower HEI of 0.73. A combined pool for the band would thus have an HEI of about 0.74[19], which is about 1 percent higher than the pre-merger HEI of 0.73 for Small Group insureds in the band. Because the level of plan cost is directly related to the HEI level, post-merger plan cost for Small Group insureds would also likely be higher. In fact, because administrative expenses for Individual insureds are greater than for Small Group insureds, and induced healthcare spending is lower (due to higher cost sharing), the plan cost increase would be a little higher than 1 percent.[20]

Of course, the example for the 200% - 400% of the FPL band is only theoretical, because in a combined risk pool all income bands would be commingled. However, applying the same logic we used in the 200% - 400% of the FPL band example to all the bands combined would produce an increase in HEI for Small Group insureds of about 3 percent. The increase in plan cost would be higher. Similarly, the *decrease* in HEI for Individual insureds would be about 8 percent, and the *decrease* in plan costs would be more.

[19] (87,000 * 0.76 + 233,000 * 0.73)/(87,000 + 233,000) = 0.74

[20] For example, if administrative expenses for Individual insureds are 10 percent greater, and induced healthcare spending is 4 percent higher, the approximate increase in premiums would be [(87,000 * 0.76 * 1.10*1.04 + 233,000 * 0.73)/(87,000 + 233,000)]/.73 = .77/.73 = 1.05, a 5 percent increase.

A. ANALYSIS OF BASELINE DATA CONTINUED

1. Merging the risk pools continued

If the markets are merged in 2014

In 2014, even with a static population, the situation will be much more complex:

- **Unemployed uninsured**. Suppose that, because of the PPACA mandate for everyone to have health insurance coverage, a substantial number of people in unemployed households who are uninsured were to elect Individual coverage. Then, because these people have relatively high HEI (eg, 1.38 for the 200% - 400% band), under a merged market the plan costs for Small Group insureds would likely increase a little more than we observed in the paragraphs above. However, because only a fraction of the 181,000 people will likely elect Individual coverage, the impact would be minimal. (see the sidebar)
- **Employed uninsured**. As the chart shows, there is a substantial number of people in employed households who are uninsured (636,000). These people have higher aggregate HEI (0.96) than Individual insureds (0.80). Thus, if — responding to the mandate — these people were to elect Individual coverage, the resulting HEI for Individual insureds would be increased to a level such that merging the risk pools would have an enhanced effect on the increase in HEI and plan cost for Small Group insureds.

Directional significance

Please note carefully that these results are only *directionally* significant, because the absolute levels of results are subject to wide variation.

The results indicate that, generally speaking, if the markets were merged today, one would expect plan costs for Small Group insureds to rise.

However, because of the lack of precision inherent in the survey results on which the HEI are based, the actual increase in HEI for Small Group from the merger could be more or less than 3 percent, perhaps by a wide margin. For comparison, when the same methodology was applied to results based on the 2008 Washington State Population Survey (WSPS), the increase was less than 3 percent. But, directionally, the results are the same.

Moreover, because the characteristics of the individuals and small employers covered by specific insurance companies may vary considerably from one company to another, the impact on specific Individual and Small Group insureds might vary considerably.

However, this result depends on the percentage of people in uninsured employed households who elect Individual coverage. In spite of the mandate, a high percentage of currently uninsured people — both those who are employed as well as those who are unemployed — may not elect insurance coverage, especially when the mandate first takes effect in 2014. Also, in 2014 the employers of those uninsured people who are part of employed households may improve their healthcare plans to such an extent that the number of employed uninsured may dramatically dwindle. In other words, the result is highly dependent on individual and employer behavior, behavior that is impossible to precisely predict in the new healthcare environment.

A. ANALYSIS OF BASELINE DATA CONTINUED

2. Definition of small employer

If today the definition of small employer were changed to employers with 1-100 employees, rather than employers with 1-50 employees, enrollment in Small Group plans might increase by about 199,000 people, plan costs for previous Small Group insureds might decrease slightly, and plan costs for employers with 51-100 employees might increase:

- **Enrollment**. The number of people covered under Group insurance with employers having 51-100 employees is 199,000.
- **Plan costs for Small Group insureds**. For three of the four income bands, the HEI of those covered by employer (51-100) Group insurance is less than or equal to the HEI of those covered by employer (1-50) Group insurance. (The exception is the 133% - 200% of the FPL band, which has only 10,000 people.) Therefore, if the two groups were combined, the resulting HEI — and the resulting plan costs — would be less than the HEI and plan costs for current Small Group insureds.
- **Plan costs for employers with 51-100 employees**. Similarly, if the definition were changed and the two groups combined, the resulting HEI and plan costs would be more than the current HEI and plan costs for people covered by employers with 51-100 employees.

However, for all these results there are two important caveats:

- From information supplied by the Washington Office of the Insurance Commissioner, it appears that a substantial number of employers with 51-100 employees have joined Association healthcare plans and thus are not subject to the State's Small Group adjusted community rating regulations. Because Association plans are, it appears, largely medically underwritten and rated (i.e., the premiums they charge an employer are dependent on the health status of its employees and their families) it is also likely that the HEI of the people associated with these employers may be lower than average, in order for these employers to obtain favorable premium rates. If this is true, the HEI of the remaining employers would be higher than those shown in Table 2, and changing the definition of small employer might even *raise* the plan costs of Small Group insureds. Unfortunately, adequate data about Association plans is unavailable: We cannot currently determine the types of employers that participate in them or the health status of their employees and families.
- Forcing employers with 51-100 employees into the Small Group pool might encourage many to change to self-insured arrangements or forego coverage altogether, thus potentially negating the HEI and plan cost effects noted above. Behavior matters.

It is also interesting to note that the definition of small employer will influence the impact of merging the Individual and Small Group markets. Changing the definition might mitigate the increase in the plan costs of Small Group insureds, for the same reasons discussed immediately above. However, the same caveats would also apply.

A. Analysis of baseline data continued

3. Federal Basic Health program

A Federal Basic Health program would cover people with household incomes in the 133% - 200% of the FPL band. If such a program were established today and if the current Washington Basic Health program were discontinued, a total of 411,000 people might join:

	Number in 133%-200% band
Unemployed uninsured	40,000
Employed uninsured	126,000
The current WA Basic Health program	22,000
Individual insurance	26,000
With employer coverage[21]	197,000
	411,000

However, not everyone eligible for the Federal Basic Health program will elect to join. Indeed, for this report we assume that no employees with employer coverage will elect to join, and that 35 percent to 100 percent of the other categories will elect to join (depending on the projection year, the Exchange Decision Option, the scenario, and the coverage category).

B. Detailed results

This section presents the results of our more detailed analyses.

Table 4 on the following page shows the baseline Washington healthcare environment after applying our assumptions for the number of people covered by employer self-insured plans and by Association healthcare plans.[22] As the table shows, we estimate that there are about 756,000 people in Association healthcare plans (including both self-insured and group-insured plans), and about 1,421,000 people covered by non-Association employer-provided plans that are self-insured.

Following Table 4 are three results summaries:

- **Table 5** is a high level summary of the impact of each key decision option
- **Table 6** is a summary of results for each of the Eight Decision Options
- **Chart 2** is a graphical representation of the material in Table 6

Following the summaries is a discussion of results and our recommendations.

[21] This number is obtained from Table 2 of Section III (Background).
[22] For information about these assumptions, see Appendix 1 (Methodology).

Household employment status and household income level	Number (thousands)														Healthcare Expenditure Index												
	Employer coverage					Non-employer coverage									Employer coverage					Non-employer coverage							
		Group insurance		Association plan		Individual insurance										Group insurance		Association plan		Individual insurance							
	Self-insurance	Outside Exchange	Inside Exchange	Self-insurance	Group insurance	Outside Exchange	Inside Exchange	Medicaid	CHIP	WA Basic Health	WSHIP	Medicare	Uninsured	Total	Self-insurance	Outside Exchange	Inside Exchange	Self-insurance	Group insurance	Outside Exchange	Inside Exchange	Medicaid	CHIP	WA Basic Health	WSHIP	Medicare and retiree medical	Uninsured	Total
A. Employed households																												
1. Small employer (1-50)																												
a. > 400% FPL	6	101	-	12	236	104	-	10	-	-	-	44	41	554	0.74	0.74	-	0.67	0.67	0.71	-	0.51	-	-	-	2.03	0.68	0.80
b. 200% - 400% FPL	4	66	-	8	155	54	-	41	4	-	-	44	94	470	0.78	0.79	-	0.70	0.71	0.71	-	0.56	0.43	-	-	2.37	0.96	0.91
c. 133% - 200% FPL	1	17	-	2	41	16	-	64	-	12	-	21	80	254	0.77	0.77	-	0.69	0.69	0.78	-	0.48	-	0.90	-	2.38	0.92	0.87
d. < 133% FPL	-	7	-	1	18	12	-	135	-	36	-	16	130	355	1.09	1.06	-	0.98	0.95	0.74	-	0.53	-	0.94	-	2.48	1.11	0.91
Total	11	191		23	450	186		250	4	48	-	125	345	1,633	0.76	0.77		0.70	0.70	0.72		0.52	0.43	0.93	-	2.27	0.97	0.87
2. Small employer (51-100)																												
a. > 400% FPL	7	67	-	5	44	4	-	3	-	-	-	6	6	142	0.69	0.69	-	0.62	0.62	0.73	-	0.52	-	-	-	2.15	0.65	0.72
b. 200% - 400% FPL	4	31	-	2	21	2	-	9	1	-	-	6	12	88	0.68	0.69	-	0.61	0.62	0.84	-	0.55	0.41	-	-	2.27	0.93	0.80
c. 133% - 200% FPL	1	5	-	-	4	-	-	9	-	1	-	1	7	28	0.76	0.80	-	0.68	0.72	-	-	0.48	-	0.83	-	2.56	0.99	0.80
d. < 133% FPL	1	4	-	-	3	1	-	21	-	2	-	3	14	49	0.70	0.73	-	0.63	0.66	0.72	-	0.56	-	0.78	-	2.51	1.05	0.85
Total	13	107		7	72	7		42	1	3	-	16	39	307	0.69	0.70		0.62	0.63	0.76		0.54	0.41	0.80	-	2.29	0.94	0.77
3. Large employer (> 100)																												
a. > 400% FPL	617	265	-	33	14	20	-	13	-	-	-	32	29	1,023	0.66	0.66	-	0.59	0.59	0.73	-	0.52	-	-	-	2.15	0.65	0.70
b. 200% - 400% FPL	289	123	-	15	7	11	-	44	4	-	-	28	63	584	0.66	0.66	-	0.59	0.59	0.84	-	0.55	0.41	-	-	2.27	0.93	0.76
c. 133% - 200% FPL	49	21	-	3	1	2	-	45	-	6	-	5	33	165	0.76	0.76	-	0.68	0.68	1.06	-	0.48	-	0.83	-	2.56	0.99	0.79
d. < 133% FPL	41	18	-	2	1	3	-	106	-	9	-	18	70	268	0.70	0.70	-	0.63	0.63	0.72	-	0.56	-	0.78	-	2.51	1.05	0.86
Total	996	427		53	23	36		208	4	15	-	83	195	2,040	0.67	0.67		0.60	0.60	0.78		0.54	0.41	0.80	-	2.29	0.94	0.75
4. Public employer																												
a. > 400% FPL	249	204	-	44	36	9	-	9	-	-	-	31	16	598	0.76	0.76	-	0.68	0.68	0.94	-	0.49	-	-	-	2.27	0.96	0.83
b. 200% - 400% FPL	127	104	-	22	18	8	-	14	1	-	-	15	17	326	0.69	0.69	-	0.62	0.62	0.73	-	0.33	0.59	-	-	2.17	0.97	0.75
c. 133% - 200% FPL	19	15	-	3	3	3	-	36	-	1	-	4	6	90	0.83	0.83	-	0.75	0.75	0.78	-	0.80	-	1.17	-	2.33	1.11	0.90
d. < 133% FPL	6	5	-	1	1	2	-	46	-	4	-	4	18	87	0.84	0.84	-	0.76	0.76	0.92	-	0.91	-	0.93	-	2.05	0.92	0.95
Total	401	328		70	58	22		105	1	5	-	54	57	1,101	0.74	0.74		0.67	0.67	0.84		0.76	0.59	0.98	-	2.23	0.97	0.82
Employed total	1,421	1,053		153	603	251		605	10	71	-	278	636	5,081	0.69	0.71		0.64	0.68	0.74		0.57	0.44	0.90	-	2.27	0.96	0.80
B. Unemployed households																												
a. > 400% FPL	-	55	-	-	-	17	-	3	-	-	2	131	19	227	-	1.17	-	-	-	0.82	-	0.59	-	-	3.76	2.09	1.12	1.69
b. 200% - 400% FPL	-	59	-	-	-	12	-	21	2	-	1	214	45	354	-	1.44	-	-	-	0.95	-	0.68	0.51	-	4.22	2.38	1.38	1.94
c. 133% - 200% FPL	-	12	-	-	-	5	-	36	-	2	-	104	40	199	-	1.57	-	-	-	1.56	-	1.05	-	3.42	-	2.67	1.29	2.01
d. < 133% FPL	-	13	-	-	-	9	-	212	-	13	-	112	77	436	-	1.26	-	-	-	1.97	-	1.12	-	1.79	-	2.93	1.48	1.69
Total	-	139	-	-	-	43		272	2	15	3	561	181	1,216		1.33				1.18		1.07	0.51	2.01	3.91	2.48	1.38	1.82
C. Grand total	1,421	1,192		153	603	294		877	12	86	3	839	817	6,297	0.69	0.78		0.64	0.68	0.80		0.72	0.45	1.09	3.91	2.41	1.05	1.00

Table 4: Current Washington State healthcare environment
after application of self-insurance and Association plan assumptions

Metric/ Coverage type	Baseline (2010)	Potential impact of: Establishing an Exchange in 2014 — 2014	Establishing an Exchange in 2014 — Ultimate year	Merging the risk pools in 2014 — 2014	Merging the risk pools in 2014 — Ultimate year	Establishing a Federal Basic Health Program in 2014 — 2014	Establishing a Federal Basic Health Program in 2014 — Ultimate year	Defining small employer as 1-100 employees for 2014 and 2015 — 2014	Defining small employer as 1-100 employees for 2014 and 2015 — Ultimate year
Enrollment (thousands)									
Individual (inside Exchange)	NA	↑ 140 - 380	↑ 170 - 430	↑ 10 - 20	↑ 0 - 10	↓ 60 - 140	↓ 80 - 140	↓ 0 - 20	NA
Small Group (inside Exchange)	NA	↑ 10 - 30	↑ 30 - 100	↓ 10	↓ 10 - 50	- 0	- 0	↑ 10 - 40	NA
Total Exchange	NA	↑ 140 - 410	↑ 200 - 520	↑ 0 - 10	↓ 10 - 40	↓ 60 - 140	↓ 80 - 140	↑ 10 - 20	NA
Individual (outside Exchange)	290	↓ 40 - 130	↓ 80 - 190	↑ 10 - 20	- 0	- 0	- 0	↓ 10 - 20	NA
Small Group (outside Exchange)	190	↓ 20 - 30	↑ 30 - 50	↓ 10	- 0	- 0	- 0	↑ 90	NA
Federal Basic Health program	NA	NA	NA	- 0	- 0	↑ 80 - 140	↑ 100 - 150	- 0	NA
Association healthcare plans	760	↓ 40 - 50	↓ 40 - 80	↓ 10	↑ 10 - 40	- 0	- 0	↑ 0 - 30	NA
Uninsured	820	↓ 350 - 530	↓ 500 - 670	↑ 0 - 10	- 0	↓ 0 - 20	↓ 10	↓ 10	NA
Plan Cost Index (percent)									
Individual	NA	↑ 10% - 15%	↑ 10% - 15%	↓ 5%	↓ 10%	↓ 5%	↓ 5%	- 0%	NA
Small Group	NA	- 0%	↓ 5%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	↓ 5%	NA
Association healthcare plans	NA	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	NA

Table 5: Summary of results

Notes:

1. The arrows (↑ and ↓) in the table indicate the direction of impact, either increasing (↑) or decreasing (↓).
2. In the table, enrollment changes are rounded to the nearest 10,000 people and plan cost changes are rounded to the nearest 5 percent.
3. The results for "Establishing an Exchange in 2014" (the first two columns) are without merged risk pools, without a Federal Basic Health Program, and without redefining small employer (for 2014 results). The ultimate year results reflect a redefinition of small employer.
4. The range of results shown in the table is a consequence of the range of assumptions we used corresponding to three scenarios of Exchange participation: Low, Medium, and High.
5. The last column of the table is NA (not applicable) because starting in 2016 "small employer" must be defined as employers with 1 – 100 employees. The "ultimate year" is assumed to be after 2016.
6. Because data about Association healthcare plans are scant, the estimate of enrollment in these plans is subject to significant error.

	Baseline	Risk pools: / Federal Basic Health: / Small employer definition:	Change from baseline: 2014								Change from baseline: Ultimate year			
			Separate / No / 50	Merged / No / 50	Separate / Yes / 50	Merged / Yes / 50	Separate / No / 100	Merged / No / 100	Separate / Yes / 100	Merged / Yes / 100	Separate / No / 100	Merged / No / 100	Separate / Yes / 100	Merged / Yes / 100
1. Low scenario														
A. Enrollment (thousands)														
Exchange - Individual	-		135	144	78	84	131	140	74	81	166	170	86	89
Exchange - Small Group	-		7	1	7	1	19	7	19	7	31	19	31	19
Exchange total			143	145	85	85	150	147	93	88	197	190	117	108
Federal Basic Health	-		-	-	78	80	-	-	78	79	-	-	99	99
Individual (outside Exchange)	294		(42)	(26)	(45)	(29)	(58)	(42)	(61)	(45)	(79)	(79)	(81)	(81)
Small Group (outside Exchange)	191		(22)	(36)	(22)	(36)	68	59	68	59	47	47	47	47
Association plans	756		(41)	(52)	(41)	(52)	(14)	(29)	(14)	(29)	(42)	(34)	(43)	(35)
Uninsured	817		(354)	(346)	(373)	(363)	(365)	(357)	(383)	(374)	(505)	(508)	(520)	(522)
B. Plan Cost Index														
Individual	0.88		10%	5%	7%	2%	11%	3%	7%	0%	10%	2%	6%	-1%
Small Group	0.84		-1%	10%	-1%	7%	-5%	8%	-5%	5%	-5%	7%	-5%	4%
Association plans	0.73		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
2. Medium scenario														
A. Enrollment (thousands)														
Exchange - Individual	-		260	274	160	171	250	264	152	163	298	304	185	188
Exchange - Small Group	-		17	8	17	8	43	20	43	20	63	33	63	33
Exchange total			276	282	177	178	293	284	195	182	362	336	249	221
Federal Basic Health	-		-	-	112	114	-	-	110	112	-	-	126	128
Individual (outside Exchange)	294		(84)	(70)	(87)	(73)	(98)	(84)	(101)	(87)	(133)	(133)	(134)	(134)
Small Group (outside Exchange)	191		(27)	(39)	(27)	(39)	61	53	61	53	40	40	39	40
Association plans	756		(44)	(56)	(44)	(56)	(29)	(34)	(29)	(34)	(63)	(39)	(63)	(40)
Uninsured	817		(440)	(435)	(450)	(443)	(450)	(444)	(458)	(452)	(590)	(593)	(600)	(602)
B. Plan Cost Index														
Individual	0.88		13%	8%	8%	3%	14%	6%	9%	1%	14%	6%	7%	0%
Small Group	0.84		-1%	13%	-1%	8%	-5%	11%	-5%	6%	-5%	11%	-5%	5%
Association plans	0.73		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
3. High scenario														
A. Enrollment (thousands)														
Exchange - Individual	-		382	403	242	257	366	387	230	245	427	435	285	287
Exchange - Small Group	-		26	15	26	15	67	32	67	32	96	46	96	46
Exchange total			408	418	268	272	433	418	297	276	523	481	380	333
Federal Basic Health	-		-	-	144	148	-	-	140	144	-	-	152	156
Individual (outside Exchange)	294		(126)	(114)	(129)	(117)	(137)	(126)	(140)	(129)	(186)	(186)	(187)	(187)
Small Group (outside Exchange)	191		(33)	(42)	(33)	(42)	55	46	55	46	32	33	31	33
Association plans	756		(47)	(60)	(47)	(60)	(44)	(38)	(44)	(38)	(83)	(44)	(84)	(45)
Uninsured	817		(525)	(522)	(525)	(521)	(532)	(529)	(532)	(528)	(672)	(675)	(679)	(680)
B. Plan Cost Index														
Individual	0.88		15%	9%	9%	5%	16%	7%	10%	2%	16%	7%	9%	2%
Small Group	0.84		-1%	14%	-1%	10%	-5%	12%	-5%	7%	-5%	12%	-5%	7%
Association plans	0.73		0%	0%	0%	0%	0%	0%	0%	0%	-1%	0%	-1%	0%

Table 6: Summary of changes from baseline
for each of the Eight Decision Options

Chart 2: Summary of changes from baseline
for each of the Eight Decision Options

C. Discussion of Results

Following are the salient results of our analysis:

Establishing an Exchange in 2014

- **Enrollment**. As Table 1 shows, in 2014 we estimate that Exchange enrollment will total 140,000 - 410,000 people, with 140,000 - 380,000 people covered under Individual insurance, and 10,000 - 30,000 people covered under Small Group insurance. Outside the Exchange, we estimate that the number of people covered by Individual insurance, Small Group insurance, and Association healthcare plans will all decrease, by 40,000 - 130,000, 20,000 - 30,000, and 40,000 - 50,000 people, respectively. We also estimate that the number of uninsured people will decrease by 350,000 - 530,000. Many of these will flow into the Exchange, but many will migrate to Medicaid and some will become covered under employer-sponsored plans.

  As the table shows, in the ultimate year, we estimate that Exchange enrollment will total 200,000 - 520,000 people, and that the number of uninsured people will drop by 500,000 - 670,000 people.

- **Plan cost level**. In 2014, for Individual coverage, the level of plan cost is expected to increase by 10 to 15 percent. After implementation of the Exchange, there will be an influx of relatively unhealthy people into Individual insurance (including formerly uninsured people and members of the Washington State Health Insurance Pool) which will increase the level of plan cost for Individual insurance. Plan costs for Small Group coverage and for Association plans are not expected to change. In the ultimate year, the increase in plan cost for Individual coverage is expected to be again 10 to 15 percent, while the level of plan cost for Small Group coverage is expected to decrease 5 percent as small employers with predominantly low-income employees drop coverage.

Merging the risk pools in 2014

- **Plan cost level**. For Individual coverage the level of plan cost is expected to decrease by 5 percent in 2014 and by 10 percent in the ultimate year, and for Small Group coverage it is expected to increase 10 to 15 percent. This inverse relationship is mainly due to the difference in average health status of people covered under Individual insurance versus people covered under Small Group insurance after implementation of the Exchange. With the advent of the Exchange, the average health status of those with Individual coverage is substantially less than the average health status of those with Small Group coverage. Consequently, if the risk pools were merged, plan costs for Individual insurance would decrease, and plan costs for Small Group insurance would increase.

C. DISCUSSION OF RESULTS CONTINUED

Merging the risk pools in 2014 continued

- **Enrollment.** In 2014, because fully-insured Small Group plan costs would increase with merged risk pools, small employers would be more likely to drop coverage, self-insure, or migrate to Association healthcare plans, thus causing a decrease in Small Group enrollment both inside and outside of the Exchange. Based on similar reasoning, Individual enrollments inside and outside the Exchange would *increase*. In the ultimate year, the migration pattern for people in the Exchange is similar, whereas for Small Group enrollment outside the Exchange no significant change is expected.

Establishing a Federal Basic Health program in 2014

- **Enrollment.** With the establishment of a Federal Basic Health program in 2014, the number of people with Individual insurance in the Exchange would decrease by 60,000 – 140,000 and the number in the Federal Basic Health program would increase by a similar number. In the ultimate year, the pattern is similar.
- **Plan cost level**. Because people migrating to the Federal Basic Health program are lower-paid, and because lower-paid people generally have poorer health status (and thus incur higher healthcare expenditures) the level of plan cost for Individual coverage would decrease by about 5 percent in both 2014 and in the ultimate year.

Defining small employer as 1-100 employees for 2014 - 2015

- **Enrollment.** If "small employer" is redefined in 2014 as employers with 1-100 employees, rather than employers with 1-50 employees, then the number of people covered under the redefined Small Group would increase both inside and outside the Exchange.
- **Plan cost level**. Because people covered by insurance provided by employers with 51 - 100 employees are, on average, in better health than people covered by employers with 1 - 50 employees, combining the groups would slightly decrease plan costs for the Small Group category. Redefining small employer would also result in a slight plan cost increase on average for employers with 51 - 100 employees. However, these cost changes would be minimal.

  The last column of Table 1 is NA (not applicable) because starting in 2016 "small employer" must be defined as employers with 1 – 100 employees. The ultimate year is assumed to be after 2016.

C. DISCUSSION OF RESULTS CONTINUED

These results are highly dependent on the current healthcare environment within the State of Washington, and on the characteristics of Washington's population. They do not translate to other States. For example, results would likely be markedly different for States that do not have community rating of their Individual and Small Group markets.

Similarly, these results do not uniformly apply to all health insurance companies operating within Washington. Because different insurance companies underwrite and design their products differently, the three key decisions will likely have varying impact among them.

D. COMPARISON TO SIMILAR STUDIES

In this section we compare our results to the results of two similar studies:

1. Health Insurance Partnership study

In 2008, Mathematica Policy Research, Inc. performed a study[23] to estimate the coverage and cost impacts of combining the Individual and Small Group markets under a program called the Preliminary Expanded Health Insurance Partnership (PHIP). The PHIP concept was an expanded version of the current Health Insurance Partnership program.

The Mathematica study report states:

> "In Washington, blending the small group and individual markets would substantially increase premiums for individuals (for their current insurance products) and reduce premiums for small group. Our estimates of PHIP enrollment assume the following effects on premiums associated with merging the small group and individual markets:
>
> - Small group premiums in the PHIP would drop 13 percent for the same coverage.
> - Individual premiums in the PHIP would increase 37 percent for the same coverage.
> - On average, premiums for small groups insured in association plans would increase 6 percent in the PHIP."[24]

By contrast, our analysis indicates that Small Group plan costs would *increase* 10 to 15 percent, Individual plan costs would decrease 10 to 15 percent, and Association plan costs would remain unchanged.

[23] Chollet, Deborah; Health Insurance Partnership Board Studies: Enrollment, cost, and implementation of a Preliminary Expanded Partnership; November 19, 2008

[24] This statement is on page 23 of the report.

D. COMPARISON TO SIMILAR STUDIES CONTINUED

It appears that the main reasons for this marked difference are twofold:

- **WSHIP impact**. For their study, Mathematica assumed that Washington health insurance carriers would turn down 5 percent of people applying for Individual coverage and direct them to the high-risk pool of the Washington State Health Insurance Pool (WSHIP). Thus, they assumed that WSHIP membership would total about 5 percent of the approximately 300,000 people with Individual coverage, or about 15,000 people. Based on a MEPS study quoted in their report[25], Mathematica appears to have further assumed that this migration to WSHIP would reduce expected expenditures of people covered by Individual insurance by about 50 percent.

  Neither assumption is appropriate for our study: **First**, under health reform, insurers may not redirect high-risk people to a separate pool. Therefore, in order to determine the impact of merging the risk pools under health reform, WSHIP members must be reintegrated into the people covered by Individual insurance. In any case, the Mathematica projection regarding the number of people who would be redirected to WSHIP is much greater than the current program enrollment. Currently, rather than 15,000 people, the WSHIP pool has about 3,000. **Second**, the Mathematica study appears to make a higher assumption about the relative cost of redirected WSHIP members than our study. According to the 2009 WSHIP annual report[26], the total claim cost for WSHIP members is $19,577 per enrollee. The 2009 total claim cost for Washington Individual enrollees appears to be more than $3,000.[27] Thus, the ratio of WSHIP to Individual claim costs appears to be less than about 6.5, compared to the Mathematica apparent assumption of approximately 10.[28]

- **Association membership migration.** The second main reason for the marked difference is that Mathematica assumed that, following the recommendations of Washington health insurance carriers, Association healthcare plan members would migrate to the PHIP (because Small Group plan costs would drop with a merged PHIP risk pool). Under health reform, our results indicate that Small Group plan costs would not drop as a result of merging the risk pools, and that therefore there would not be a high rate of Association membership migration to the Exchange.

[25] Yu, William W and Ezzati-Rice, Trena M.; (May 2005) Concentration of health care expenditures in the U.S. noninstitutionalized population. MEPS Statistical Brief #81. Agency for Healthcare Research and Quality (AHRQ)

[26] To find the WSHIP 2009 annual report, go to www.wship.org/annual_reports.asp.

[27] Based on quarterly filings of Washington health insurers.

[28] (50% x 300,000 x Average Individual claim cost)/(5% x 300,000) = 10 x Average Individual claim cost

D. COMPARISON TO SIMILAR STUDIES CONTINUED

2. Massachusetts study

In 2006, three actuarial firms (Gorman Actuarial, LLC; DeWeese Consulting, Inc.; and Hinckley, Allen & Tringale LP) analyzed the impact of merging the Massachusetts Individual and Small Group markets.[29]

The Gorman et al. study report states[30]:

> "Our major findings are as follows:
>
> - The effect of the merger of the Small Group and the Non-group markets is a decrease in current Non-group rates of approximately 15% and an increase in current Small Group rates of approximately 1 to 1.5%."

Although the Massachusetts health insurance environment in 2006 was different from Washington's current environment (in particular the population in Massachusetts covered by Individual insurance was relatively smaller) the Gorman et al. results are directionally the same as our results.

[29] Gorman Actuarial, LLC et al; (December 26, 2006) Impact of merging the Massachusetts Non-Group and Small Group health insurance markets.

[30] This statement is from page 10 of the report.

E. RECOMMENDATIONS

We make the following recommendations related to the three key decisions:

- **Defer making the decision about merging risk pools**. The risk pools can be merged at any time during or after 2014. A more-informed merger decision can be made after the State assesses the post-Exchange healthcare market, and the impact of Exchange subsidies on the affordability of health insurance. In particular, before adding another layer of complexity to the State's health insurance risk management system, it is important for the State and its health insurers to first determine how well the risk-adjustment mechanisms introduced by the health reform law work.[31]

  Another reason to defer the decision is to decouple the expected increase in Small Group plan costs from the establishment of the Exchange. Otherwise, in the business community the Exchange may become associated with excessive plan cost increases.

- **Defer the decision about establishing a Federal Basic Health program**. The decision about establishing a Federal Basic Health program depends on how the Exchange will be financed, marketed, and operated – considerations outside this report's scope. As Table 5 shows, establishing a separate Federal Basic Health program could potentially remove a large number of people from the Exchange, which in turn could reduce both the Exchange's ability to pay for itself and its leverage in the healthcare marketplace, and thus hinder its sustainability.[32] On the other hand, a Federal Basic Health program might be implemented in a way that could provide lower premiums and cost sharing for its members than they could obtain through the Exchange, as well as providing them greater continuity of care with Medicaid[33] – considerations that are also outside this report's scope. Before making the decision about establishing a Federal Basic Health program, it is important for the State to explore these additional considerations.
- **For redefining small employer, default to the required 2016 implementation**. Because redefinition of small employer will likely have an adverse impact on employers with 51 to 100 employees (by subjecting them to Small Group adjusted community rating regulations, and consequently increasing their plan costs) redefinition in 2014 could become a politically contentious issue and could cause disruption in the healthcare market, as employers with 51 to 100 employers either self-insure their healthcare plans or drop coverage. Further, as with the other two decisions, it may prove wise to observe the post-Exchange Washington healthcare environment before making this decision. Deferring the decision would also give the State time to further study the characteristics and potential behavior of employers with 51 to 100 employees.

[31] For more information about the law's risk adjustment mechanisms, see the HCA issue brief titled "Managing health insurance expenditure risks" at www.hca.wa.gov/hcr/exchange.html.

[32] For more information about the relationship between Exchange sustainability and the Exchange enrollment level, see the HCA issue brief titled "Exchange sustainability" at www.hca.wa.gov/hcr/exchange.html.

[33] For information about these topics, see the Milliman briefing paper titled "Healthcare reform and the basic health program option", at publications.milliman.com/publications/healthreform/pdfs/healthcare-reform-basic-health.pdf.

F. POLICY CONSIDERATIONS

Following are potential impacts of the three key decisions in major policy areas:

1. **Number of uninsured people**: As Table 1 shows, the Exchange itself, together with expanded Medicaid eligibility, is expected to dramatically reduce the number of Washington's uninsured people. However, each of the three key decisions is expected to have only a relatively minor impact, with the changes in uninsured people expected to be at most 10,000 to 20,000.
2. **Healthcare expenditure trend**: Although the Exchange itself, if appropriately designed and implemented, could potentially help to mitigate the long-term rise in healthcare expenditures[34], it is unlikely that any of the three key decisions would materially impact the trend.
3. **Quality and outcomes**: Although the Exchange itself, if appropriately designed and implemented, could improve healthcare quality and health outcomes in Washington, it is unlikely that either merging the risk pools or redefining small employer would materially affect quality or outcomes. However, a Federal Basic Health program might be implemented in a way that could increase the continuity of care—and consequently healthcare quality and health outcomes—for low-income people.
4. **Consumer choice**: Although the Exchange itself may increase consumer choice of healthcare plans, it is unlikely that any of the three key decisions would increase consumer choice. In fact, implementing a Federal Basic Health program could *decrease* the available plan options for people eligible for the program, because they would likely be excluded from the Exchange.
5. **Administrative simplicity**: While the Exchange itself, if appropriately designed and implemented, may reduce healthcare administrative complexity for consumers, it is unlikely that either merely merging the risk pools (absent further elaboration, such as harmonizing Individual and Small Group products) or redefining small employer would add to the simplification. However, establishing a Federal Basic Health program might further reduce administrative complexity for the people eligible for it.
6. **Healthcare market stability**: Both merging the risk pools and redefining small employer could slightly destabilize the healthcare market, since employers might respond to both by moving to Association healthcare plans, self-insuring, or dropping coverage.
7. **Existing State healthcare plans**: None of the three key decisions would necessarily affect existing State-administered healthcare plans. However, the Federal Basic Health program could potentially replace the Washington Basic Health program.
8. **Exchange sustainability**: Establishing a separate Federal Basic Health program could remove a large number of people from the Exchange, and thus reduce the Exchange population below a critical mass necessary for its long-term sustainability. It is unlikely that the other two decisions would materially impact the Exchange's long-term sustainability.[35]

[34] To learn more about the potential impact of an Exchange on cost containment, see the HCA issue brief titled, "Cost containment opportunities", found at www.hca.wa.gov/hcr/exchange.html.

[35] For more information about the relationship between Exchange sustainability and the Exchange enrollment level, see the HCA issue brief titled "Exchange sustainability" at www.hca.wa.gov/hcr/exchange.html.

V. NEXT STEPS

Although the data, model, methodology, and analyses underlying this report appear to be sufficient to support both our recommendations and substantive stakeholder discussion about the potential impact of the three key policy decisions on the Washington healthcare environment, a few additional steps would further facilitate future related policy considerations:

- **Association healthcare plans**. Currently, there is little data available about Washington's Association healthcare plans, even though these plans cover a large percentage of small employers. It would be useful to incorporate more accurate information about these plans in future estimates of Exchange enrollment.
- **Headcount reconciliation**. As discussed in Appendix 3 (Data reasonability tests), there are significant discrepancies in headcounts for various population categories between the following two sources: (1) the Washington State Population Survey (the basis for this report) and (2) estimates from the Washington State Office of the Insurance Commissioner. In order to incorporate more accurate population headcounts in future estimates of Exchange enrollment, it would be useful to reconcile these differences.
- **Non-static population**. Although there are valid reasons for having used a static population for this report, the Washington population may change significantly over the next three years. For example, the population will become older as baby boomers age. As they exceed age 65 and enter Medicare, this aging will remove many older and less healthy people from the focal population of this study. It would be useful to better understand the potential impact of a non-static population.
- **Competitive environment**. The potential impact of the three key decisions on Washington's health insurers may vary greatly from one to another. In order to determine the potential for a policy decision to destabilize the competitive environment, it would be useful to study the impact on the State's major health insurers. In particular, it would be useful to study the potential impact as part of the development of the risk adjustment mechanisms introduced by the health reform law.
- **Different rating areas**. It is likely that different geographic areas of Washington will be affected differently by the three key decisions. It would be useful to study these differences.
- **Employer impact**. It would be useful to study how the three key decisions affect different types of employers in Washington State.
- **Human behavior**. One of the great unknowns is how individuals and employers will behave in the new healthcare environment. It would be useful to conduct either surveys or simple experiments with individuals and employers in Washington to better understand their potential behavior.

- **Individual vs. Small Group health status**. One of the most significant potential discrepancies between the results of this report and the data and experience of stakeholders is the relationship between the health status of people currently covered under Individual and Small Group health insurance. Our study found that, on average, the health status of those currently covered by Individual insurance is worse than the health status of those covered by Small Group insurance. However, it appears that the data and experience of some Washington insurers indicates the opposite relationship. It would be useful to investigate this matter further.

VI. CAVEATS

The information contained in this report has been prepared for the Washington State Health Care Authority (HCA). It is our understanding that the information contained in this report may be utilized in a public document. To the extent that the information contained in this report is provided to third parties, the report should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and health care modeling so as not to misinterpret the data presented.

This report is not intended to benefit third parties. Milliman makes no representations or warranties regarding the contents of this report to third parties. Likewise, third parties are instructed that they are to place no reliance upon this report prepared for the HCA by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this report must rely upon their own experts in drawing conclusions about the likely impact in Washington associated with the implementation of a Health Benefit Exchange.

This analysis has relied extensively on data as documented throughout this report. This data was reviewed for reasonableness but no independent audits were performed. Should errors or omissions be discovered in the source data, the results of our analysis would need to be modified.

APPENDIX 1. METHODOLOGY

This section describes the methodology we used to produce the report's results. The section's purpose is transparency: to enable anyone to reproduce the results.

The methodology we followed is conceptually simple. Starting with a current Washington population allocated into relevant categories of employment status, household income level, and health insurance coverage, we used individual and employer "behavior rules" to move portions of the population to new health insurance coverage categories after the new Exchange becomes effective. We then compared health insurance enrollment and cost levels before and after implementation of the Exchange, under each of the eight Decision Options (for details about these options, see Section II (Introduction)), and for each of the following health insurance coverage categories:

- Individual coverage inside the Exchange
- Small Group coverage inside the Exchange
- Individual coverage outside the Exchange
- Small Group coverage outside the Exchange
- Federal Basic Health program coverage
- Association healthcare plan coverage

We made the comparison at two points in time after implementation of the Exchange, namely the year 2014 (when the Exchange first becomes effective) and an "ultimate" year (when the Exchange is assumed to reach a steady state).

The methodology includes the following key components:

Static population. The comparison of enrollment and cost levels is based on a "static" Washington population that does not change its underlying demographic characteristics (i.e., age, health status, employment status, and household income level) between 2010 and the "ultimate" year. Section A below describes how we developed the static population.

Behavior rules. The migration of people from current healthcare coverage categories in 2010 to their coverage categories in 2014 and the "ultimate" year (such as from uninsured status to Individual coverage inside the Exchange) is determined by individual and employer "behavior rules". These are described in Section B of this appendix.

Healthcare Expenditure Index. Comparison of relative cost levels is based on a comparison of "Healthcare Expenditure Indices" (HEI), a relative measure of expected healthcare expenditure propensity under a standard health insurance plan. Section C describes how we developed the HEI.

Plan Cost Index. The "Plan Cost Index" (PCI) is a relative measure of the expected total cost of health care (i.e., the expected amount that consumers and the government together would pay) for a particular population group under a particular coverage category. Section D describes the PCI.

A. STATIC POPULATION

The underlying population for this report does not change over time. It is static. People do not age or change their health status; neither do they change employers or their household income levels. We employ a static population in order to reduce the number of moving parts and simplify the analysis, thereby — we hope — contributing to the report's goal of helping stakeholders understand the new healthcare dynamics and make good long-term policy decisions.

Developing the static population involved the following steps:

Step 1: Develop core population

To develop population headcounts and health expenditures for the majority of relevant categories, we relied mainly on the 2010 Washington State Population Survey (WSPS). (see the sidebar) Following are the WSPS data items we used and how we used them[37]

Washington State Population Survey

The Washington State Population Survey is a biennial survey conducted since 1998 of about 8,000 randomly-selected Washington households, including about 19,000 people. It is managed by the governor's budget and policy office, the Office of Financial Management.

The survey includes questions about employment, income, and health insurance coverage.

A weight is assigned to each respondent's set of responses, according to the total number of Washington residents that the respondent is believed to represent. In this way, the survey provides an estimate of the entire Washington population.

For more information about the survey, visit www.ofm.wa.gov/sps.

Data item	Description	Used to develop
1. age	age	Health Expenditure Index
2. cur_ins	flag whether currently covered by health insurance	insurance coverage type
3. hhpovlev	household income as percent of FPL	household income level
4. ins_bhp	Washington Basic Health plan member	insurance coverage type
5. ins_emp	employer-sponsored health insurance member	insurance coverage type
6. ins_maa	Medicaid member	insurance coverage type
7. ins_mdcr	Medicare member	insurance coverage type
8. ins_mil	military insurance member	excluded population
9. ins_out	insurance from outside the household	insurance coverage type
10. ins_own	self-purchased insurance member	insurance coverage type
11. ins_other	other health insurance member	excluded population
12. lfs	labor force status	employment status
13. primecov	primary healthcare coverage	insurance coverage type
14. pwgt00	person weights	headcounts
15. q2p15[36]	active duty in the U.S. military	excluded population
16. q4p3	employment status	employment status
17. q4p8	hours per week at main job	employment status
18. q4p9	type of employment	type of employment
19. q4p16	number of employees with employer	employer size
20. q4p17	hours per week at other jobs	employment status
21. q7p3E	employer that provides coverage	employer size
22. q7p11	self-reported health status	Health Expenditure Index

[36] The abbreviation "Q2p15" refers to question 2, part 15, of the survey. A similar naming strategy is used throughout.
[37] Further information about these data items is available at www.ofm.wa.gov/sps/2010/dictionary2010v1.pdf.

A. STATIC POPULATION CONTINUED

Step 1: Develop core population continued

Generally, we used the WSPS data in an obvious way to produce most of the results in Table 2 of Section III (Background). In particular, note that the employer identified in Table 2 is the employer providing health insurance coverage rather than each individual's employer. However, in a few instances special manipulation was required:

1. WSPS responses that did not clearly identify employer size were distributed proportionately across employer size categories. Including these responses increased headcounts for employed households by about 10 percent.
2. Because some people reported multiple insurance coverages, the "primecov" data item was used to determine their primary coverage, so that they would not be double-counted. In cases where multiple coverages were indicated and "primecov" was not definitive, government programs such as Medicare were assumed to be primary if available, followed by employer plans, individual plans, and the Washington Basic Health plan.
3. There are approximately 139,000 people who are members of unemployed households but who are covered by primary employer-provided insurance. We assume that these are mainly people with retiree medical or COBRA coverage.
4. Because the method to determine the population covered under small group insurance is complex, it is described separately in Appendix 2.

Step 2: Determine employed households associated with employers having 51-100 employees

Because the WSPS differentiates only between employer sizes above and below 50 employees, we used data from another source to determine the proportion of people in employed households associated with employers having 51-100 employees. The data is from a merged business database developed by the State of Washington, incorporating data from the Washington State Department of Revenue, Employment Security Department, and the Washington State Department of Labor & Industries as of 2008.

According to an extract from the database, of those employees who work with firms employing more than 50 employees: 11.7 percent work for firms with 51-100 employees and are covered under employer-sponsored health insurance; and 16.4 percent work for firms with 51-100 employees and are not covered under employer-sponsored health insurance. We used these percentages to estimate the number of people in employed households associated with firms in the private sector having 51-100 employees.

A. STATIC POPULATION CONTINUED

Step 3: Determine CHIP and WSHIP populations

The WSPS does not include information about the Washington Children's Health Insurance Program (CHIP), or about the Washington State Health Insurance Pool (WSHIP). CHIP provides coverage for certain low-income uninsured residents under age 19, and WSHIP provides coverage for residents who are at high risk for medical expenditures.

The WSHIP 2008 annual report states that, as of December 31, 2009, enrollment was 3,578.[38] To reflect these people in the data, we identified the 3,578 people with the worst health status who reported that they had individually purchased health insurance coverage. We then placed these people in the WSHIP category.

Regarding CHIP, the Washington State Office of Financial Management informed us that, as of March 2008, enrollment was 13,033. According to Milliman analyses, the member count for 2009 was 13,118.[39] Similar to what we did with WSHIP members, to reflect these children in the data, we subtracted them from employed households with Medicaid coverage at the income level of 200% - 400% of the FPL, and placed them in a separate CHIP category.

B. BEHAVIOR RULES

In 2014 when an Exchange becomes available, what percentage of uninsured Washington residents who are members of unemployed households will choose to obtain insurance through the Exchange? And how many will elect to remain uninsured, even though they may be subject to penalties? Similarly, what percentage of small employers currently providing their employees with health insurance will participate in the Exchange? And how many will drop coverage, letting employees find their own insurance?

These are questions about the behavior of individuals and employers, under conditions neither has previously experienced. Not surprisingly, the answers are unknown. Nevertheless, to assess the potential market impact of the Eight Decision Options,[40] such behavior must be modeled. For this report, we model individual and employer behavior using "take-up rates" under three scenarios:

1. Low participation: In this scenario, we estimate that a relatively low percentage of eligible individuals and employers will move from existing coverage to participate in the Exchange.

[38] To find the 2009 annual report, go to www.wship.org/annual_reports.asp.
[39] Based on the total number of member months in 2009 of 157,418, derived from Milliman analyses.
[40] For an explanation of the Eight Decision Options, see Section II (Introduction).

B. BEHAVIOR RULES CONTINUED

2. High participation: In this scenario, we estimate a relatively high percentage of participation in the Exchange. It assumes the Exchange will employ extensive marketing, outreach, and education — as well as simple and efficient enrollment and consumer incentive processes — to encourage employers and individuals to participate.

3. Medium participation: This scenario is mid-way between the Low and High scenarios.

Appendix 6 presents the "take-up rates" we used to model individual and employer behavior under the three scenarios, for each of the Eight Decision Options. (see the sidebar)

Applying the take-up rates is straightforward: To determine the number of people who will migrate from Category A to Category B, simply multiply the number of people in Category A by the appropriate take-up rate for Category B. For example to determine the number of people who will migrate *from* members of unemployed households with income between 200% and 400% of the FPL who are uninsured in the baseline year, *to* Individual insurance inside the Exchange under option "2014-S-FBH-50" under the Medium scenario, multiply the number of people (45,000) by the appropriate take-up rate (43%) to obtain 19,000 (rounded to the nearest thousand).

There is one wrinkle, though. Order matters: for each option and scenario, employer take-up rates must be applied before individual take-up rates. This makes sense when one considers that the insurance status of people in employed households depends on the coverage that employers offer. For example, if — through application of employer take-up rates — an employer drops insurance coverage, then that employer's employees and their household members become uninsured (assuming, as we do, that no one else in the household is employed with coverage). These uninsured households must then decide the type of coverage they will elect, through application of individual take-up rates.

Take-up rates

A common way to model aggregate behavior for a group of people, especially when more refined behavior rules are unknown, is to use 'take-up rates'.

For people in a Category A, a 'take-up rate' relative to a Category B is the percentage of people in Category A who decide to migrate to (or, who "take up") Category B.

For example, suppose we estimate that 50 percent of uninsured Washington residents with household income between 200% and 400% of FPL will elect Individual insurance coverage. The take-up rate for the people going from uninsured status to Individual coverage is thus 50 percent.

B. BEHAVIOR RULES CONTINUED

The complete set of principles that guided our selection of take-up rates are given in Appendix 6 (Take-up rates). Key among them are the following:

- It has been thoroughly researched and demonstrated that, in general, not all individuals and employers make economically rational decisions. Accordingly, for this report we assume that, when individuals and employers decide to change their insurance coverage, most of them (but generally not all) will choose options that are economically most beneficial to them.
- In response to PPACA's mandate, more uninsured people will elect to obtain insurance coverage in the ultimate year than in 2014.
- Take-up rates vary by income level, generally with rates for movement to the Exchange increasing with decreasing income.

C. HEALTHCARE EXPENDITURE INDEX

In addition to comparing healthcare coverage enrollment before and after implementation of the Exchange, this report also compares relative costs of coverage (i.e., the amounts that consumers and the government together pay for the coverage). Unfortunately, there is no database that contains either healthcare expenditure or healthcare cost data for all the groups of Washington's population that are relevant for this report. One reason is that cost data do not (by definition) exist for some of the groups, such as for Washington's substantial uninsured population.

Therefore, to develop consistent relative costs for all relevant population groups, we developed a "Healthcare Expenditure Index" (HEI), a consistent measure of the relative healthcare expenditures expected from the various population groups, if they were all covered under a standard commercial insurance plan. The HEI is based on age and self-reported health status, a combination of factors that has been shown to be a good predictor of health expenditures.[41]

From the HEI, we then develop consistent relative costs across population groups, using a measure called the "Plan Cost Index" (PCI) described in the next section of this Appendix.

[41] For example, see DeSalvo, Karen B. et al (2009) Health care expenditure prediction with a single item, self-rated health measure; Medical Care; volume 47, number 4, April 2009.

C. HEALTHCARE EXPENDITURE INDEX CONTINUED

Following are the steps to develop the HEI:

Step 1: Develop standard relative healthcare expenditure risk factors

In any population covered by health insurance, it is well known that healthcare expenditures tend to rise with increasing age and with worsening self-reported health status. For example, a person who is 64 years old and self-reports health status as "Poor" will likely require far more healthcare expenditures than someone who is 24 years and self-reports health status as "Excellent". The 64-year-old's healthcare expenditure risk is greater.

It is also known that, for standard private insurance coverage, the ratios of healthcare expenditure risks among various age/health status categories are relatively stable over time and among populations. In other words, the ratio of the healthcare expenditure risk for the 64 year-old above to that for the 24-year-old will be relatively constant over time and among populations.

We used these facts to develop a standard set of relative healthcare expenditure risk factors for the Washington population. To do this, we used the MEPS Household Component for the entire United States (MEPS-HC-US) for people covered by private insurance during the years 2006-2008, to compare average total healthcare expenditures for combinations of five self-reported health statuses (Excellent, Very Good, Good, Fair, and Poor) and five age ranges (0-17, 18-24, 25-44, 45-64, and 65+). (see sidebar) Because of the prevalence of Medicare coverage after age 65, for those age 65 and over we used the entire population rather than those with private sector coverage. Expenditures in 2006 and 2007 were multiplied by a trend factor, so that total expenditures would equal those in 2008.

MEPS

Managed by the federal Agency for Healthcare Research and Quality, the Medical Expenditure Panel Survey (MEPS) is the most extensive and complete source of data about US health insurance coverage.

Commencing in 1996, MEPS is a comprehensive healthcare survey of families and individuals, medical providers, and employers across the US. It has two primary components:

Household Component. The Household Component collects data about individual and family demographics, health conditions, health status, use of medical services, healthcare charges, satisfaction with care, health insurance coverage, income, and employment.

Insurance Component. The Insurance Component collects data from private and public sector employers about the health plans they offer their employees.

For more information about MEPS, go to: www.meps.ahrq.gov/mepsweb/about_meps

C. HEALTHCARE EXPENDITURE INDEX CONTINUED

Step 1: Develop standard relative healthcare expenditure risk factors continued

Based on the relative expenditures, we then developed the following matrix of standard relative healthcare expenditure risk factors:

Age range	Self-reported health status				
	Excellent	Very good	Good	Fair	Poor
0-17	**1.2**	**1.6**	**2.0**	**5.7**	**20.0**
18-24	**1.0**	**1.5**	**2.0**	**5.7**	**15.0**
25-44	**1.6**	**2.2**	**3.5**	**5.2**	**11.6**
45-64	**2.6**	**3.6**	**5.1**	**9.7**	**21.7**
65+	**4.6**	**6.7**	**9.3**	**14.4**	**23.2**

The matrix is "normalized" to 1.0 for the average expenditures of the 18-24 age range with a health status of Excellent (circled above), so that all other cells are relative to a 1.0 in that cell. We also smoothed the results slightly to ensure a smooth progression in factors for increasing age (after the 0-17 range) and health status.

Thus, for example, the healthcare expenditure risk of a 64-year-old with self-reported health status of Poor is 23.2 times the healthcare expenditure risk of a 24-year-old with a self-reported health status of Excellent.

Step 2: Determine age/health status population counts

For each relevant category of employment status, household income level, and health insurance coverage, we then used the 2010 WSPS to determine the number of people in each cell of the age/health status matrix.

We made the following special modifications: We assumed that CHIP members are in the 0-17 age range, and that their health status is distributed the same as for Medicaid members in the 0-17 age range for the 200% - 400% of the FPL household income level.

C. HEALTHCARE EXPENDITURE INDEX CONTINUED

Step 3: Determine population average healthcare expenditure factors

In this step, we applied the risk factor matrix developed in Step 1 to the age/health status distribution of each population group, to determine the average healthcare expenditure factor for each group. For example, we applied the matrix to the population group containing those people who have group insurance coverage provided by small employers with less than 50 employees, and whose household income is more than 400 percent of the FPL. For each such group, the average healthcare expenditure risk is obtained by summing the products of risk factors and headcounts for each cell in the age/health status matrix, and dividing the sum by the group's total headcount.

Step 4: Adjust for varying member cost sharing

We adjusted the expenditure factors from the previous step to reflect differences in expenditures that result from different levels of member cost sharing among coverage types. For example, we assumed that expenditures for Individual coverage would be 4 percent lower than expenditures for Group coverage, everything else being equal, because cost sharing for Individual is 10 percent higher than cost sharing for Group.[42] The factors were adjusted accordingly.

In preparing these adjustments, we assumed the following average cost sharing percentages: Small Group 20 percent, large group 15 percent, individual 30 percent, and Medicare 20 percent.

Step 5: Normalize the results

The results from Step 3 are then "normalized" so that the weighted average of the factors developed in Step 4 (weighted by each group's total headcount) is 1.0 for the entire Washington population. We refer to the resulting factors as "Healthcare Expenditure Indices", or HEI. Note that the HEI indicate relative expenditure levels if everyone were covered under a standard commercial insurance plan. They do not reflect the difference in expenditure levels between different types of plans. Standardization based on commercial coverage is appropriate for the focus of this report, but may not be appropriate for analyses focused on public plans such as Medicaid.

D. PLAN COST INDEX

In order to provide a measure of the expected changes in the costs of coverage from the Eight Decision Options and three scenarios, we developed a "Plan Cost Index", or PCI. The PCI for a particular population group with a particular type of health insurance coverage is equal to the group's HEI times an adjustment factor to reflect the expected impact of cost sharing on expenditures, divided by a "medical expense ratio" for the group's insurance coverage.

[42] These results are based on the RAND Health Insurance Experiment and on Milliman research. For information about the RAND study, see Manning, Willard G. et al. (1988) Health insurance and the demand for medical care – evidence from a randomized experiment. Health insurance experiment series.

D. PLAN COST INDEX CONTINUED

For this purpose, we assumed the following factors for cost-sharing adjustment and medical loss ratios:

Coverage type	Baseline	2014 and Ultimate year	
		Inside Exchange	Outside Exchange
A. Cost-sharing factors			
1. Individual	**88%**	**88%**	**88%**
2. Small Group	**92%**	**92%**	**92%**
3. Association plans	**92%**	**NA**	**92%**
B. Medical loss ratios			
1. Individual	**80%**	**80%**	**80%**
2. Small Group	**85%**	**85%**	**85%**
3. Association plans	**85%**	**NA**	**85%**

F. ASSUMPTIONS

Underlying the methodology are the following assumptions:

Simplifying assumptions

- All public employers have more than 100 employees.
- No small employers will have grandfathered plans in 2014.[43]
- For purposes of this report, the population covered by the Health Insurance Partnership is negligible.
- The Washington Basic Health plan will be phased out by 2014.
- The Washington State Health Insurance Pool (WSHIP) will be phased out by 2014.
- Large employers do not employ vouchers to allow their employees to enter the Exchange.
- Because they cover relatively small numbers of people, Association healthcare plans covering Individuals would have negligible impact on the three key decisions, and so were not modeled separately.
- There is no normal "churn" into and out of the static population coverage categories that is independent of the establishment of the Exchange and the effects of the three key decisions. For example, in the normal course of events, as people drop and add coverage, there is normal "churn" into and out of the Individual insurance coverage category, even though the population of the category remains relatively stable over time. For this report, such normal "churn" is ignored.

[43] A Towers Watson analysis concluded that 80 percent to 90 percent of healthcare plans will cease to be grandfathered by 2012. See Towers Watson September 2010 report "Changes ahead – Health care reform in a challenging economy". Similarly, in a survey conducted by Hewitt Associates, Inc. (August 2010), 90 percent of companies said they expect to lose grandfathered status by 2014.

F. ASSUMPTIONS CONTINUED

Association healthcare plan assumptions

- We assume that, because of their regulatory status, Association plans will not participate in the Exchange. However, see Appendix 5 (Sensitivity analysis) for a discussion of the potential impact if the regulatory status of Association plan were changed.
- We assume the following percentages of people in employed households with employer-provided coverage participate in Association healthcare plans:

Small private employers (1-50):	**70%**
Small private employers (51-100):	**40%**
Large private employers (> 100):	**5%**
Public employers:	**15%**

  These assumptions are not based on data about Association plan participation per se, because such data is not available. Rather, we developed these assumptions so that the resulting number of enrollees in non-Association plans would approximately equal the number of such enrollees estimated by the Washington Office of the Insurance Commissioner (OIC).

  For example, we assume that 70 percent of people in employed households covered by small private employers (1-50) participate in Association plans. We chose this assumption so that the number of people covered by fully-insured small private employers (1-50) who do not participate in Association plans would approximately match OIC estimates. The OIC estimated that 172,000 people are covered by fully-insured small private employers (1-50). [44] Our assumption produces a corresponding estimate of 191,000.

  Similarly, the OIC estimated that approximately 926,000 people are covered by large employers (51+) and public employers.[45] Based on the assumptions above, the corresponding number of people for this report is approximately 1,001,000 people (including 139,000 people from unemployed households who we assume are covered by employer-provided retiree medical or COBRA plans).

- The Healthcare Expenditure Index for population groups covered under Association plans is 90 percent of the Healthcare Expenditure Index for population groups covered under equivalent non-Association plans. We estimate that at least a 10 percent differential in plan cost (which are based linearly on Healthcare Expenditure Indices) is necessary for employers to move from conventional group insurance to an Association plan. It is interesting to note that in their reinsurance study, the Urban Institute assumed a 25 percent differential. [46]

[44] This result is based on an unpublished OIC estimate that was derived from insurance company filings.
[45] This result is based on an unpublished OIC estimate that was derived from insurance company filings, and includes an estimated 228,000 enrollees in the Federal Employees Health Plan.
[46] Bovbjerg, Randall R. et al; Reinsurance in Washington State; The Urban Institute; February 2008

F. ASSUMPTIONS CONTINUED

Self-insured plan assumptions

- Following are the assumed percentages of Washington residents with employer-provided health insurance who are covered by self-insured plans:

Small private employers (1-50):	**5%**
Small private employers (51-100):	**10%**
Large private employers (> 100):	**70%**
Public employers:	**55%**

  We chose these assumptions so that the number of people covered by self-insured plans, as well as the number not covered under such plans, would approximately equal the OIC's estimates. The OIC estimated that the number of people covered by self-insured plans is approximately 1,560,000. For this report, the estimated number of people covered by self-insured plans is 1,574,000.

  See Appendix 5 (Sensitivity analysis) for a sensitivity analysis of this assumption.

- Healthcare Expenditure Indices are the same for group-insured and self-insured population groups at the same household income level and employer type. (This assumption is necessary because we do not have data regarding the age and health status distributions of population groups covered by self-insured employers.)

Because the WSPS does not differentiate between self-insured and group-insured employers, we used data from the 2008 MEPS Insurance Component for Washington State (MEPS-IC-WA) database to determine the population covered by self-insured employers. MEPS-IC-WA reports that 9.5 percent of employees enrolled in health insurance with firms having fewer than 50 employees are enrolled in self-insured plans. Using similar MEPS-IC-WA results, we determined (using weighted averages) that 74.0 percent of employees enrolled in health insurance with firms having more than 100 employees are enrolled in self-insured plans, and that 10.4 percent of employees enrolled in health insurance with firms having 51-100 employees are enrolled in self-insured plans. We applied these percentages to determine the employed household population covered by self-insurance. Based on stakeholder input, we adjusted these percentages slightly to more accurately reflect the Washington healthcare market.

G. COMPARISON TO METHODOLOGIES OF SIMILAR STUDIES

To see this methodology from a wider perspective, following is a comparison of it to methodologies used in three similar recent studies:

1. Health Insurance Partnership study

In 2008, Mathematica Policy Research, Inc. performed a study[47] to estimate the coverage and cost impacts of combining the Individual and Small Group markets under a program called the Preliminary Expanded Health Insurance Partnership (PHIP). The PHIP concept was an expanded version of the current Health Insurance Partnership program.

Mathematica's methodology

Mathematica's methodology was based on developing data and behavior rules at the individual person and firm level for use in a micro-simulation model.[48] For this purpose, Mathematica used the 2006 WSPS as the primary source of its population data, reweighted to reflect the Washington Office of Financial Management's population projection to 2010. It supplemented this data with two years of data (2004 and 2005) from the MEPS-HC for the West and Midwest, and three years of data (2003-2005) from the MEPS-IC specially extracted for Washington State.

The methodology includes algorithms that compute the price-driven behavioral probabilities that:

- An individual firm will offer health insurance to an individual employee
- An individual employee will accept an employer's offer of health insurance
- An individual not offered employer-sponsored coverage will purchase Individual insurance

In the report, these algorithms are not described in detail. Also, from the report, it appears that premiums for covered individuals are derived from the MEPS-HC database (using regional data with adjusted weights to match the Washington population) and that "premiums" for uninsured individuals are imputed.

Comparison with our methodology

Although we are using similar databases to those Mathematica used, our approach is different:

- Whereas Mathematica's approach was bottom-up, employing micro-simulation and individual-level data, our approach is top-down and based on aggregate group-level data.
- Our behavior rules are based on aggregate take-up rates. Mathematica's behavior rules are at the individual level and are not specified in the report.
- Whereas Mathematica's methodology is not transparent, we use a fully-specified method based on Washington-specific age and health status data (rather than on regional data).

[47] Chollet, Deborah; Health Insurance Partnership Board Studies: Enrollment, cost, and implementation of a Preliminary Expanded Partnership; November 19, 2008

[48] Micro-simulation models deal with entities at the individual person and firm level, rather than at an aggregated level.

G. COMPARISON TO METHODOLOGIES OF SIMILAR STUDIES CONTINUED

2. Reinsurance study

In 2008, the Urban Institute performed a study[49] to examine the potential role of reinsurance in expanding health insurance coverage in Washington, including its potential costs and benefits.

Urban Institute's methodology

As with Mathematica, the Urban Institute's methodology was based on data and behavior rules at individual person and firm levels for use in a micro-simulation model. For this purpose the Urban Institute constructed a baseline population primarily with national data from the MEPS-HC database for three years (2003-2005), reweighted to match results from the WSPS. In the report, the data preparation method is not described in adequate detail to be reproduced.

Comparison with our methodology

Our approach is different from the Urban Institute's:

- As with Mathematica, the Urban Institute's approach was bottom-up, employing micro-simulation and individual-level data. Our approach is top-down.
- As with Mathematica, the Urban Institute's methodology description does not enable someone the reproduction of their results.

3. Massachusetts study

In 2006, three actuarial firms (Gorman Actuarial, LLC; DeWeese Consulting, Inc.; and Hinckley, Allen & Tringale LP) analyzed the impact of merging the Massachusetts Individual and Small Group markets.[50]

Gorman et al.'s methodology

Their baseline data for the insured population was primarily obtained from the six largest Individual and Small Group health insurance carriers in Massachusetts. Data for the uninsured population was obtained from three databases:

- A survey conducted by the Massachusetts Division of Health Care Finance and Policy
- U.S. census data
- An analysis of U.S. census data performed by the Urban Institute for the Blue Cross Blue Shield of Massachusetts Foundation

Numbers of uninsured people who, largely because of the insurance mandate, elect various coverage options (or elect to remain uninsured) were modeled using take-up rates.

[49] Bovbjerg, Randall R. et al; Reinsurance in Washington State; The Urban Institute; February 2008

[50] Gorman Actuarial, LLC et al; (December 26, 2006) Impact of merging the Massachusetts Non-Group and Small Group health insurance markets.

G. COMPARISON TO METHODOLOGIES OF SIMILAR STUDIES CONTINUED

3. Massachusetts study continued

Comparison with our methodology

Gorman et al. developed their baseline insured population data from health insurance carrier data and their baseline uninsured population data from U.S. census data and a Massachusetts-specific survey. Our methodology does not rely on health insurance carrier data or U.S. census data.

As with the Gorman et al. model, to model behavior our methodology applies take-up rates.

H. POTENTIAL WEAKNESSES

Every model and modeling methodology is, by definition, inaccurate. None can represent reality exactly.

Following are ways in which our methodology is not an exact representation of reality:

1. **The Washington population is not static**. Contrary to the methodology, the Washington population will not be static. People will age, their household income levels will increase or decrease, they will move from one type of employer to another, they will move into and out of the State, and they will be born and die. As discussed above, we employed a static population in order to simplify the analysis and make it easier for stakeholders to understand the dynamics of the new healthcare environment and to make good long-term policy decisions.
2. **Behavior does not happen in the aggregate**. The methodology incorporates behavior at a group level (with aggregate take-up rates) rather than at the levels of the individual person and firm where decisions are actually made. Unfortunately, how individual people and firms will behave in 2014 under the new healthcare environment is unknown.
3. **The economy is not static**. Implicit in the methodology is an assumed static economy. But, the economy will likely change between 2010 and 2014 (and certainly will change between 2010 and the ultimate year), and so will the number of uninsured people, the number of employed people, and the number of people at various household income levels.
4. **Healthcare Expenditure Indices are approximate.** The methodology determines Healthcare Expenditure Indices based on two surveys, one of which (MEPS-HC) is not Washington-specific. Because surveys have inherent accuracy limitations, one should consider results based on the Healthcare Expenditure Indices to be only approximate and only directionally significant.
5. **Take-up rates do not vary by HEI**. Although in reality people who have the worst health are more likely to migrate first to Individual insurance coverage, this is not reflected in the take-up rates. Thus, the model likely understates the resulting HEI of people with Individual coverage.

APPENDIX 2. SMALL GROUP DATA PREPARATION

This section presents the major steps of the data preparation logic that we used to count the number of people with health insurance coverage provided through a small employer using the Washington State Population Survey. The table below summarizes the results of our methodology. Following the table is a description of each item in it. In the description, WSPS field names are indicated in brackets. Note that the result of this illustration is not exactly the result shown in Table 2 – some detailed manipulations that are made during the development of Table 2 are omitted here for the sake of clarity.

Data preparation step	Number of people (thousands)
1. State population	**6,733**
2. No employer or union health insurance coverage	**2,886**
Subtotal	**3,847**
3. Different primary coverage	**(477)**
4. Unemployed households	**(142)**
Subtotal	**3,228**
5. Not Covered by a small employer	**(2,385)**
6. Undetermined employer size adjustment	**(187)**
Result	**656**

1. **State population:** We start with all WSPS respondents, and assign Household Employment Status and Employer Size for each person, as described below. To determine state wide population estimates, WSPS individual responses are multiplied by person level weights [pwgt00].

   Household Employment Status: Household Employment Status is defined for each member of a household, where households are differentiated according to the household identification number [ID]. If any household member is employed (labor force status [LFS]=1) then all household members are considered to have a Household Employment Status of "Employed". Thus, a particular household member may be unemployed ([LFS]≠1) yet have a Household Employment Status of Employed.

A. SMALL GROUP DATA PREPARATION CONTINUED

Employer Size: Employer Size is defined for each household member based on responses to questions about employer size [q4p16], employer type [q4p9] and a question asking which member of the household is the plan's policyholder (for employer based coverage, [q7p3E]).

The following method is used to determine the employer size for each respondent who did not identify another member of their household as policyholder. If the person is employed ([LFS] = 1), Employer Size is "Small" if their employer has 50 or fewer employees, or if the member is self employed ([q4p16] = 1 OR [q4p9] = 4). Otherwise, Employer Size is "Not Small" if their employer has more than 50 employees or if the member is employed by the government ([q4p16] = 2 OR [q4p9] = 1). If the employer size cannot be classified using either of these definitions, the member's Employer Size is "Undetermined". For unemployed ([LFS] ≠ 1) members of employed households, the Employer Size of the employed member of their household who reports the highest number of average weekly working hours is used (the highest [hourweek] response).

Finally, those who indicate that another member of their household is their plan's policyholder are assigned the policyholder's Employer Size [q7p3E]. This means that each person's Employer Size represents the size of the policyholder's employer, not the size of their own employer.

2. **No employer or union health insurance coverage:** Next we eliminate responses for household members who are not covered by health insurance provided through an employer or union. (i.e., drop responses where [ins_emp] ≠ 1)

3. **Different primary coverage:** Eliminate responses for household members who have health insurance coverage from multiple sources and who do not rely on their employer or union coverage as their primary health insurance coverage. This is accomplished in two steps based on responses to questions about the number of health insurance plans the member is covered by [numplans] and the primary source of health insurance coverage [primecov]:

   a. Eliminate responses indicating another primary source of coverage ([numplans] > 1 and [primecov] is one of 2, 3, 4, 5, 6, 7 or 8).
   b. Eliminate responses where the primary source of coverage is not specified and coverage is available to the individual either through the military, Medicare or through Medicaid/MAA (([primecov] is .N, .D, .R, .A or .S) and ([ins_mil] = 1 or [ins_mdcr] = 1 or [ins_maa] = 1)).

A. SMALL GROUP DATA PREPARATION CONTINUED

4. **Unemployed households:** Eliminate responses for members for whom Household Employment Status is not "Employed". We assume that these people are early retirees or COBRA enrollees (Household Employment Status ≠ Employed)

5. **Not covered by a small employer:** Eliminate responses for household members covered by health insurance provided through employers where Employer Size is "Not Small" (Employer Size = Not Small)

6. **Undetermined employer size adjustment:** Eliminate a portion of the person weighted responses [pwgt00] for the household members whose Employer Size is "Undetermined". The number eliminated is equal to the weighting total of those with "Undetermined" Employer Size (sum of [pwgt00] where Employer Size is Undetermined), 187,000, multiplied by the ratio of total weighted responses after Step 5 where Employer Size is "Not Small" divided by the total weighted responses where Employer Size is either "Small" or "Not Small" (235,000*(2,385,000/2,993,000) = 187,000). We assume that these people are covered by an employer whose size is not small.

APPENDIX 3. DATA REASONABILITY TESTS

This appendix discusses the reasonability of the numbers of people and the healthcare expenditure indices shown in Table 2 of Section III (Background). To examine the reasonability of the results shown in Table, 2, we performed several reasonability tests. Among these was a comparison of the headcounts in Table 2 to headcounts estimated by the Washington State Office of the Insurance Commissioner (OIC). As you will see, for both Individual insurance and employer coverage, there is wide divergence between the headcounts shown in Table 2 and OIC results. In Section V (Next steps) we suggest that the State reconcile these differences.

A. NUMBER OF PEOPLE

1. Total population

According to Washington State Population Survey (WSPS) tabulations, in 2010 there were 6,733,250 non-institutionalized residents in Washington.[51]

Of these, we excluded approximately 361,000 people who are covered by military health plans.[52] We assume that these people include those who are in active military service, the National Guard, or the Reserves, and their families, as well as veterans who receive primary healthcare coverage through the Veterans Health Administration. This number is not separately identified in WSPS tabulations.

We also excluded approximately 78,000 people with inadequate data. In general, these are people who had healthcare coverage from a source not specified in the WSPS.

After subtracting these exclusions, the total population for Table 2 is 6,297,000.

[51] See www.ofm.wa.gov/sps/2010/tabulations/pnum.txt

[52] To determine this number, we examined responses to three WSPS questions:

- Whether the respondent received military health insurance coverage
- Whether the coverage was primary
- Whether the respondent was an active member of the military

We excluded people responding affirmatively to both of the first two questions, and people responding affirmatively to the third question.

A. NUMBER OF PEOPLE CONTINUED

2. Uninsured population

According to WSPS tabulations, in 2010 there were about 819,000 residents who were uninsured.[53] The 2009 estimate of the uninsured from the American Community Survey (ACS) is about 878,000 ± 21,000.[54] The ACS may over-count the uninsured because it does not ask the apparently uninsured respondents a confirmatory follow-up question, whereas the WSPS does ask such a follow-up question.

Therefore, the uninsured headcount of 817,000 in Table 2 appears to be reasonable.

3. Insured population

Based on the results above, the number of non-military non-institutionalized people in Washington covered by health insurance is approximately 5,480,000.

4. Population covered by public plans

Of the approximately 5,480,000 people covered by health insurance, following is a breakdown of those whose primary healthcare coverage is with public plans (i.e., plans that are neither Individual insurance plans nor provided by employers).

a. Medicare

According to WSPS tabulations, in 2010 there were about 993,000 residents covered by Medicare.[55] Of these, approximately 154,000 had primary coverage elsewhere. Therefore, Table 2 shows 839,000 people with primary coverage through Medicare.

b. Washington State Health Insurance Pool

The WSHIP 2009 annual report states that, as of December 31, 2009, enrollment was 3,578.[56] Therefore, the enrollment of 3,000 shown in Table 2 appears to be reasonable.

c. WA Basic Health

According to the Washington Basic Health 2009 Annual Report, as of December 2009 there were 75,678 people enrolled in the Basic Health program. [57] Therefore, the enrollment of 86,000 shown in Table 2 appears to be reasonable.

[53] See www.ofm.wa.gov/sps/2010/tabulations/medical/cur_ins.txt
[54] See factfinder.census.gov/servlet/DatasetMainPageServlet?_program=ACS&_submenuId=&_lang=en&_ts=
[55] See www.ofm.wa.gov/sps/2010/tabulations/medical/ins_mdcr.txt
[56] To find the 2009 annual report, go to www.wship.org/annual_reports.asp

A. NUMBER OF PEOPLE CONTINUED

4. Population covered by public plans continued

d. Children's Health Insurance Program (CHIP)

The Washington State Office of Financial Management informed us that, as of March 2008, enrollment in CHIP was 13,033. From Milliman analyses of claims-level data, we determined that the member count for 2009 was 13,118. Therefore, the enrollment of 12,000 shown in Table 2 appears to be reasonable.

e. Medicaid

According to WSPS tabulations, in 2010 there were about 1,068,000 residents who received healthcare coverage under Medicaid or another DSHS plan. Of these, about 178,000 have different primary coverage, and about 13,000 are enrolled in the Children's Health Insurance Program, leaving about 877,000 Medicaid enrollees, which is equal to the Medicaid population shown in Table 2.

Table 2 shows that many residents covered by Medicaid have household incomes over 200 percent of the FPL. Among the reasons for this result are:

- Medicaid eligibility is based on family income (rather than household income), and for many people household income is larger than family income.
- For Medicaid eligibility some expenses, such as childcare expenses, are ignored.
- Eligibility for some children is based on their personal income, rather than on family income.

Nevertheless, we are unable to completely explain this result. However, because we assume that the current Medicaid population will not migrate to other plans, this apparent anomaly does not affect the report's results.

[57] To find the 2009 annual report, go to www.basichealth.hca.wa.gov/documents/2009AnnualReport.pdf

A. NUMBER OF PEOPLE CONTINUED

4. Population covered by public plans continued

As summarized below, the total number of Washington residents covered by public plans is approximately 1,817,000:

Public plan	Number of people (thousands)
1. Medicare	**839**
2. WSHIP	**3**
3. WA Basic Health	**86**
4. CHIP	**12**
5. Medicaid	**877**
Total	**1,817**

This implies that the total number of Washington residents with primary healthcare coverage either through Individual insurance or employer-provided plans is 3,663,000 (the total number covered by health insurance, 5,480,000, less the number covered by public plans, 1,817,000).

5. Population covered by individual insurance

According to WSPS tabulations, in 2010 there were about 733,000 residents who purchased their own health insurance.[58] Of these about 142,000 had other primary coverage and were under age 65, about 293,000 were over age 64 (we assume they purchased Medicare supplemental or Medicare Advantage coverage), and about 4,000 were covered under the Washington State Health Insurance Pool, giving a net number of people with primary Individual coverage of 294,000 (the number shown in Table 2).

By comparison, the OIC recently estimated that as of December 31, 2009, there were approximately 319,000 people with Individual coverage (excluding those with Medicare supplemental and Medicare Advantage coverage)[59]. The corresponding WSPS-based number is 436,000 people (294,000 + 142,000 with other primary coverage). Thus, the OIC figure is lower than the WSPS-based estimate by about 117,000 people. Possible reasons for the discrepancy are: some out-of-state insurers do not report their Individual coverage population to the OIC, some Association healthcare plans do not report their Individual coverage population to the OIC, and the WSPS results may be inaccurate.

[58] See www.ofm.wa.gov/sps/2010/tabulations/medical/ins_own.txt

[59] This result is based on unpublished OIC estimates that were derived from insurance company filings. The results include an estimate of the number of people covered by Association plans of about 20,000.

A. NUMBER OF PEOPLE CONTINUED

6. Population with employer-provided coverage

According to WSPS tabulations, in 2010 there were about 3,847,000 residents who received employer- or union-sponsored health insurance coverage.[60] Of these, about 478,000 had other primary coverage (such as Medicaid or Medicare), giving a net number of people with primary employer coverage of 3,369,000. Note that approximately 139,000 of these are in unemployed households. We assume that, in the main, these are people covered under retiree medical plans or COBRA.

By comparison, the OIC recently estimated that as of December 31, 2009, there were approximately 3,133,000 people with employer coverage.[61] The corresponding WSPS-based number is 3,847,000 (3,369,000 + 478,000 people with other primary coverage). Thus, the OIC figure is lower than the WSPS-based results by approximately 714,000 people (3,847,000 – 3,133,000). As with the discrepancy in Individual coverage headcounts, possible reasons for the discrepancy are that some out-of-state insurers do not report their Individual coverage population to the OIC, and some Association healthcare plans do not report their Individual coverage population to the OIC. Of course, another potential reason is that the WSPS survey results do not accurately represent the Washington population.

It appears that a great part of the discrepancy in employer-provided coverage lies in the Small Group (1-50) coverage category. As shown in Table 2, WSPS-based results indicate that 675,000 people have primary employer-based coverage provided by employers with 1-50 employees. By contrast, OIC estimates indicate that only about 384,000 people have such coverage, including people with non-primary coverage. Thus, for small employers, there is a discrepancy of at least 291,000 people.

For this report, we address this discrepancy by assuming that the OIC results are accurate for both non-Association Plan coverage and for total self-insured coverage. We further assume that the excess of people who, according to the WSPS survey, have employer-provided coverage, but who are not included in the OIC estimates for non-Association healthcare plan or self-insured coverage are members of Association healthcare plans. Thus, our assumption for the number of people in Association healthcare plans exceeds the OIC estimate of participation in these plans by a wide margin. To learn more about our assumptions for Association healthcare plan membership, and the sensitivity of these assumptions, see Appendix 1 (Methodology) and Appendix 5 (Sensitivity analysis).

[60] See www.ofm.wa.gov/sps/2010/tabulations/medical/ins_emp.txt

[61] These results are based on unpublished OIC estimates that were derived from insurance company filings. The results include an estimated maximum number of people covered by self-insured plans of 1,570,000, and an estimated 228,000 enrollees in the Federal Employees Health Plan.

B. HEALTHCARE EXPENDITURE INDEX

To check the reasonableness of the Healthcare Expenditure Index (HEI) results, we compared the underlying data to results from the Medical Expenditure Panel Survey (MEPS)[62] and to results for two Washington insurers.

Comparison to MEPS

Chart 1 below compares the distribution of self-reported health status for Washington residents in 2010 from the Washington State Population Survey (WSPS) to the distribution for all U.S. residents in 2008 from MEPS.

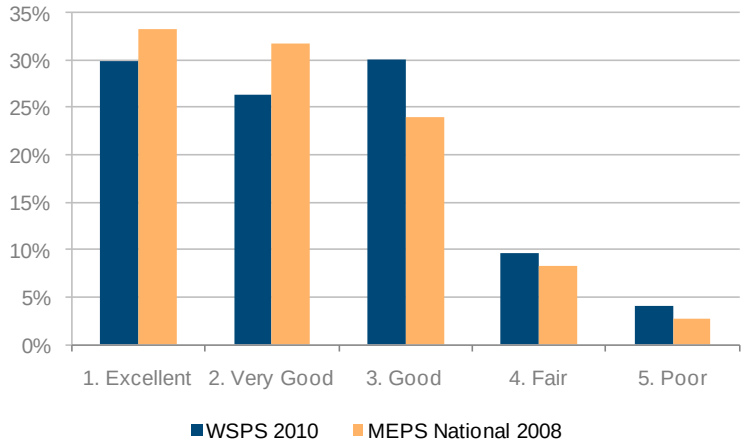


Chart 1: Self-reported health status comparison – WSPS vs. National MEPS – All coverage

As you can see from Chart 1, the distribution of self-reported health status among Washington residents deviates from the national distribution. In Washington, more people report themselves in poorer health. This relationship also holds between WSPS 2010 and the MEPS Western region survey in 2008, which includes Washington. As you can see from Chart 2 below, this deviation even more pronounced for people covered by Individual insurance.

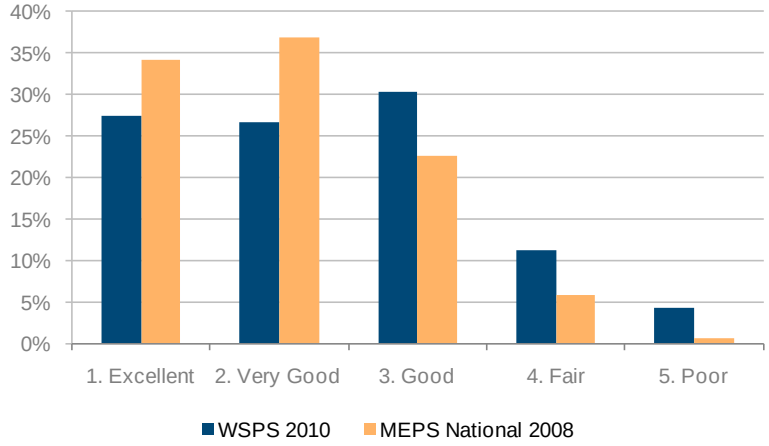


Chart 2: Self-reported health status comparison – WSPS vs. National MEPS – Individual coverage

[62] See www.meps.ahrq.gov

B. HEALTHCARE EXPENDITURE INDEX CONTINUED

Comparison to Washington insurers

When stakeholders from Washington's health insurers questioned our initial finding that people covered by Individual insurance are less healthy than those covered by Small Group insurance, we sent them charts such as the following:

Small Employer (1-50)
Group Insurance

Age band	Enrollment (thousands) Self-reported health status						Distribution Self-reported health status					
	1	2	3	4	5	Total	1	2	3	4	5	Total
0-4	23	6	6	-	-	35	4%	1%	1%	0%	0%	6%
5-17	59	25	14	1	1	100	10%	4%	2%	0%	0%	16%
18-24	27	11	24	3	1	66	4%	2%	4%	1%	0%	11%
25-44	69	64	59	10	2	204	11%	11%	10%	2%	0%	34%
45-64	52	63	60	16	4	194	9%	10%	10%	3%	1%	32%
65-90	3	1	2	0	0	6	0%	0%	0%	0%	0%	1%
Total	232	171	163	30	8	605	38%	28%	27%	5%	1%	100%

Total
Individual

Age Band	Enrollment (thousands) Self-reported health status						Distribution Self-reported health status					
	1	2	3	4	5	Total	1	2	3	4	5	Total
0-4	9	3	2	-	-	14	4%	1%	1%	0%	0%	5%
5-17	14	8	5	1	-	28	5%	3%	2%	0%	0%	11%
18-24	9	3	7	2	0	21	3%	1%	3%	1%	0%	8%
25-44	36	26	19	4	1	86	14%	10%	7%	2%	0%	33%
45-64	31	30	37	12	4	114	12%	11%	14%	5%	2%	43%
65-90	-	-	-	-	-	-	0%	0%	0%	0%	0%	0%
	99	68	71	19	5	263	38%	26%	27%	7%	2%	100%

These charts show that people in Washington covered by Individual insurance are, on average, both older and have higher (worse) self-reported health status than people covered by Small Group insurance, both of which contribute to higher healthcare expenditures.[63] (We also developed these distributions from the WSPS survey results for 2004, 2006, and 2008, and found that, in aggregate, those covered by Individual insurance are consistently older than those covered by Small Group insurance, and in 2004 and 2006 are also in worse health.)

We asked the insurers to report the average age of their Individual and Small Group members. Together the insurers reported on about 70 percent of the Washington market for Individual coverage and about 40 percent of the market for Small Group coverage. The results: On average, members with Individual coverage had an average age higher than members with Small Group coverage, confirming at least directionally the results we obtained.

[63] These distributions do not exactly match the data in Table 2 of Section III (Background) because they represent data before certain detailed final data manipulations.

Comparison to Washington insurers continued

However, the insurers also reported that claims-based risk scores indicated that people covered under Individual insurance have a lower propensity to healthcare expenditures than those covered under Small Group insurance. Although this is important information that appears to contradict our results, some skepticism is appropriate. Risk scores are dependent on robust data, and people covered by Individual insurance generally have less robust data than those covered by Small Group insurance, because Individual insureds typically have lower utilization (induced by higher cost sharing under Individual plans) as well as higher lapse rates. These phenomena can lead to different risk scores for people with identical health status.

Taking all the evidence into account, we conclude that the WSPS data showing Washington Individual insureds to be less healthy on average than Small Group insureds is plausible.

APPENDIX 4. DETAILED RESULTS

This section presents the detailed results of our analysis for each of the three scenarios.

Risk pools: / Federal Basic Health: / Small employer definition:		2014								Ultimate			
		Separate No 50	Merged No 50	Separate Yes 50	Merged Yes 50	Separate No 100	Merged No 100	Separate Yes 100	Merged Yes 100	Separate No 100	Merged No 100	Separate Yes 100	Merged Yes 100
A. Enrollment (thousands)	Baseline												
Exchange - Individual	-	135	144	78	84	131	140	74	81	166	170	86	89
Exchange - Small Group	-	7	1	7	1	19	7	19	7	31	19	31	19
Federal Basic Health	-	-	-	78	80	-	-	78	79	-	-	99	99
Uninsured	817	463	471	444	454	452	460	434	443	312	309	297	295
WSHIP	3	-	-	-	-	-	-	-	-	-	-	-	-
WA Basic Health	86	-	-	-	-	-	-	-	-	-	-	-	-
CHIP	12	12	12	12	12	12	12	12	12	12	12	12	12
Medicaid	877	1,066	1,065	1,066	1,065	1,069	1,067	1,069	1,067	1,141	1,140	1,141	1,140
Medicare and retiree medical	839	839	839	839	839	839	839	839	839	839	839	839	839
Individual (outside Exchange)	294	252	268	249	265	236	252	233	249	215	215	213	213
Small employer - Self-insured	11	10	10	10	10	32	37	32	37	32	37	32	37
Small employer - Small Group (outside Exchange)	191	169	155	169	155	259	250	259	250	238	238	238	238
Large employer - Self-insured	1,009	1,109	1,109	1,109	1,109	1,094	1,094	1,094	1,094	1,144	1,144	1,144	1,144
Large employer - Group insurance	534	585	585	585	585	476	476	476	476	501	501	501	501
Association - Self-insured	153	152	155	152	155	157	158	157	158	156	158	156	158
Association - Group insurance	603	563	549	563	549	585	568	585	568	558	564	557	563
Public employer - Self-insured	401	426	426	426	426	426	426	426	426	443	443	443	443
Public employer - Group insurance	328	370	370	370	370	370	370	370	370	370	370	370	370
Unemployed - Employer coverage	139	139	139	139	139	139	139	139	139	139	139	139	139
Total	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297
B. Healthcare expenditure index (HEI)													
Exchange - Individual	-	1.00	0.99	0.96	0.95	1.01	1.00	0.98	0.96	1.00	1.00	0.97	0.97
Exchange - Small Group	-	0.76	0.77	0.76	0.77	0.75	0.76	0.75	0.76	0.75	0.75	0.75	0.75
Federal Basic Health	-	-	-	1.04	1.04	-	-	1.05	1.04	-	-	1.04	1.04
Uninsured	1.05	1.04	1.03	1.04	1.03	1.05	1.04	1.05	1.04	1.02	1.02	1.02	1.02
WSHIP	3.91	-	-	-	-	-	-	-	-	-	-	-	-
WA Basic Health	1.09	-	-	-	-	-	-	-	-	-	-	-	-
CHIP	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45
Medicaid	0.72	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.82	0.83	0.82	0.83
Medicare and retiree medical	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41
Individual (outside Exchange)	0.80	0.82	0.81	0.82	0.81	0.83	0.82	0.82	0.82	0.79	0.79	0.79	0.79
Small employer - Self-insured	0.76	0.76	0.76	0.76	0.76	0.72	0.71	0.72	0.71	0.72	0.71	0.72	0.71
Small employer - Small Group (outside Exchange)	0.77	0.77	0.77	0.77	0.77	0.74	0.75	0.74	0.75	0.74	0.74	0.74	0.74
Large employer - Self-insured	0.67	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.70	0.70	0.70	0.70
Large employer - Group insurance	0.67	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.70	0.70	0.70	0.70
Association - Self-insured	0.64	0.64	0.65	0.64	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65	0.65
Association - Group insurance	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68
Public employer - Self-insured	0.74	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76
Public employer - Group insurance	0.74	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76
Unemployed - Employer coverage	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33
Total	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Individual total	0.80	0.88	0.87	0.85	0.84	0.89	0.88	0.86	0.85	0.88	0.88	0.84	0.84
Small Group total	0.77	0.77	0.77	0.77	0.77	0.74	0.75	0.74	0.75	0.74	0.74	0.74	0.74
Merged (Individual + Small Group)	-	-	0.84	-	0.82	-	0.83	-	0.81	-	0.83	-	0.80
C. Plan Cost Index													
Exchange - Individual (non-merged)	-	1.10	1.09	1.06	1.05	1.11	1.10	1.08	1.06	1.10	1.10	1.07	1.07
Exchange - Small Group (non-merged)	-	0.82	0.83	0.82	0.83	0.81	0.82	0.81	0.82	0.81	0.81	0.81	0.81
Individual (outside Exchange)	0.88	0.90	0.89	0.90	0.89	0.91	0.90	0.90	0.90	0.87	0.87	0.87	0.87
Small employer - Small Group (outside Exchange)	0.84	0.83	0.83	0.83	0.83	0.80	0.81	0.80	0.81	0.80	0.80	0.80	0.80
Association plans	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Individual total	0.88	0.97	0.96	0.94	0.93	0.98	0.97	0.94	0.94	0.97	0.97	0.93	0.93
Small Group total	0.84	0.83	0.83	0.83	0.83	0.80	0.81	0.80	0.81	0.80	0.80	0.80	0.80
Merged (Individual + Small Group)	-	-	0.92	-	0.90	-	0.91	-	0.88	-	0.90	-	0.87

Detailed results – Low participation (1 of 2)

		2014								Ultimate			
Risk pools:		Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged
Federal Basic Health:		No	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
Small employer definition:		50	50	50	50	100	100	100	100	100	100	100	100
D. Change in Enrollment	**Baseline**												
Exchange - Individual	-	135	144	78	84	131	140	74	81	166	170	86	89
Exchange - Small Group	-	7	1	7	1	19	7	19	7	31	19	31	19
Federal Basic Health	-	-	-	78	80	-	-	78	79	-	-	99	99
Uninsured	-	(354)	(346)	(373)	(363)	(365)	(357)	(383)	(374)	(505)	(508)	(520)	(522)
WSHIP	-	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
WA Basic Health	-	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)
CHIP	-	-	-	-	-	-	-	-	-	-	-	-	-
Medicaid	-	189	188	189	188	192	190	192	190	264	263	264	263
Medicare	-	-	-	-	-	-	-	-	-	-	-	-	-
Individual (outside Exchange)	-	(42)	(26)	(45)	(29)	(58)	(42)	(61)	(45)	(79)	(79)	(81)	(81)
Small employer - Self-insured	-	(1)	(1)	(1)	(1)	21	26	21	26	21	26	21	26
Small employer - Small Group (outside Exchange)	-	(22)	(36)	(22)	(36)	68	59	68	59	47	47	47	47
Large employer - Self-insured	-	100	100	100	100	85	85	85	85	135	135	135	135
Large employer - Group insurance	-	51	51	51	51	(58)	(58)	(58)	(58)	(33)	(33)	(33)	(33)
Association - Self-insured	-	(1)	2	(1)	2	4	5	4	5	3	5	3	5
Association - Group insurance	-	(40)	(54)	(40)	(54)	(18)	(35)	(18)	(35)	(45)	(39)	(46)	(40)
Public employer - Self-insured	-	25	25	25	25	25	25	25	25	42	42	42	42
Public employer - Group insurance	-	42	42	42	42	42	42	42	42	42	42	42	42
Total		-	(0)	-	(0)	0	-	0	0	(0)	(0)	(0)	(0)
E. Percent change in HEI													
Uninsured	-	-1%	-2%	-1%	-2%	0%	-1%	0%	-1%	-3%	-3%	-3%	-3%
WSHIP	-	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%
WA Basic Health	-	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%
CHIP	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Medicaid	-	10%	10%	10%	10%	10%	10%	10%	10%	13%	14%	13%	14%
Medicare	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Individual (outside Exchange)	-	2%	1%	2%	1%	3%	2%	2%	2%	-2%	-2%	-2%	-2%
Small employer - Self-insured	-	0%	0%	0%	0%	-5%	-6%	-5%	-6%	-5%	-6%	-5%	-6%
Small employer - Small Group (outside Exchange)	-	0%	0%	0%	0%	-4%	-3%	-4%	-3%	-4%	-4%	-4%	-4%
Large employer - Self-insured	-	3%	3%	3%	3%	3%	3%	3%	3%	4%	4%	4%	4%
Large employer - Group insurance	-	3%	3%	3%	3%	3%	3%	3%	3%	4%	4%	4%	4%
Association - Self-insured	-	-1%	1%	-1%	1%	1%	1%	1%	1%	1%	1%	1%	1%
Association - Group insurance	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Public employer - Self-insured	-	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Public employer - Group insurance	-	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Individual total	-	9%	8%	6%	4%	11%	9%	7%	6%	9%	9%	4%	4%
Small Group total	-	0%	0%	0%	0%	-4%	-3%	-4%	-3%	-4%	-4%	-4%	-4%
Merged - Individual	-	-	4%	-	2%	-	3%	-	1%	-	3%	-	0%
Merged - Small Group	-	-	9%	-	6%	-	8%	-	5%	-	8%	-	4%
F. Percent change in Plan Cost Index													
Individual total	-	10%	9%	7%	6%	11%	10%	7%	7%	10%	10%	6%	6%
Small Group total	-	-1%	-1%	-1%	-1%	-5%	-4%	-5%	-4%	-5%	-5%	-5%	-5%
Merged - Individual		-	5%	-	2%	-	3%	-	0%	-	2%	-	-1%
Merged - Small Group		-	10%	-	7%	-	8%	-	5%	-	7%	-	4%
Association plans		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Detailed results – Low participation (2 of 2)

		2014								Ultimate			
Risk pools:		Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged
Federal Basic Health:		No	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
Small employer definition:		50	50	50	50	100	100	100	100	100	100	100	100
A. Enrollment (thousands)	**Baseline**												
Exchange - Individual	-	260	274	160	171	250	264	152	163	298	304	185	188
Exchange - Small Group	-	17	8	17	8	43	20	43	20	63	33	63	33
Federal Basic Health	-	-	-	112	114	-	-	110	112	-	-	126	128
Uninsured	817	377	382	367	374	367	373	359	365	227	224	217	215
WSHIP	3	-	-	-	-	-	-	-	-	-	-	-	-
WA Basic Health	86	-	-	-	-	-	-	-	-	-	-	-	-
CHIP	12	12	12	12	12	12	12	12	12	12	12	12	12
Medicaid	877	1,069	1,068	1,069	1,068	1,072	1,070	1,072	1,070	1,145	1,143	1,145	1,143
Medicare and retiree medical	839	839	839	839	839	839	839	839	839	839	839	839	839
Individual (outside Exchange)	294	210	224	207	221	196	210	193	207	161	161	160	160
Small employer - Self-insured	11	10	10	10	10	32	37	32	37	31	36	31	36
Small employer - Small Group (outside Exchange)	191	164	152	164	152	252	244	252	244	231	231	230	231
Large employer - Self-insured	1,009	1,109	1,109	1,109	1,109	1,094	1,094	1,094	1,094	1,144	1,144	1,144	1,144
Large employer - Group insurance	534	585	585	585	585	476	476	476	476	501	501	501	501
Association - Self-insured	153	152	155	152	155	156	158	156	158	155	158	155	158
Association - Group insurance	603	560	545	560	545	571	564	571	564	539	559	538	558
Public employer - Self-insured	401	426	426	426	426	426	426	426	426	443	443	443	443
Public employer - Group insurance	328	370	370	370	370	370	370	370	370	370	370	370	370
Unemployed - Employer coverage	139	139	139	139	139	139	139	139	139	139	139	139	139
Total	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297
B. Healthcare expenditure index (HEI)													
Exchange - Individual	-	0.97	0.96	0.93	0.92	0.98	0.97	0.94	0.93	0.97	0.97	0.92	0.93
Exchange - Small Group	-	0.78	0.80	0.78	0.80	0.75	0.78	0.75	0.78	0.74	0.77	0.74	0.77
Federal Basic Health	-	-	-	1.03	1.03	-	-	1.04	1.03	-	-	1.04	1.03
Uninsured	1.05	1.05	1.04	1.05	1.04	1.06	1.05	1.06	1.05	1.02	1.02	1.02	1.02
WSHIP	3.91	-	-	-	-	-	-	-	-	-	-	-	-
WA Basic Health	1.09	-	-	-	-	-	-	-	-	-	-	-	-
CHIP	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45
Medicaid	0.72	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.83	0.83	0.83	0.83
Medicare and retiree medical	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41
Individual (outside Exchange)	0.80	0.82	0.81	0.82	0.81	0.82	0.82	0.82	0.82	0.79	0.79	0.78	0.78
Small employer - Self-insured	0.76	0.76	0.76	0.76	0.76	0.72	0.71	0.72	0.71	0.72	0.71	0.72	0.71
Small employer - Small Group (outside Exchange)	0.77	0.77	0.77	0.77	0.77	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74
Large employer - Self-insured	0.67	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.70	0.70	0.70	0.70
Large employer - Group insurance	0.67	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.70	0.70	0.70	0.70
Association - Self-insured	0.64	0.64	0.65	0.64	0.65	0.65	0.65	0.65	0.65	0.64	0.65	0.64	0.65
Association - Group insurance	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68
Public employer - Self-insured	0.74	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76
Public employer - Group insurance	0.74	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76
Unemployed - Employer coverage	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33
Total	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Individual total	0.80	0.90	0.89	0.87	0.86	0.91	0.90	0.87	0.87	0.91	0.91	0.86	0.86
Small Group total	0.77	0.77	0.77	0.77	0.77	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74
Merged (Individual + Small Group)	-	-	0.86	-	0.83	-	0.85	-	0.82	-	0.85	-	0.81
C. Plan Cost Index													
Exchange - Individual (non-merged)	-	1.07	1.06	1.02	1.01	1.08	1.07	1.03	1.02	1.07	1.07	1.01	1.02
Exchange - Small Group (non-merged)	-	0.84	0.87	0.84	0.87	0.81	0.84	0.81	0.84	0.80	0.83	0.80	0.83
Individual (outside Exchange)	0.88	0.90	0.89	0.90	0.89	0.90	0.90	0.90	0.90	0.87	0.87	0.86	0.86
Small employer - Small Group (outside Exchange)	0.84	0.83	0.83	0.83	0.83	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80
Association plans	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73
Individual total	0.88	0.99	0.98	0.95	0.94	1.00	0.99	0.96	0.95	1.00	1.00	0.94	0.95
Small Group total	0.84	0.83	0.83	0.83	0.83	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80
Merged (Individual + Small Group)	-	-	0.95	-	0.91	-	0.93	-	0.89	-	0.93	-	0.88

Detailed results – Medium participation (1 of 2)

		2014								Ultimate			
Risk pools:		Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged
Federal Basic Health:		No	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
Small employer definition:		50	50	50	50	100	100	100	100	100	100	100	100
D. Change in Enrollment	**Baseline**												
Exchange - Individual	-	260	274	160	171	250	264	152	163	298	304	185	188
Exchange - Small Group	-	17	8	17	8	43	20	43	20	63	33	63	33
Federal Basic Health	-	-	-	112	114	-	-	110	112	-	-	126	128
Uninsured	-	(440)	(435)	(450)	(443)	(450)	(444)	(458)	(452)	(590)	(593)	(600)	(602)
WSHIP	-	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
WA Basic Health	-	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)
CHIP	-	-	-	-	-	-	-	-	-	-	-	-	-
Medicaid	-	192	191	192	191	195	193	195	193	268	266	268	266
Medicare	-	-	-	-	-	-	-	-	-	-	-	-	-
Individual (outside Exchange)	-	(84)	(70)	(87)	(73)	(98)	(84)	(101)	(87)	(133)	(133)	(134)	(134)
Small employer - Self-insured	-	(1)	(1)	(1)	(1)	21	26	21	26	20	25	20	25
Small employer - Small Group (outside Exchange)	-	(27)	(39)	(27)	(39)	61	53	61	53	40	40	39	40
Large employer - Self-insured	-	100	100	100	100	85	85	85	85	135	135	135	135
Large employer - Group insurance	-	51	51	51	51	(58)	(58)	(58)	(58)	(33)	(33)	(33)	(33)
Association - Self-insured	-	(1)	2	(1)	2	3	5	3	5	2	5	2	5
Association - Group insurance	-	(43)	(58)	(43)	(58)	(32)	(39)	(32)	(39)	(64)	(44)	(65)	(45)
Public employer - Self-insured	-	25	25	25	25	25	25	25	25	42	42	42	42
Public employer - Group insurance	-	42	42	42	42	42	42	42	42	42	42	42	42
Total		-	(0)	-	(0)	0	0	0	0	(0)	(0)	(0)	(0)
E. Percent change in HEI													
Uninsured	-	0%	-1%	0%	-1%	1%	0%	1%	0%	-3%	-3%	-3%	-3%
WSHIP	-	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%
WA Basic Health	-	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%
CHIP	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Medicaid	-	10%	10%	10%	10%	10%	10%	10%	10%	14%	14%	14%	14%
Medicare	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Individual (outside Exchange)	-	2%	1%	2%	1%	2%	2%	2%	2%	-2%	-2%	-3%	-3%
Small employer - Self-insured	-	0%	0%	0%	0%	-5%	-6%	-5%	-6%	-5%	-6%	-5%	-6%
Small employer - Small Group (outside Exchange)	-	0%	0%	0%	0%	-4%	-4%	-4%	-4%	-4%	-4%	-4%	-4%
Large employer - Self-insured	-	3%	3%	3%	3%	3%	3%	3%	3%	4%	4%	4%	4%
Large employer - Group insurance	-	3%	3%	3%	3%	3%	3%	3%	3%	4%	4%	4%	4%
Association - Self-insured	-	-1%	1%	-1%	1%	1%	1%	1%	1%	-1%	1%	-1%	1%
Association - Group insurance	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Public employer - Self-insured	-	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Public employer - Group insurance	-	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Individual total	-	12%	11%	8%	7%	13%	12%	8%	8%	13%	13%	7%	7%
Small Group total	-	0%	0%	0%	0%	-4%	-4%	-4%	-4%	-4%	-4%	-4%	-4%
Merged - Individual	-	-	7%	-	3%	-	6%	-	2%	-	6%	-	1%
Merged - Small Group	-	-	11%	-	8%	-	10%	-	6%	-	10%	-	5%
F. Percent change in Plan Cost Index													
Individual total	-	13%	11%	8%	7%	14%	13%	9%	8%	14%	14%	7%	8%
Small Group total	-	-1%	-1%	-1%	-1%	-5%	-5%	-5%	-5%	-5%	-5%	-5%	-5%
Merged - Individual		-	8%	-	3%	-	6%	-	1%	-	6%	-	0%
Merged - Small Group		-	13%	-	8%	-	11%	-	6%	-	11%	-	5%
Association plans		0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Detailed results – Medium participation (2 of 2)

Risk pools: / Federal Basic Health: / Small employer definition:		2014								Ultimate			
		Separate No 50	Merged No 50	Separate Yes 50	Merged Yes 50	Separate No 100	Merged No 100	Separate Yes 100	Merged Yes 100	Separate No 100	Merged No 100	Separate Yes 100	Merged Yes 100
A. Enrollment (thousands)	Baseline												
Exchange - Individual	-	382	403	242	257	366	387	230	245	427	435	285	287
Exchange - Small Group	-	26	15	26	15	67	32	67	32	96	46	96	46
Federal Basic Health	-	-	-	144	148	-	-	140	144	-	-	152	156
Uninsured	817	292	295	292	296	285	288	285	289	145	142	138	137
WSHIP	3	-	-	-	-	-	-	-	-	-	-	-	-
WA Basic Health	86	-	-	-	-	-	-	-	-	-	-	-	-
CHIP	12	12	12	12	12	12	12	12	12	12	12	12	12
Medicaid	877	1,071	1,071	1,071	1,071	1,076	1,074	1,076	1,074	1,148	1,147	1,148	1,147
Medicare and retiree medical	839	839	839	839	839	839	839	839	839	839	839	839	839
Individual (outside Exchange)	294	168	180	165	177	157	168	154	165	108	108	107	107
Small employer - Self-insured	11	10	10	10	10	32	37	32	37	30	36	30	36
Small employer - Small Group (outside Exchange)	191	158	149	158	149	246	237	246	237	223	224	222	224
Large employer - Self-insured	1,009	1,109	1,109	1,109	1,109	1,094	1,094	1,094	1,094	1,144	1,144	1,144	1,144
Large employer - Group insurance	534	585	585	585	585	476	476	476	476	501	501	501	501
Association - Self-insured	153	152	155	152	155	156	158	156	158	154	158	154	158
Association - Group insurance	603	557	541	557	541	557	560	557	560	519	554	518	554
Public employer - Self-insured	401	426	426	426	426	426	426	426	426	443	443	443	443
Public employer - Group insurance	328	370	370	370	370	370	370	370	370	370	370	370	370
Unemployed - Employer coverage	139	139	139	139	139	139	139	139	139	139	139	139	139
Total	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297	6,297
B. Healthcare expenditure index (HEI)													
Exchange - Individual	-	0.96	0.95	0.92	0.91	0.97	0.96	0.93	0.92	0.96	0.95	0.91	0.91
Exchange - Small Group	-	0.79	0.80	0.79	0.80	0.75	0.79	0.75	0.79	0.74	0.77	0.74	0.77
Federal Basic Health	-	-	-	1.03	1.02	-	-	1.04	1.03	-	-	1.04	1.03
Uninsured	1.05	1.07	1.06	1.07	1.06	1.07	1.07	1.07	1.07	1.04	1.04	1.04	1.04
WSHIP	3.91	-	-	-	-	-	-	-	-	-	-	-	-
WA Basic Health	1.09	-	-	-	-	-	-	-	-	-	-	-	-
CHIP	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45	0.45
Medicaid	0.72	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.83	0.83	0.83	0.83
Medicare and retiree medical	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41	2.41
Individual (outside Exchange)	0.80	0.82	0.81	0.81	0.81	0.82	0.82	0.82	0.81	0.78	0.78	0.77	0.77
Small employer - Self-insured	0.76	0.76	0.76	0.76	0.76	0.72	0.72	0.72	0.72	0.72	0.71	0.72	0.71
Small employer - Small Group (outside Exchange)	0.77	0.76	0.76	0.76	0.76	0.74	0.74	0.74	0.74	0.74	0.74	0.74	0.74
Large employer - Self-insured	0.67	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.70	0.70	0.70	0.70
Large employer - Group insurance	0.67	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.69	0.70	0.70	0.70	0.70
Association - Self-insured	0.64	0.64	0.65	0.64	0.65	0.64	0.65	0.64	0.65	0.64	0.65	0.64	0.65
Association - Group insurance	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.68	0.67	0.68	0.67	0.68
Public employer - Self-insured	0.74	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76
Public employer - Group insurance	0.74	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76	0.76
Unemployed - Employer coverage	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33	1.33
Total	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00	1.00
Individual total	0.80	0.92	0.91	0.88	0.87	0.92	0.92	0.89	0.88	0.92	0.92	0.87	0.87
Small Group total	0.77	0.76	0.76	0.76	0.76	0.74	0.75	0.74	0.75	0.74	0.75	0.74	0.75
Merged (Individual + Small Group)	-	-	0.88	-	0.84	-	0.86	-	0.82	-	0.86	-	0.82
C. Plan Cost Index													
Exchange - Individual (non-merged)	-	1.06	1.05	1.01	1.00	1.07	1.06	1.02	1.01	1.06	1.05	1.00	1.00
Exchange - Small Group (non-merged)	-	0.86	0.87	0.86	0.87	0.81	0.86	0.81	0.86	0.80	0.83	0.80	0.83
Individual (outside Exchange)	0.88	0.90	0.89	0.89	0.89	0.90	0.90	0.90	0.89	0.86	0.86	0.85	0.85
Small employer - Small Group (outside Exchange)	0.84	0.82	0.82	0.82	0.82	0.80	0.80	0.80	0.80	0.80	0.80	0.80	0.80
Association plans	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.73	0.72	0.73	0.72	0.73
Individual total	0.88	1.01	1.00	0.96	0.96	1.02	1.01	0.97	0.96	1.02	1.01	0.96	0.96
Small Group total	0.84	0.83	0.82	0.83	0.82	0.80	0.81	0.80	0.81	0.80	0.81	0.80	0.81
Merged (Individual + Small Group)	-	-	0.96	-	0.92	-	0.94	-	0.90	-	0.94	-	0.90

Detailed results – High participation (1 of 2)

		2014								Ultimate			
Risk pools:		Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged	Separate	Merged
Federal Basic Health:		No	No	Yes	Yes	No	No	Yes	Yes	No	No	Yes	Yes
Small employer definition:		50	50	50	50	100	100	100	100	100	100	100	100
D. Change in Enrollment	**Baseline**												
Exchange - Individual	-	382	403	242	257	366	387	230	245	427	435	285	287
Exchange - Small Group	-	26	15	26	15	67	32	67	32	96	46	96	46
Federal Basic Health	-	-	-	144	148	-	-	140	144	-	-	152	156
Uninsured	-	(525)	(522)	(525)	(521)	(532)	(529)	(532)	(528)	(672)	(675)	(679)	(680)
WSHIP	-	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)	(3)
WA Basic Health	-	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)	(86)
CHIP	-	-	-	-	-	-	-	-	-	-	-	-	-
Medicaid	-	194	194	194	194	199	197	199	197	271	270	271	270
Medicare	-	-	-	-	-	-	-	-	-	-	-	-	-
Individual (outside Exchange)	-	(126)	(114)	(129)	(117)	(137)	(126)	(140)	(129)	(186)	(186)	(187)	(187)
Small employer - Self-insured	-	(1)	(2)	(1)	(2)	21	26	21	26	19	25	19	25
Small employer - Small Group (outside Exchange)	-	(33)	(42)	(33)	(42)	55	46	55	46	32	33	31	33
Large employer - Self-insured	-	100	100	100	100	85	85	85	85	135	135	135	135
Large employer - Group insurance	-	51	51	51	51	(58)	(58)	(58)	(58)	(33)	(33)	(33)	(33)
Association - Self-insured	-	(1)	2	(1)	2	3	5	3	5	1	5	1	5
Association - Group insurance	-	(46)	(62)	(46)	(62)	(46)	(43)	(46)	(43)	(84)	(49)	(85)	(49)
Public employer - Self-insured	-	25	25	25	25	25	25	25	25	42	42	42	42
Public employer - Group insurance	-	42	42	42	42	42	42	42	42	42	42	42	42
Total		0	0	0	-	0	0	0	-	(0)	0	(0)	(0)
E. Percent change in HEI													
Uninsured	-	2%	1%	2%	1%	2%	2%	2%	2%	-1%	-1%	-1%	-1%
WSHIP	-	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%
WA Basic Health	-	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%	-100%
CHIP	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Medicaid	-	10%	10%	10%	10%	10%	10%	10%	10%	14%	14%	14%	14%
Medicare	-	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Individual (outside Exchange)	-	2%	1%	1%	1%	2%	2%	2%	1%	-3%	-3%	-4%	-4%
Small employer - Self-insured	-	0%	0%	0%	0%	-5%	-5%	-5%	-5%	-5%	-6%	-5%	-6%
Small employer - Small Group (outside Exchange)	-	-2%	-2%	-2%	-2%	-4%	-4%	-4%	-4%	-4%	-4%	-4%	-4%
Large employer - Self-insured	-	3%	3%	3%	3%	3%	3%	3%	3%	4%	4%	4%	4%
Large employer - Group insurance	-	3%	3%	3%	3%	3%	3%	3%	3%	4%	4%	4%	4%
Association - Self-insured	-	-1%	1%	-1%	1%	-1%	1%	-1%	1%	-1%	1%	-1%	1%
Association - Group insurance	-	0%	0%	0%	0%	0%	0%	0%	0%	-2%	0%	-2%	0%
Public employer - Self-insured	-	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Public employer - Group insurance	-	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%
Individual total	-	14%	13%	9%	8%	14%	14%	11%	9%	14%	14%	8%	8%
Small Group total	-	-2%	-2%	-2%	-2%	-4%	-3%	-4%	-3%	-4%	-3%	-4%	-3%
Merged - Individual	-	-	9%	-	4%	-	7%	-	2%	-	7%	-	2%
Merged - Small Group	-	-	14%	-	9%	-	11%	-	6%	-	11%	-	6%
F. Percent change in Plan Cost Index													
Individual total	-	15%	14%	9%	9%	16%	15%	10%	9%	16%	15%	9%	9%
Small Group total	-	-1%	-2%	-1%	-2%	-5%	-4%	-5%	-4%	-5%	-4%	-5%	-4%
Merged - Individual		-	9%	-	5%	-	7%	-	2%	-	7%	-	2%
Merged - Small Group		-	14%	-	10%	-	12%	-	7%	-	12%	-	7%
Association plans		0%	0%	0%	0%	0%	0%	0%	0%	-1%	0%	-1%	0%

Detailed results – High participation (2 of 2)

APPENDIX 5. SENSITIVITY ANALYSIS

This section presents an analysis of the sensitivity of assumptions for Association plan participation and self-insured plan participation. The section also includes a discussion about the potential impact of changing the regulatory status of some Association plans covering small employers (1-50).

ASSOCIATION PLAN PARTICIPATION

As noted in Appendix 1 (Methodology), we assume the following Association healthcare plan participation percentages for people in employed households who have employer-provided coverage:

Small private employers (1-50):	**70%**
Small private employers (51-100):	**40%**
Large private employers (> 100):	**5%**
Public employers:	**15%**

Cutting the participation percentages in half for small employers (51-100), large employers, and public employers has a negligible impact on the results shown in Table 5 (Summary of results) of Section IV (Results). Thus, results are relatively insensitive to changes in the Association participation assumptions for small private employers (51-100), large private employers, and public employers.

However, results are moderately sensitive to changes in the participation assumption for small private employers (1-50). As the table on the following page shows, decreasing the participation percentage has a moderate impact on enrollment after establishing an Exchange, a moderate impact on enrollment under merging the risk pools, and little impact for the other two key decisions.

Following is a discussion of the impact of assumption changes at baseline (i.e., before establishing an Exchange), after establishing an Exchange, and after merging the risk pools.

- **Baseline**. At baseline (i.e., before establishing an Exchange) decreasing the participation percentage *decreases* the number of people covered by Association healthcare plans, and *increases* the number of people covered by Small Group plans (outside the Exchange). In both cases, the number of people involved is about the same. For example, decreasing the Association plan participation assumption from 70 percent to 20 percent decreases the number of people covered by Association plans by 340,000, and increases the number of people covered by Small Group plans by 320,000.
- **Establishing an Exchange**. Decreasing the Association plan participation percentage increases the number of people covered by Small Group plans inside the Exchange, in both 2014 and the ultimate year. For example, decreasing the assumption from 70 percent to 20 percent increases the expected number of people covered by Small Group plans within the Exchange from 30,000 – 100,000 to 70,000 – 120,000. **The reason**: Decreasing the participation percentage increases the number of people covered by Small Group plans at baseline (i.e., before establishing an Exchange) and thereby increases the number of people who can migrate to the Exchange. Because take-up rates are fixed percentages, increasing (decreasing) the size of a baseline population increases (decreases) the number of people who will migrate in accordance with the rates.

Metric/Coverage type/ Association plan participation assumption	Baseline (2010)	Potential impact of: Establishing an Exchange in 2014 — 2014	Establishing an Exchange in 2014 — Ultimate year	Merging the risk pools in 2014 — 2014	Merging the risk pools in 2014 — Ultimate year	Establishing a Federal Basic Health Program in 2014 — 2014	Establishing a Federal Basic Health Program in 2014 — Ultimate year	Defining small employer as 1-100 employees for 2014 and 2015 — 2014	Defining small employer as 1-100 employees for 2014 and 2015 — Ultimate year
Enrollment (thousands)									
Small Group (inside Exchange)									
70%	NA	↑ 10 – 30	↑ 30 – 100	↓ 10	↓ 10 – 50	- 0	- 0	↑ 10 – 40	NA
60%	NA	↑ 10 – 30	↑ 40 – 100	↓ 10	↓ 10 – 50	- 0	- 0	↑ 10 – 40	NA
50%	NA	↑ 10 – 30	↑ 40 – 110	↓ 10 – 20	↓ 20 – 50	- 0	- 0	↑ 20 – 40	NA
40%	NA	↑ 10 – 40	↑ 50 – 110	↓ 10 – 20	↓ 20 – 50	- 0	- 0	↑ 20 – 40	NA
30%	NA	↑ 10 – 40	↑ 60 – 120	↓ 10 – 20	↓ 20 – 40	- 0	- 0	↑ 20 – 40	NA
20%	NA	↑ 10 – 50	↑ 70 – 120	↓ 10 – 30	↓ 30 – 40	- 0	- 0	↑ 30 – 40	NA
Small Group (outside Exchange)									
70%	190	↓ 20 – 30	↑ 30 – 50	↓ 10	- 0	- 0	- 0	↑ 90	NA
60%	260	↓ 30 – 40	↑ 10 – 30	↓ 10 – 20	- 0	- 0	- 0	↑ 90	NA
50%	320	↓ 40 – 50	↑ 0 – 20	↓ 20	↑ 10	- 0	- 0	↑ 90	NA
40%	390	↓ 40 – 70	↓ 0 – 20	↓ 20 – 30	↑ 10	- 0	- 0	↑ 90	NA
30%	450	↓ 50 – 80	↓ 10 – 40	↓ 20 – 30	↑ 10	- 0	- 0	↑ 90	NA
20%	510	↓ 60 – 90	↓ 20 – 60	↓ 30 – 40	↑ 20	- 0	- 0	↑ 90	NA
Association healthcare plans									
70%	760	↓ 40 – 50	↓ 40 – 80	↓ 10	↑ 10 – 40	- 0	- 0	↑ 0 – 30	NA
60%	690	↓ 30 – 40	↓ 30 – 70	↓ 0 – 10	↑ 10 – 30	- 0	- 0	↑ 0 – 20	NA
50%	620	↓ 30	↓ 30 – 60	- 0	↑ 10 – 30	- 0	- 0	↑ 0 – 20	NA
40%	550	↓ 20 – 30	↓ 20 – 40	↑ 10	↑ 10 – 20	- 0	- 0	↑ 0 – 20	NA
30%	480	↓ 20	↓ 10 – 30	↑ 10	↑ 10 – 20	- 0	- 0	↑ 10 – 20	NA
20%	420	↓ 10	↓ 10 – 20	↑ 20	↑ 10	- 0	- 0	↑ 10	NA
Plan Cost Index (percent)									
Small Group									
70%	NA	- 0%	↓ 5%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	↓ 5%	NA
60%	NA	- 0%	↓ 5%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	- 0%	NA
50%	NA	- 0%	- 0%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	- 0%	NA
40%	NA	- 0%	- 0%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	- 0%	NA
30%	NA	- 0%	↓ 0%-5%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	- 0%	NA
20%	NA	- 0%	- 0%	↑ 10% - 15%	↑ 10% - 15%	- 0%	- 0%	- 0%	NA
Association healthcare plans									
All	NA	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	- 0%	NA

Sensitivity analysis of Small employer (1-50) Association plan participation assumption

ASSOCIATION PLAN PARTICIPATION CONTINUED

- **Establishing an Exchange continued.** In 2014 and the ultimate year, decreasing the Association participation percentage increases the number of people migrating away from Small Group plans outside the Exchange. **The reason**: Decreasing the participation percentage increases the number of people covered by Small Group plans at baseline (i.e., before establishing an Exchange) and thereby increases the number of people who are expected to migrate away from Small Group plans as a result of establishing an Exchange.

  Decreasing the participation percentage decreases the number of people who are expected to migrate away from Association healthcare plans, in both 2014 and the ultimate year, for reasons similar to those given above.

- **Merging the risk pools in 2014**. Decreasing the participation percentage decreases the number of people with Small Group coverage inside the Exchange. For example, in the ultimate year, decreasing the percentage from 70 percent to 40 percent increases the number of people who will leave Small Group coverage inside the Exchange from 10,000 – 50,000 people, to 20,000 – 50,000 people. **The reason**: As we saw above, decreasing the participation percentage increases the number of people covered by Small Group plans in the Exchange. Therefore, when the risk pools are merged, and premiums increase for Small Group plans, there are more people who can migrate away from the plans.

Impact of regulatory status change

The sensitivity analysis of the Association plan participation assumption also illuminates the potential impact of changing the regulatory status of some Association healthcare plans covering small employers (1-50).

As noted in Section III (Background) of the report, some associations are organized solely for the purpose of providing health benefits for their members. By virtue of being Association healthcare plans, these plans are in a separate regulatory class and are not regulated as Small Group insurance. As a consequence, these plans can determine premiums using pure experience rating, rather than adjusted community rating. For the purpose of this appendix, let's call such associations "single-purpose associations", and their health plans "Single-purpose Association healthcare plans".

As a result of health reform regulations or other turn of events, it is possible that the regulatory status of Single-purpose Association healthcare plans could change. Such a change might cause such plans covering small employers (1-50) to be treated like normal Small Group plans and to become subject to Washington health insurance regulations for normal Small Group plans. In this case, the number of people covered under normal Small Group plans would increase, and the number of people covered under Association plans would decrease.

ASSOCIATION PLAN PARTICIPATION CONTINUED

Impact of regulatory status change continued

The sensitivity analysis above provides a rough estimate of the potential impact of such a change. For example, suppose that it is expected that at baseline (i.e., before establishing an Exchange) such a regulatory change would increase the number of people covered under normal Small Group plans outside the Exchange by 200,000, from 190,000 to 390,000. Then, the expected impact of the regulatory change is given by the 40 percent Association participation assumption:

- In the ultimate year after establishing an Exchange, instead of 30,000 – 100,000 people covered by Small Group plans in the Exchange, one would expect to see 50,000 – 110,000.
- In the ultimate year after merging the risk pools, instead of seeing a drop of 10,000 to 50,000 people from Small Group coverage inside the Exchange, one would expect to see a drop of 20,000 to 50,000 people.

Such a rough analysis does not take into account the following factors:

- **Lower migration to Association plans**. If the regulatory status of single-purpose association plans were to change, it is reasonable to assume that take-up rates for migration of Small Group plans to Association plans would decrease. However, the sensitivity analysis above does not account for the impact of such a decrease in take-up rates. If this factor were taken into account, the number of people in Association plans would be lower than the results shown in the sensitivity analysis.
- **Lower Association enrollee HEI**. As noted in Appendix 1 (Methodology), we assume that the Healthcare Expenditure Index (HEI) for Association plan enrollees is 90 percent of the HEI for enrollees in equivalent non-Association plans. However, the sensitivity analysis above does not account for the impact of Association enrollees with lower HEIs migrating to Small Group regulatory status. If this factor were taken into account, the impact on the Plan Cost Index for Small Group would likely be negligible.

SELF-INSURED PLAN PARTICIPATION

As noted in Appendix 1 (Methodology), we assume that the following percentages of Washington residents with employer-provided health insurance are covered by self-insured plans:

Small private employers (1-50):	**5%**
Small private employers (51-100):	**10%**
Large private employers (> 100):	**70%**
Public employers:	**55%**

Increasing these percentages by 10 percent has negligible impact on results. Thus, these assumptions are insensitive to change.

APPENDIX 6. TAKE-UP RATES

On the following pages are the take-up rates that we use to model employer and individual behavior.[64] The rates are in the following order:

- Employer take up rates for the Low, Medium, and High scenarios
- Individual take-up rates for the Low, Medium and High scenarios

The following principles were applied in determining these take-up rates:

General

- It has been thoroughly researched and demonstrated that, in general, not all individuals and employers make economically rational decisions. Accordingly, for this report we assume that, when individuals and employers decide to change their insurance coverage, most of them (but generally not all) will choose options that are economically most beneficial to them.

Employer take-up rates

- The Exchange is expected to offer a single entrance to health insurance services for Medicaid, possibly a Federal Basic Health program, and Premium subsidies for some income bands. These incentives for Exchange enrollment result in increasing take up rates as income levels decrease.
- Similarly, employers are more likely to drop health insurance coverage and replace it with income enhancements for Exchange participation as the average income of their workers decreases. For example, an employer may take a defined contribution approach to providing healthcare benefits.
- An increase in Group insurance plan costs (such as the increase resulting from merging risk pools) moves membership into self-insured and Association plan alternatives. Similarly, a reduction in Group insurance plan cost (such as the reduction resulting from expanding the definition of small employer) results in fewer employers electing to drop coverage.
- The Exchange has minimal impact on employers that currently do not offer coverage. The Exchange is assumed to enroll employees of these employers through the Individual exchange.
- Non-participation penalties will induce some employers with 51 to 100 employees that currently do not offer coverage to take up some form of coverage. However, we assume that such penalties are not severe enough to induce a majority of such employers to sponsor health insurance coverage.
- The lack of non-participation penalties for employers with less than 50 employees reduces their coverage take-up rates relative to employers with more than 50 employees.

[64] To learn how take-up rates are used for this report, see Appendix 1 (Methodology), Section C.

Individual take-up rates

- In response to health reform's individual mandate provision, we assume more uninsured people will elect to obtain insurance coverage in the ultimate year than in 2014.
- People with existing Basic Health or WSHIP coverage will select either (a) one of the available coverage options within the Exchange or, if available, (b) the Federal Basic Health program. Because their need for coverage is high, none of these people will become uninsured.
- Those with income below 133 percent of the FPL are eligible for Medicaid, and will either enroll in that program or be uninsured.
- As an individual's household income level becomes lower, participation in the Exchange through Individual insurance is increased.
- Because we assume that Federal Basic Health premiums would be lower than premiums in the Exchange for equivalent plans, take-up rates for people with income of 133 - 200 percent of the FPL are greater for the Federal Basic Health program than for the Exchange.
- As with the historical experience of the Medicaid program, we assume many eligible people will not enroll for coverage even when heavily subsidized.

Baseline period	2014-S-X-50						2014-M-X-50						2014-S-FBH-50						2014-M-FBH-50					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%
2. 200% - 400% FPL	90%	0%	0%	0%	0%	10%	85%	0%	0%	0%	0%	15%	90%	0%	0%	0%	0%	10%	85%	0%	0%	0%	0%	15%
3. 133% - 200% FPL	80%	0%	5%	0%	0%	15%	80%	0%	0%	0%	0%	20%	80%	0%	5%	0%	0%	15%	80%	0%	0%	0%	0%	20%
4. <133% FPL	70%	0%	10%	0%	0%	20%	70%	0%	5%	0%	0%	25%	70%	0%	10%	0%	0%	20%	70%	0%	5%	0%	0%	25%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	95%	0%	0%	0%	5%	0%	85%	0%	2%	3%	10%	0%	95%	0%	0%	0%	5%	0%	85%	0%	2%	3%	10%
2. 200% - 400% FPL	0%	85%	5%	0%	0%	10%	0%	80%	0%	2%	3%	15%	0%	85%	5%	0%	0%	10%	0%	80%	0%	2%	3%	15%
3. 133% - 200% FPL	0%	75%	10%	0%	0%	15%	0%	70%	5%	2%	3%	20%	0%	75%	10%	0%	0%	15%	0%	70%	5%	2%	3%	20%
4. <133% FPL	0%	65%	15%	0%	0%	20%	0%	60%	10%	2%	3%	25%	0%	65%	15%	0%	0%	20%	0%	60%	10%	2%	3%	25%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%
2. 200% - 400% FPL	0%	0%	0%	90%	0%	10%	0%	0%	0%	85%	0%	15%	0%	0%	0%	90%	0%	10%	0%	0%	0%	85%	0%	15%
3. 133% - 200% FPL	0%	0%	5%	80%	0%	15%	0%	0%	0%	80%	0%	20%	0%	0%	5%	80%	0%	15%	0%	0%	0%	80%	0%	20%
4. <133% FPL	0%	0%	10%	70%	0%	20%	0%	0%	5%	70%	0%	25%	0%	0%	10%	70%	0%	20%	0%	0%	5%	70%	0%	25%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%
2. 200% - 400% FPL	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	85%	15%
3. 133% - 200% FPL	0%	0%	5%	0%	80%	15%	0%	0%	0%	0%	80%	20%	0%	0%	5%	0%	80%	15%	0%	0%	0%	0%	80%	20%
4. <133% FPL	0%	0%	10%	0%	70%	20%	0%	0%	5%	0%	70%	25%	0%	0%	10%	0%	70%	20%	0%	0%	5%	0%	70%	25%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%
4. <133% FPL	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%
4. <133% FPL	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%
4. <133% FPL	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%
4. <133% FPL	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%
e. No insurance																								
1. > 400% FPL	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%
2. 200% - 400% FPL	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%
3. 133% - 200% FPL	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – Low participation (1 of 6)

Baseline period	2014-S-X-50						2014-M-X-50						2014-S-FBH-50						2014-M-FBH-50					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
2. 200% - 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
3. 133% - 200% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. <133% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
2. 200% - 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
3. 133% - 200% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
4. <133% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%

Employer take-up rates – Low participation (2 of 6)

Baseline period	2014-S-X-100						2014-M-X-100						2014-S-FBH-100						2014-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	95%	0%	0%	0%	0%	5%	100%	0%	0%	0%	0%	0%	95%	0%	0%	0%	0%	5%
2. 200% - 400% FPL	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%
3. 133% - 200% FPL	80%	0%	10%	0%	0%	10%	80%	0%	5%	0%	0%	15%	80%	0%	10%	0%	0%	10%	80%	0%	5%	0%	0%	15%
4. <133% FPL	65%	0%	15%	0%	0%	20%	70%	0%	10%	0%	0%	20%	65%	0%	15%	0%	0%	20%	70%	0%	10%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	95%	5%	0%	0%	0%	0%	95%	0%	0%	0%	5%	0%	95%	5%	0%	0%	0%	0%	95%	0%	0%	0%	5%
2. 200% - 400% FPL	0%	85%	10%	0%	0%	5%	0%	85%	5%	0%	0%	10%	0%	85%	10%	0%	0%	5%	0%	85%	5%	0%	0%	10%
3. 133% - 200% FPL	0%	75%	15%	0%	0%	10%	0%	75%	10%	0%	0%	15%	0%	75%	15%	0%	0%	10%	0%	75%	10%	0%	0%	15%
4. <133% FPL	0%	60%	20%	0%	0%	20%	0%	65%	15%	0%	0%	20%	0%	60%	20%	0%	0%	20%	0%	65%	15%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	95%	0%	5%	0%	0%	0%	100%	0%	0%	0%	0%	0%	95%	0%	5%
2. 200% - 400% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%
3. 133% - 200% FPL	0%	0%	10%	80%	0%	10%	0%	0%	5%	80%	0%	15%	0%	0%	10%	80%	0%	10%	0%	0%	5%	80%	0%	15%
4. <133% FPL	0%	0%	15%	65%	0%	20%	0%	0%	10%	70%	0%	20%	0%	0%	15%	65%	0%	20%	0%	0%	10%	70%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	95%	5%
2. 200% - 400% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%
3. 133% - 200% FPL	0%	0%	10%	0%	80%	10%	0%	0%	5%	0%	80%	15%	0%	0%	10%	0%	80%	10%	0%	0%	5%	0%	80%	15%
4. <133% FPL	0%	0%	15%	0%	65%	20%	0%	0%	10%	0%	70%	20%	0%	0%	15%	0%	65%	20%	0%	0%	10%	0%	70%	20%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	90%	0%	3%	0%	0%	7%	91%	0%	0%	0%	0%	9%	90%	0%	3%	0%	0%	7%	91%	0%	0%	0%	0%	9%
4. <133% FPL	67%	0%	15%	0%	0%	18%	75%	0%	5%	0%	0%	20%	67%	0%	15%	0%	0%	18%	75%	0%	5%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%
2. 200% - 400% FPL	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%
3. 133% - 200% FPL	5%	78%	5%	2%	3%	7%	10%	68%	3%	5%	5%	9%	5%	78%	5%	2%	3%	7%	10%	68%	3%	5%	5%	9%
4. <133% FPL	0%	62%	20%	0%	0%	18%	0%	65%	15%	0%	0%	20%	0%	62%	20%	0%	0%	18%	0%	65%	15%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	3%	90%	0%	7%	0%	0%	0%	91%	0%	9%	0%	0%	3%	90%	0%	7%	0%	0%	0%	91%	0%	9%
4. <133% FPL	0%	0%	15%	67%	0%	18%	0%	0%	5%	75%	0%	20%	0%	0%	15%	67%	0%	18%	0%	0%	5%	75%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	3%	0%	90%	7%	0%	0%	0%	0%	91%	9%	0%	0%	3%	0%	90%	7%	0%	0%	0%	0%	91%	9%
4. <133% FPL	0%	0%	15%	0%	67%	18%	0%	0%	5%	0%	75%	20%	0%	0%	15%	0%	67%	18%	0%	0%	5%	0%	75%	20%
e. No insurance																								
1. > 400% FPL	5%	5%	0%	5%	5%	80%	5%	5%	0%	5%	5%	80%	5%	5%	0%	5%	5%	80%	5%	5%	0%	5%	5%	80%
2. 200% - 400% FPL	4%	4%	0%	4%	4%	84%	4%	4%	0%	4%	4%	84%	4%	4%	0%	4%	4%	84%	4%	4%	0%	4%	4%	84%
3. 133% - 200% FPL	2%	2%	0%	2%	2%	92%	2%	2%	0%	2%	2%	92%	2%	2%	0%	2%	2%	92%	2%	2%	0%	2%	2%	92%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – Low participation (3 of 6)

Baseline period	2014-S-X-100						2014-M-X-100						2014-S-FBH-100						2014-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
2. 200% - 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
3. 133% - 200% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. <133% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
2. 200% - 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
3. 133% - 200% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
4. <133% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%

Employer take-up rates – Low participation (4 of 6)

Baseline period	Ultimate-S-X-100						Ultimate-M-X-100						Ultimate-S-FBH-100						Ultimate-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%
2. 200% - 400% FPL	90%	0%	0%	0%	0%	10%	90%	0%	0%	0%	0%	10%	90%	0%	0%	0%	0%	10%	90%	0%	0%	0%	0%	10%
3. 133% - 200% FPL	70%	0%	15%	0%	0%	15%	75%	0%	10%	0%	0%	15%	68%	0%	15%	0%	0%	17%	73%	0%	10%	0%	0%	17%
4. <133% FPL	55%	0%	25%	0%	0%	20%	65%	0%	15%	0%	0%	20%	55%	0%	25%	0%	0%	20%	65%	0%	15%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	85%	10%	0%	0%	5%	0%	90%	5%	0%	0%	5%	0%	85%	10%	0%	0%	5%	0%	90%	5%	0%	0%	5%
2. 200% - 400% FPL	0%	75%	15%	0%	0%	10%	0%	80%	10%	0%	0%	10%	0%	75%	15%	0%	0%	10%	0%	80%	10%	0%	0%	10%
3. 133% - 200% FPL	0%	65%	20%	0%	0%	15%	0%	70%	15%	0%	0%	15%	0%	63%	20%	0%	0%	17%	0%	68%	15%	0%	0%	17%
4. <133% FPL	0%	55%	25%	0%	0%	20%	0%	60%	20%	0%	0%	20%	0%	55%	25%	0%	0%	20%	0%	60%	20%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%
2. 200% - 400% FPL	0%	0%	0%	90%	0%	10%	0%	0%	0%	90%	0%	10%	0%	0%	0%	90%	0%	10%	0%	0%	0%	90%	0%	10%
3. 133% - 200% FPL	0%	0%	15%	70%	0%	15%	0%	0%	10%	75%	0%	15%	0%	0%	15%	68%	0%	17%	0%	0%	10%	73%	0%	17%
4. <133% FPL	0%	0%	25%	55%	0%	20%	0%	0%	15%	65%	0%	20%	0%	0%	25%	55%	0%	20%	0%	0%	15%	65%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%
2. 200% - 400% FPL	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	90%	10%
3. 133% - 200% FPL	0%	0%	15%	0%	70%	15%	0%	0%	10%	0%	75%	15%	0%	0%	15%	0%	68%	17%	0%	0%	10%	0%	73%	17%
4. <133% FPL	0%	0%	25%	0%	55%	20%	0%	0%	15%	0%	65%	20%	0%	0%	25%	0%	55%	20%	0%	0%	15%	0%	65%	20%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	81%	0%	10%	0%	0%	9%	82%	0%	8%	0%	0%	10%	79%	0%	10%	0%	0%	11%	80%	0%	8%	0%	0%	12%
4. <133% FPL	45%	0%	25%	0%	0%	30%	35%	0%	25%	0%	0%	40%	45%	0%	25%	0%	0%	30%	35%	0%	25%	0%	0%	40%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%
2. 200% - 400% FPL	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%
3. 133% - 200% FPL	5%	71%	10%	2%	3%	9%	9%	64%	8%	4%	5%	10%	5%	69%	10%	2%	3%	11%	9%	62%	8%	4%	5%	12%
4. <133% FPL	0%	45%	25%	0%	0%	30%	0%	35%	25%	0%	0%	40%	0%	45%	25%	0%	0%	30%	0%	35%	25%	0%	0%	40%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	10%	81%	0%	9%	0%	0%	8%	82%	0%	10%	0%	0%	10%	79%	0%	11%	0%	0%	8%	80%	0%	12%
4. <133% FPL	0%	0%	25%	45%	0%	30%	0%	0%	25%	35%	0%	40%	0%	0%	25%	45%	0%	30%	0%	0%	25%	35%	0%	40%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	10%	0%	81%	9%	0%	0%	8%	0%	82%	10%	0%	0%	10%	0%	79%	11%	0%	0%	8%	0%	80%	12%
4. <133% FPL	0%	0%	25%	0%	45%	30%	0%	0%	25%	0%	35%	40%	0%	0%	25%	0%	45%	30%	0%	0%	25%	0%	35%	40%
e. No insurance																								
1. > 400% FPL	5%	3%	0%	5%	5%	82%	5%	3%	0%	5%	5%	82%	5%	3%	0%	5%	5%	82%	5%	3%	0%	5%	5%	82%
2. 200% - 400% FPL	4%	0%	0%	4%	4%	88%	4%	0%	0%	4%	4%	88%	4%	0%	0%	4%	4%	88%	4%	0%	0%	4%	4%	88%
3. 133% - 200% FPL	2%	0%	0%	2%	2%	94%	2%	0%	0%	2%	2%	94%	2%	0%	0%	2%	2%	94%	2%	0%	0%	2%	2%	94%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – Low participation (5 of 6)

Baseline period	Ultimate-S-X-100						Ultimate-M-X-100						Ultimate-S-FBH-100						Ultimate-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
2. 200% - 400% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
3. 133% - 200% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
4. <133% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
2. 200% - 400% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
3. 133% - 200% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
4. <133% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%

Employer take-up rates – Low participation (6 of 6)

Baseline period	2014-S-X-50						2014-M-X-50						2014-S-FBH-50						2014-M-FBH-50					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%
2. 200% - 400% FPL	90%	0%	0%	0%	0%	10%	85%	0%	0%	0%	0%	15%	90%	0%	0%	0%	0%	10%	85%	0%	0%	0%	0%	15%
3. 133% - 200% FPL	75%	0%	10%	0%	0%	15%	75%	0%	5%	0%	0%	20%	75%	0%	10%	0%	0%	15%	75%	0%	5%	0%	0%	20%
4. <133% FPL	60%	0%	20%	0%	0%	20%	60%	0%	15%	0%	0%	25%	60%	0%	20%	0%	0%	20%	60%	0%	15%	0%	0%	25%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	93%	3%	0%	0%	5%	0%	85%	0%	2%	3%	10%	0%	93%	3%	0%	0%	5%	0%	85%	0%	2%	3%	10%
2. 200% - 400% FPL	0%	83%	8%	0%	0%	10%	0%	78%	3%	2%	3%	15%	0%	83%	8%	0%	0%	10%	0%	78%	3%	2%	3%	15%
3. 133% - 200% FPL	0%	73%	13%	0%	0%	15%	0%	68%	8%	2%	3%	20%	0%	73%	13%	0%	0%	15%	0%	68%	8%	2%	3%	20%
4. <133% FPL	0%	53%	28%	0%	0%	20%	0%	48%	23%	2%	3%	25%	0%	53%	28%	0%	0%	20%	0%	48%	23%	2%	3%	25%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%
2. 200% - 400% FPL	0%	0%	0%	90%	0%	10%	0%	0%	0%	85%	0%	15%	0%	0%	0%	90%	0%	10%	0%	0%	0%	85%	0%	15%
3. 133% - 200% FPL	0%	0%	8%	78%	0%	15%	0%	0%	5%	75%	0%	20%	0%	0%	8%	78%	0%	15%	0%	0%	5%	75%	0%	20%
4. <133% FPL	0%	0%	20%	60%	0%	20%	0%	0%	15%	60%	0%	25%	0%	0%	20%	60%	0%	20%	0%	0%	15%	60%	0%	25%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%
2. 200% - 400% FPL	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	85%	15%
3. 133% - 200% FPL	0%	0%	8%	0%	78%	15%	0%	0%	5%	0%	75%	20%	0%	0%	8%	0%	78%	15%	0%	0%	5%	0%	75%	20%
4. <133% FPL	0%	0%	20%	0%	60%	20%	0%	0%	15%	0%	60%	25%	0%	0%	20%	0%	60%	20%	0%	0%	15%	0%	60%	25%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	4%	0%	0%	97%	0%	0%	3%	0%	0%	98%	0%	0%	4%	0%	0%	97%	0%	0%	3%	0%	0%	98%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%
4. <133% FPL	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%
4. <133% FPL	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%
4. <133% FPL	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%
4. <133% FPL	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%
e. No insurance																								
1. > 400% FPL	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%
2. 200% - 400% FPL	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%
3. 133% - 200% FPL	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – Medium participation (1 of 6)

Baseline period	2014-S-X-50						2014-M-X-50						2014-S-FBH-50						2014-M-FBH-50					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
2. 200% - 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
3. 133% - 200% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. <133% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
2. 200% - 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
3. 133% - 200% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
4. <133% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%

Employer take-up rates – Medium participation (2 of 6)

Baseline period	2014-S-X-100						2014-M-X-100						2014-S-FBH-100						2014-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	98%	0%	3%	0%	0%	0%	95%	0%	0%	0%	0%	5%	98%	0%	3%	0%	0%	0%	95%	0%	0%	0%	0%	5%
2. 200% - 400% FPL	93%	0%	3%	0%	0%	5%	90%	0%	0%	0%	0%	10%	93%	0%	3%	0%	0%	5%	90%	0%	0%	0%	0%	10%
3. 133% - 200% FPL	75%	0%	15%	0%	0%	10%	75%	0%	10%	0%	0%	15%	75%	0%	15%	0%	0%	10%	75%	0%	10%	0%	0%	15%
4. <133% FPL	55%	0%	25%	0%	0%	20%	60%	0%	20%	0%	0%	20%	55%	0%	25%	0%	0%	20%	60%	0%	20%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	93%	8%	0%	0%	0%	0%	93%	3%	0%	0%	5%	0%	93%	8%	0%	0%	0%	0%	93%	3%	0%	0%	5%
2. 200% - 400% FPL	0%	83%	13%	0%	0%	5%	0%	83%	8%	0%	0%	10%	0%	83%	13%	0%	0%	5%	0%	83%	8%	0%	0%	10%
3. 133% - 200% FPL	0%	73%	18%	0%	0%	10%	0%	73%	13%	0%	0%	15%	0%	73%	18%	0%	0%	10%	0%	73%	13%	0%	0%	15%
4. <133% FPL	0%	50%	30%	0%	0%	20%	0%	55%	25%	0%	0%	20%	0%	50%	30%	0%	0%	20%	0%	55%	25%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	3%	98%	0%	0%	0%	0%	0%	95%	0%	5%	0%	0%	3%	98%	0%	0%	0%	0%	0%	95%	0%	5%
2. 200% - 400% FPL	0%	0%	3%	93%	0%	5%	0%	0%	0%	90%	0%	10%	0%	0%	3%	93%	0%	5%	0%	0%	0%	90%	0%	10%
3. 133% - 200% FPL	0%	0%	15%	75%	0%	10%	0%	0%	10%	75%	0%	15%	0%	0%	15%	75%	0%	10%	0%	0%	10%	75%	0%	15%
4. <133% FPL	0%	0%	25%	55%	0%	20%	0%	0%	20%	60%	0%	20%	0%	0%	25%	55%	0%	20%	0%	0%	20%	60%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	3%	0%	98%	0%	0%	0%	0%	0%	95%	5%	0%	0%	3%	0%	98%	0%	0%	0%	0%	0%	95%	5%
2. 200% - 400% FPL	0%	0%	3%	0%	93%	5%	0%	0%	0%	0%	90%	10%	0%	0%	3%	0%	93%	5%	0%	0%	0%	0%	90%	10%
3. 133% - 200% FPL	0%	0%	15%	0%	75%	10%	0%	0%	10%	0%	75%	15%	0%	0%	15%	0%	75%	10%	0%	0%	10%	0%	75%	15%
4. <133% FPL	0%	0%	25%	0%	55%	20%	0%	0%	20%	0%	60%	20%	0%	0%	25%	0%	55%	20%	0%	0%	20%	0%	60%	20%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	5%	0%	0%	96%	0%	0%	4%	0%	0%	97%	0%	0%	5%	0%	0%	96%	0%	0%	4%	0%	0%	97%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	87%	0%	7%	0%	0%	7%	89%	0%	3%	0%	0%	9%	87%	0%	7%	0%	0%	7%	89%	0%	3%	0%	0%	9%
4. <133% FPL	57%	0%	25%	0%	0%	18%	63%	0%	18%	0%	0%	20%	57%	0%	25%	0%	0%	18%	63%	0%	18%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%
2. 200% - 400% FPL	8%	82%	2%	4%	4%	0%	13%	74%	2%	6%	6%	0%	8%	82%	2%	4%	4%	0%	13%	74%	2%	6%	6%	0%
3. 133% - 200% FPL	5%	73%	10%	2%	3%	7%	10%	64%	8%	5%	5%	9%	5%	73%	10%	2%	3%	7%	10%	64%	8%	5%	5%	9%
4. <133% FPL	0%	52%	30%	0%	0%	18%	0%	55%	25%	0%	0%	20%	0%	52%	30%	0%	0%	18%	0%	55%	25%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	7%	87%	0%	7%	0%	0%	3%	89%	0%	9%	0%	0%	7%	87%	0%	7%	0%	0%	3%	89%	0%	9%
4. <133% FPL	0%	0%	25%	57%	0%	18%	0%	0%	18%	63%	0%	20%	0%	0%	25%	57%	0%	18%	0%	0%	18%	63%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	7%	0%	87%	7%	0%	0%	3%	0%	89%	9%	0%	0%	7%	0%	87%	7%	0%	0%	3%	0%	89%	9%
4. <133% FPL	0%	0%	25%	0%	57%	18%	0%	0%	18%	0%	63%	20%	0%	0%	25%	0%	57%	18%	0%	0%	18%	0%	63%	20%
e. No insurance																								
1. > 400% FPL	5%	5%	3%	5%	5%	78%	5%	5%	3%	5%	5%	78%	5%	5%	3%	5%	5%	78%	5%	5%	3%	5%	5%	78%
2. 200% - 400% FPL	4%	4%	2%	4%	4%	82%	4%	4%	2%	4%	4%	82%	4%	4%	2%	4%	4%	82%	4%	4%	2%	4%	4%	82%
3. 133% - 200% FPL	2%	2%	5%	2%	2%	88%	2%	2%	4%	2%	2%	89%	2%	2%	5%	2%	2%	88%	2%	2%	4%	2%	2%	89%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – Medium participation (3 of 6)

Baseline period	2014-S-X-100						2014-M-X-100						2014-S-FBH-100						2014-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
2. 200% - 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
3. 133% - 200% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. <133% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
2. 200% - 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
3. 133% - 200% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
4. <133% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%

Employer take-up rates – Medium participation (4 of 6)

Baseline period	Ultimate-S-X-100						Ultimate-M-X-100						Ultimate-S-FBH-100						Ultimate-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	92%	0%	4%	0%	0%	5%	95%	0%	0%	0%	0%	5%	92%	0%	4%	0%	0%	5%	95%	0%	0%	0%	0%	5%
2. 200% - 400% FPL	86%	0%	4%	0%	0%	10%	90%	0%	0%	0%	0%	10%	86%	0%	4%	0%	0%	10%	90%	0%	0%	0%	0%	10%
3. 133% - 200% FPL	65%	0%	20%	0%	0%	15%	70%	0%	15%	0%	0%	15%	63%	0%	20%	0%	0%	17%	68%	0%	15%	0%	0%	17%
4. <133% FPL	45%	0%	35%	0%	0%	20%	55%	0%	25%	0%	0%	20%	45%	0%	35%	0%	0%	20%	55%	0%	25%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	83%	13%	0%	0%	5%	0%	88%	8%	0%	0%	5%	0%	83%	13%	0%	0%	5%	0%	88%	8%	0%	0%	5%
2. 200% - 400% FPL	0%	73%	18%	0%	0%	10%	0%	78%	13%	0%	0%	10%	0%	73%	18%	0%	0%	10%	0%	78%	13%	0%	0%	10%
3. 133% - 200% FPL	0%	63%	23%	0%	0%	15%	0%	68%	18%	0%	0%	15%	0%	61%	23%	0%	0%	17%	0%	66%	18%	0%	0%	17%
4. <133% FPL	0%	45%	35%	0%	0%	20%	0%	50%	30%	0%	0%	20%	0%	45%	35%	0%	0%	20%	0%	50%	30%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	4%	92%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	4%	92%	0%	5%	0%	0%	0%	95%	0%	5%
2. 200% - 400% FPL	0%	0%	4%	86%	0%	10%	0%	0%	0%	90%	0%	10%	0%	0%	4%	86%	0%	10%	0%	0%	0%	90%	0%	10%
3. 133% - 200% FPL	0%	0%	20%	65%	0%	15%	0%	0%	15%	70%	0%	15%	0%	0%	20%	63%	0%	17%	0%	0%	15%	68%	0%	17%
4. <133% FPL	0%	0%	35%	45%	0%	20%	0%	0%	25%	55%	0%	20%	0%	0%	35%	45%	0%	20%	0%	0%	25%	55%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	4%	0%	92%	5%	0%	0%	0%	0%	95%	5%	0%	0%	4%	0%	92%	5%	0%	0%	0%	0%	95%	5%
2. 200% - 400% FPL	0%	0%	4%	0%	86%	10%	0%	0%	0%	0%	90%	10%	0%	0%	4%	0%	86%	10%	0%	0%	0%	0%	90%	10%
3. 133% - 200% FPL	0%	0%	20%	0%	65%	15%	0%	0%	15%	0%	70%	15%	0%	0%	20%	0%	63%	17%	0%	0%	15%	0%	68%	17%
4. <133% FPL	0%	0%	35%	0%	45%	20%	0%	0%	25%	0%	55%	20%	0%	0%	35%	0%	45%	20%	0%	0%	25%	0%	55%	20%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	6%	0%	0%	95%	0%	0%	4%	0%	0%	97%	0%	0%	6%	0%	0%	95%	0%	0%	4%	0%	0%	97%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	99%	0%	1%	0%	0%	0%	100%	0%	1%	0%	0%	0%	99%	0%	1%	0%	0%	0%	100%	0%	1%	0%	0%	0%
2. 200% - 400% FPL	99%	0%	2%	0%	0%	0%	99%	0%	1%	0%	0%	0%	99%	0%	2%	0%	0%	0%	99%	0%	1%	0%	0%	0%
3. 133% - 200% FPL	78%	0%	14%	0%	0%	9%	80%	0%	11%	0%	0%	10%	76%	0%	14%	0%	0%	11%	78%	0%	11%	0%	0%	12%
4. <133% FPL	35%	0%	35%	0%	0%	30%	25%	0%	35%	0%	0%	40%	35%	0%	35%	0%	0%	30%	25%	0%	35%	0%	0%	40%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	8%	83%	1%	4%	4%	0%	13%	75%	1%	6%	6%	0%	8%	83%	1%	4%	4%	0%	13%	75%	1%	6%	6%	0%
2. 200% - 400% FPL	8%	81%	4%	4%	4%	0%	13%	73%	3%	6%	6%	0%	8%	81%	4%	4%	4%	0%	13%	73%	3%	6%	6%	0%
3. 133% - 200% FPL	5%	66%	15%	2%	3%	9%	9%	60%	13%	4%	5%	10%	5%	64%	15%	2%	3%	11%	9%	58%	13%	4%	5%	12%
4. <133% FPL	0%	35%	35%	0%	0%	30%	0%	25%	35%	0%	0%	40%	0%	35%	35%	0%	0%	30%	0%	25%	35%	0%	0%	40%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	1%	99%	0%	0%	0%	0%	1%	100%	0%	0%	0%	0%	1%	99%	0%	0%	0%	0%	1%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	2%	99%	0%	0%	0%	0%	1%	99%	0%	0%	0%	0%	2%	99%	0%	0%	0%	0%	1%	99%	0%	0%
3. 133% - 200% FPL	0%	0%	14%	78%	0%	9%	0%	0%	11%	80%	0%	10%	0%	0%	14%	76%	0%	11%	0%	0%	11%	78%	0%	12%
4. <133% FPL	0%	0%	35%	35%	0%	30%	0%	0%	35%	25%	0%	40%	0%	0%	35%	35%	0%	30%	0%	0%	35%	25%	0%	40%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	1%	0%	99%	0%	0%	0%	1%	0%	100%	0%	0%	0%	1%	0%	99%	0%	0%	0%	1%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	2%	0%	99%	0%	0%	0%	1%	0%	99%	0%	0%	0%	2%	0%	99%	0%	0%	0%	1%	0%	99%	0%
3. 133% - 200% FPL	0%	0%	14%	0%	78%	9%	0%	0%	11%	0%	80%	10%	0%	0%	14%	0%	76%	11%	0%	0%	11%	0%	78%	12%
4. <133% FPL	0%	0%	35%	0%	35%	30%	0%	0%	35%	0%	25%	40%	0%	0%	35%	0%	35%	30%	0%	0%	35%	0%	25%	40%
e. No insurance																								
1. > 400% FPL	5%	3%	3%	5%	5%	80%	5%	3%	3%	5%	5%	80%	5%	3%	3%	5%	5%	80%	5%	3%	3%	5%	5%	80%
2. 200% - 400% FPL	4%	0%	2%	4%	4%	86%	4%	0%	2%	4%	4%	86%	4%	0%	2%	4%	4%	86%	4%	0%	2%	4%	4%	86%
3. 133% - 200% FPL	2%	0%	5%	2%	2%	90%	2%	0%	4%	2%	2%	91%	2%	0%	5%	2%	2%	90%	2%	0%	4%	2%	2%	91%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – Medium participation (5 of 6)

Baseline period	Ultimate-S-X-100						Ultimate-M-X-100						Ultimate-S-FBH-100						Ultimate-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
2. 200% - 400% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
3. 133% - 200% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
4. <133% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
2. 200% - 400% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
3. 133% - 200% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
4. <133% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%

Employer take-up rates – Medium participation (6 of 6)

Baseline period	2014-S-X-50						2014-M-X-50						2014-S-FBH-50						2014-M-FBH-50					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%	95%	0%	0%	0%	0%	5%	90%	0%	0%	0%	0%	10%
2. 200% - 400% FPL	90%	0%	0%	0%	0%	10%	85%	0%	0%	0%	0%	15%	90%	0%	0%	0%	0%	10%	85%	0%	0%	0%	0%	15%
3. 133% - 200% FPL	70%	0%	15%	0%	0%	15%	70%	0%	10%	0%	0%	20%	70%	0%	15%	0%	0%	15%	70%	0%	10%	0%	0%	20%
4. <133% FPL	50%	0%	30%	0%	0%	20%	50%	0%	25%	0%	0%	25%	50%	0%	30%	0%	0%	20%	50%	0%	25%	0%	0%	25%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	90%	5%	0%	0%	5%	0%	85%	0%	2%	3%	10%	0%	90%	5%	0%	0%	5%	0%	85%	0%	2%	3%	10%
2. 200% - 400% FPL	0%	80%	10%	0%	0%	10%	0%	75%	5%	2%	3%	15%	0%	80%	10%	0%	0%	10%	0%	75%	5%	2%	3%	15%
3. 133% - 200% FPL	0%	70%	15%	0%	0%	15%	0%	65%	10%	2%	3%	20%	0%	70%	15%	0%	0%	15%	0%	65%	10%	2%	3%	20%
4. <133% FPL	0%	40%	40%	0%	0%	20%	0%	35%	35%	2%	3%	25%	0%	40%	40%	0%	0%	20%	0%	35%	35%	2%	3%	25%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%	0%	0%	0%	95%	0%	5%	0%	0%	0%	90%	0%	10%
2. 200% - 400% FPL	0%	0%	0%	90%	0%	10%	0%	0%	0%	85%	0%	15%	0%	0%	0%	90%	0%	10%	0%	0%	0%	85%	0%	15%
3. 133% - 200% FPL	0%	0%	10%	75%	0%	15%	0%	0%	10%	70%	0%	20%	0%	0%	10%	75%	0%	15%	0%	0%	10%	70%	0%	20%
4. <133% FPL	0%	0%	30%	50%	0%	20%	0%	0%	25%	50%	0%	25%	0%	0%	30%	50%	0%	20%	0%	0%	25%	50%	0%	25%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	90%	10%
2. 200% - 400% FPL	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	90%	10%	0%	0%	0%	0%	85%	15%
3. 133% - 200% FPL	0%	0%	10%	0%	75%	15%	0%	0%	10%	0%	70%	20%	0%	0%	10%	0%	75%	15%	0%	0%	10%	0%	70%	20%
4. <133% FPL	0%	0%	30%	0%	50%	20%	0%	0%	25%	0%	50%	25%	0%	0%	30%	0%	50%	20%	0%	0%	25%	0%	50%	25%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	7%	0%	0%	93%	0%	0%	5%	0%	0%	95%	0%	0%	7%	0%	0%	93%	0%	0%	5%	0%	0%	95%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%	95%	0%	0%	0%	0%	5%
4. <133% FPL	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%	85%	0%	0%	0%	0%	15%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%	0%	95%	0%	0%	0%	5%
4. <133% FPL	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%	0%	85%	0%	0%	0%	15%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	0%	95%	0%	5%
4. <133% FPL	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%	0%	0%	0%	85%	0%	15%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%	0%	0%	0%	0%	95%	5%
4. <133% FPL	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%	0%	0%	0%	0%	85%	15%
e. No insurance																								
1. > 400% FPL	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%	5%	10%	0%	5%	5%	75%
2. 200% - 400% FPL	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%	4%	8%	0%	4%	4%	80%
3. 133% - 200% FPL	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%	3%	6%	0%	3%	3%	85%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – High participation (1 of 6)

Baseline period	2014-S-X-50						2014-M-X-50						2014-S-FBH-50						2014-M-FBH-50					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
2. 200% - 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
3. 133% - 200% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. <133% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
2. 200% - 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
3. 133% - 200% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
4. <133% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%

Employer take-up rates – High participation (2 of 6)

Baseline period	2014-S-X-100						2014-M-X-100						2014-S-FBH-100						2014-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	95%	0%	5%	0%	0%	0%	95%	0%	0%	0%	0%	5%	95%	0%	5%	0%	0%	0%	95%	0%	0%	0%	0%	5%
2. 200% - 400% FPL	90%	0%	5%	0%	0%	5%	90%	0%	0%	0%	0%	10%	90%	0%	5%	0%	0%	5%	90%	0%	0%	0%	0%	10%
3. 133% - 200% FPL	70%	0%	20%	0%	0%	10%	70%	0%	15%	0%	0%	15%	70%	0%	20%	0%	0%	10%	70%	0%	15%	0%	0%	15%
4. <133% FPL	45%	0%	35%	0%	0%	20%	50%	0%	30%	0%	0%	20%	45%	0%	35%	0%	0%	20%	50%	0%	30%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	90%	10%	0%	0%	0%	0%	90%	5%	0%	0%	5%	0%	90%	10%	0%	0%	0%	0%	90%	5%	0%	0%	5%
2. 200% - 400% FPL	0%	80%	15%	0%	0%	5%	0%	80%	10%	0%	0%	10%	0%	80%	15%	0%	0%	5%	0%	80%	10%	0%	0%	10%
3. 133% - 200% FPL	0%	70%	20%	0%	0%	10%	0%	70%	15%	0%	0%	15%	0%	70%	20%	0%	0%	10%	0%	70%	15%	0%	0%	15%
4. <133% FPL	0%	40%	40%	0%	0%	20%	0%	45%	35%	0%	0%	20%	0%	40%	40%	0%	0%	20%	0%	45%	35%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	5%	95%	0%	0%	0%	0%	0%	95%	0%	5%	0%	0%	5%	95%	0%	0%	0%	0%	0%	95%	0%	5%
2. 200% - 400% FPL	0%	0%	5%	90%	0%	5%	0%	0%	0%	90%	0%	10%	0%	0%	5%	90%	0%	5%	0%	0%	0%	90%	0%	10%
3. 133% - 200% FPL	0%	0%	20%	70%	0%	10%	0%	0%	15%	70%	0%	15%	0%	0%	20%	70%	0%	10%	0%	0%	15%	70%	0%	15%
4. <133% FPL	0%	0%	35%	45%	0%	20%	0%	0%	30%	50%	0%	20%	0%	0%	35%	45%	0%	20%	0%	0%	30%	50%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	5%	0%	95%	0%	0%	0%	0%	0%	95%	5%	0%	0%	5%	0%	95%	0%	0%	0%	0%	0%	95%	5%
2. 200% - 400% FPL	0%	0%	5%	0%	90%	5%	0%	0%	0%	0%	90%	10%	0%	0%	5%	0%	90%	5%	0%	0%	0%	0%	90%	10%
3. 133% - 200% FPL	0%	0%	20%	0%	70%	10%	0%	0%	15%	0%	70%	15%	0%	0%	20%	0%	70%	10%	0%	0%	15%	0%	70%	15%
4. <133% FPL	0%	0%	35%	0%	45%	20%	0%	0%	30%	0%	50%	20%	0%	0%	35%	0%	45%	20%	0%	0%	30%	0%	50%	20%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	9%	0%	0%	91%	0%	0%	7%	0%	0%	93%	0%	0%	9%	0%	0%	91%	0%	0%	7%	0%	0%	93%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	83%	0%	10%	0%	0%	7%	86%	0%	5%	0%	0%	9%	83%	0%	10%	0%	0%	7%	86%	0%	5%	0%	0%	9%
4. <133% FPL	47%	0%	35%	0%	0%	18%	50%	0%	30%	0%	0%	20%	47%	0%	35%	0%	0%	18%	50%	0%	30%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%	8%	84%	0%	4%	4%	0%	13%	75%	0%	6%	6%	0%
2. 200% - 400% FPL	8%	80%	4%	4%	4%	0%	13%	72%	3%	6%	6%	0%	8%	80%	4%	4%	4%	0%	13%	72%	3%	6%	6%	0%
3. 133% - 200% FPL	5%	68%	15%	2%	3%	7%	10%	59%	12%	5%	5%	9%	5%	68%	15%	2%	3%	7%	10%	59%	12%	5%	5%	9%
4. <133% FPL	0%	42%	40%	0%	0%	18%	0%	45%	35%	0%	0%	20%	0%	42%	40%	0%	0%	18%	0%	45%	35%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	10%	83%	0%	7%	0%	0%	5%	86%	0%	9%	0%	0%	10%	83%	0%	7%	0%	0%	5%	86%	0%	9%
4. <133% FPL	0%	0%	35%	47%	0%	18%	0%	0%	30%	50%	0%	20%	0%	0%	35%	47%	0%	18%	0%	0%	30%	50%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	10%	0%	83%	7%	0%	0%	5%	0%	86%	9%	0%	0%	10%	0%	83%	7%	0%	0%	5%	0%	86%	9%
4. <133% FPL	0%	0%	35%	0%	47%	18%	0%	0%	30%	0%	50%	20%	0%	0%	35%	0%	47%	18%	0%	0%	30%	0%	50%	20%
e. No insurance																								
1. > 400% FPL	5%	5%	5%	5%	5%	75%	5%	5%	5%	5%	5%	75%	5%	5%	5%	5%	5%	75%	5%	5%	5%	5%	5%	75%
2. 200% - 400% FPL	4%	4%	4%	4%	4%	80%	4%	4%	4%	4%	4%	80%	4%	4%	4%	4%	4%	80%	4%	4%	4%	4%	4%	80%
3. 133% - 200% FPL	2%	1%	9%	2%	2%	84%	2%	2%	7%	2%	2%	85%	2%	1%	9%	2%	2%	84%	2%	2%	7%	2%	2%	85%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – High participation (3 of 6)

Baseline period	2014-S-X-100						2014-M-X-100						2014-S-FBH-100						2014-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
2. 200% - 400% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
3. 133% - 200% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. <133% FPL	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%	40%	20%	0%	0%	0%	40%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
2. 200% - 400% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
3. 133% - 200% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%
4. <133% FPL	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%	30%	50%	0%	0%	0%	20%

Employer take-up rates – High participation (4 of 6)

Baseline period	Ultimate-S-X-100						Ultimate-M-X-100						Ultimate-S-FBH-100						Ultimate-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
1. Small employer (1-50)																								
a. Self-insurance																								
1. > 400% FPL	88%	0%	7%	0%	0%	5%	95%	0%	0%	0%	0%	5%	88%	0%	7%	0%	0%	5%	95%	0%	0%	0%	0%	5%
2. 200% - 400% FPL	82%	0%	8%	0%	0%	10%	90%	0%	0%	0%	0%	10%	82%	0%	8%	0%	0%	10%	90%	0%	0%	0%	0%	10%
3. 133% - 200% FPL	60%	0%	25%	0%	0%	15%	65%	0%	20%	0%	0%	15%	58%	0%	25%	0%	0%	17%	63%	0%	20%	0%	0%	17%
4. <133% FPL	35%	0%	45%	0%	0%	20%	45%	0%	35%	0%	0%	20%	35%	0%	45%	0%	0%	20%	45%	0%	35%	0%	0%	20%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	80%	15%	0%	0%	5%	0%	85%	10%	0%	0%	5%	0%	80%	15%	0%	0%	5%	0%	85%	10%	0%	0%	5%
2. 200% - 400% FPL	0%	70%	20%	0%	0%	10%	0%	75%	15%	0%	0%	10%	0%	70%	20%	0%	0%	10%	0%	75%	15%	0%	0%	10%
3. 133% - 200% FPL	0%	60%	25%	0%	0%	15%	0%	65%	20%	0%	0%	15%	0%	58%	25%	0%	0%	17%	0%	63%	20%	0%	0%	17%
4. <133% FPL	0%	35%	45%	0%	0%	20%	0%	40%	40%	0%	0%	20%	0%	35%	45%	0%	0%	20%	0%	40%	40%	0%	0%	20%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	7%	88%	0%	5%	0%	0%	0%	95%	0%	5%	0%	0%	7%	88%	0%	5%	0%	0%	0%	95%	0%	5%
2. 200% - 400% FPL	0%	0%	8%	82%	0%	10%	0%	0%	0%	90%	0%	10%	0%	0%	8%	82%	0%	10%	0%	0%	0%	90%	0%	10%
3. 133% - 200% FPL	0%	0%	25%	60%	0%	15%	0%	0%	20%	65%	0%	15%	0%	0%	25%	58%	0%	17%	0%	0%	20%	63%	0%	17%
4. <133% FPL	0%	0%	45%	35%	0%	20%	0%	0%	35%	45%	0%	20%	0%	0%	45%	35%	0%	20%	0%	0%	35%	45%	0%	20%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	7%	0%	88%	5%	0%	0%	0%	0%	95%	5%	0%	0%	7%	0%	88%	5%	0%	0%	0%	0%	95%	5%
2. 200% - 400% FPL	0%	0%	8%	0%	82%	10%	0%	0%	0%	0%	90%	10%	0%	0%	8%	0%	82%	10%	0%	0%	0%	0%	90%	10%
3. 133% - 200% FPL	0%	0%	25%	0%	60%	15%	0%	0%	20%	0%	65%	15%	0%	0%	25%	0%	58%	17%	0%	0%	20%	0%	63%	17%
4. <133% FPL	0%	0%	45%	0%	35%	20%	0%	0%	35%	0%	45%	20%	0%	0%	45%	0%	35%	20%	0%	0%	35%	0%	45%	20%
e. No insurance																								
1. > 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. 200% - 400% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
3. 133% - 200% FPL	0%	0%	11%	0%	0%	89%	0%	0%	7%	0%	0%	93%	0%	0%	11%	0%	0%	89%	0%	0%	7%	0%	0%	93%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%
2. Small employer (51-100)																								
a. Self-insurance																								
1. > 400% FPL	98%	0%	2%	0%	0%	0%	99%	0%	1%	0%	0%	0%	98%	0%	2%	0%	0%	0%	99%	0%	1%	0%	0%	0%
2. 200% - 400% FPL	97%	0%	3%	0%	0%	0%	98%	0%	2%	0%	0%	0%	97%	0%	3%	0%	0%	0%	98%	0%	2%	0%	0%	0%
3. 133% - 200% FPL	74%	0%	17%	0%	0%	9%	77%	0%	13%	0%	0%	10%	72%	0%	17%	0%	0%	11%	75%	0%	13%	0%	0%	12%
4. <133% FPL	25%	0%	45%	0%	0%	30%	15%	0%	45%	0%	0%	40%	25%	0%	45%	0%	0%	30%	15%	0%	45%	0%	0%	40%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	8%	82%	2%	4%	4%	0%	13%	74%	1%	6%	6%	0%	8%	82%	2%	4%	4%	0%	13%	74%	1%	6%	6%	0%
2. 200% - 400% FPL	8%	77%	7%	4%	4%	0%	13%	70%	5%	6%	6%	0%	8%	77%	7%	4%	4%	0%	13%	70%	5%	6%	6%	0%
3. 133% - 200% FPL	5%	61%	20%	2%	3%	9%	9%	55%	17%	4%	5%	10%	5%	59%	20%	2%	3%	11%	9%	53%	17%	4%	5%	12%
4. <133% FPL	0%	25%	45%	0%	0%	30%	0%	15%	45%	0%	0%	40%	0%	25%	45%	0%	0%	30%	0%	15%	45%	0%	0%	40%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	2%	98%	0%	0%	0%	0%	1%	99%	0%	0%	0%	0%	2%	98%	0%	0%	0%	0%	1%	99%	0%	0%
2. 200% - 400% FPL	0%	0%	3%	97%	0%	0%	0%	0%	2%	98%	0%	0%	0%	0%	3%	97%	0%	0%	0%	0%	2%	98%	0%	0%
3. 133% - 200% FPL	0%	0%	17%	74%	0%	9%	0%	0%	13%	77%	0%	10%	0%	0%	17%	72%	0%	11%	0%	0%	13%	75%	0%	12%
4. <133% FPL	0%	0%	45%	25%	0%	30%	0%	0%	45%	15%	0%	40%	0%	0%	45%	25%	0%	30%	0%	0%	45%	15%	0%	40%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	2%	0%	98%	0%	0%	0%	1%	0%	99%	0%	0%	0%	2%	0%	98%	0%	0%	0%	1%	0%	99%	0%
2. 200% - 400% FPL	0%	0%	3%	0%	97%	0%	0%	0%	2%	0%	98%	0%	0%	0%	3%	0%	97%	0%	0%	0%	2%	0%	98%	0%
3. 133% - 200% FPL	0%	0%	17%	0%	74%	9%	0%	0%	13%	0%	77%	10%	0%	0%	17%	0%	72%	11%	0%	0%	13%	0%	75%	12%
4. <133% FPL	0%	0%	45%	0%	25%	30%	0%	0%	45%	0%	15%	40%	0%	0%	45%	0%	25%	30%	0%	0%	45%	0%	15%	40%
e. No insurance																								
1. > 400% FPL	5%	3%	5%	5%	5%	77%	5%	3%	5%	5%	5%	77%	5%	3%	5%	5%	5%	77%	5%	3%	5%	5%	5%	77%
2. 200% - 400% FPL	4%	0%	4%	4%	4%	84%	4%	0%	4%	4%	4%	84%	4%	0%	4%	4%	4%	84%	4%	0%	4%	4%	4%	84%
3. 133% - 200% FPL	2%	0%	9%	2%	2%	85%	2%	0%	7%	2%	2%	87%	2%	0%	9%	2%	2%	85%	2%	0%	7%	2%	2%	87%
4. <133% FPL	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%

Employer take-up rates – High participation (5 of 6)

Baseline period	Ultimate-S-X-100						Ultimate-M-X-100						Ultimate-S-FBH-100						Ultimate-M-FBH-100					
		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No		Group insurance		Association plan		No
	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage	Self-insurance	Outside Exchange	Inside Exchange	Self-Insurance	Group-Insurance	employer coverage
3. Large employer (> 100)																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
2. 200% - 400% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
3. 133% - 200% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
4. <133% FPL	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%	60%	30%	0%	0%	0%	10%
4. Public employer																								
a. Self-insurance																								
1. > 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
2. 200% - 400% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
3. 133% - 200% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
4. <133% FPL	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%
b. Group insurance - Outside Exchange																								
1. > 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. 200% - 400% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
3. 133% - 200% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
4. <133% FPL	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%
c. Association plan - Self-insurance																								
1. > 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
2. 200% - 400% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
3. 133% - 200% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
4. <133% FPL	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%
d. Association plan - Group insurance																								
1. > 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
2. 200% - 400% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
3. 133% - 200% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
4. <133% FPL	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%
e. No insurance																								
1. > 400% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
2. 200% - 400% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
3. 133% - 200% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%
4. <133% FPL	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%	50%	50%	0%	0%	0%	0%

Employer take-up rates – High participation (6 of 6)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Low participation (1 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Low participation (2 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
b. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
c. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
d. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
2. 200% - 400% FPL																				
a. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
b. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
c. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
d. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
3. 133% - 200% FPL																				
a. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
b. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
c. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
d. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
4. < 133% FPL																				
a. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
b. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
c. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
d. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Low participation (3 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Low participation (4 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
3. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
4. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
b. 200% - 400% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
2. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
3. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
c. 133% - 200% FPL																				
1. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
2. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Low participation (5 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
b. WA Basic Health	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
c. WSHIP	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
d. Uninsured	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%	0%	10%	0%	0%	90%	0%	11%	0%	0%	89%
2. 200% - 400% FPL																				
a. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
b. WA Basic Health	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
c. WSHIP	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
d. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
3. 133% - 200% FPL																				
a. Individual insurance	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	65%	0%	35%	0%	0%	65%	0%	35%	0%	0%
b. WA Basic Health	0%	80%	0%	0%	20%	0%	80%	0%	0%	20%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
c. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
d. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	0%	35%	0%	65%	0%	0%	35%	0%	65%
4. < 133% FPL																				
a. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
b. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
c. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
d. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Low participation (6 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
3. WSHIP	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
4. Uninsured	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%
b. 200% - 400% FPL																				
1. Individual insurance	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%
c. 133% - 200% FPL																				
1. Individual insurance	55%	45%	0%	0%	0%	55%	45%	0%	0%	0%	45%	0%	55%	0%	0%	45%	0%	55%	0%	0%
2. WA Basic Health	0%	90%	0%	0%	10%	0%	90%	0%	0%	10%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
3. WSHIP	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
4. Uninsured	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%
b. 200% - 400% FPL																				
1. Individual insurance	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%
c. 133% - 200% FPL																				
1. Individual insurance	55%	45%	0%	0%	0%	55%	45%	0%	0%	0%	45%	0%	55%	0%	0%	45%	0%	55%	0%	0%
2. WA Basic Health	0%	90%	0%	0%	10%	0%	90%	0%	0%	10%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – Low participation (7 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
3. WSHIP	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
4. Uninsured	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%
b. 200% - 400% FPL																				
1. Individual insurance	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%
c. 133% - 200% FPL																				
1. Individual insurance	55%	45%	0%	0%	0%	55%	45%	0%	0%	0%	45%	0%	55%	0%	0%	45%	0%	55%	0%	0%
2. WA Basic Health	0%	90%	0%	0%	10%	0%	90%	0%	0%	10%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
2. WA Basic Health	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
3. WSHIP	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
4. Uninsured	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%
b. 200% - 400% FPL																				
1. Individual insurance	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%
c. 133% - 200% FPL																				
1. Individual insurance	55%	45%	0%	0%	0%	55%	45%	0%	0%	0%	45%	0%	55%	0%	0%	45%	0%	55%	0%	0%
2. WA Basic Health	0%	90%	0%	0%	10%	0%	90%	0%	0%	10%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – Low participation (8 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%
b. WA Basic Health	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
c. WSHIP	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%	75%	25%	0%	0%	0%
d. Uninsured	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%	0%	15%	0%	0%	85%	0%	16%	0%	0%	84%
2. 200% - 400% FPL																				
a. Individual insurance	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%	70%	30%	0%	0%	0%
b. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
c. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
d. Uninsured	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%	0%	30%	0%	0%	70%	0%	31%	0%	0%	69%
3. 133% - 200% FPL																				
a. Individual insurance	55%	45%	0%	0%	0%	55%	45%	0%	0%	0%	45%	0%	55%	0%	0%	45%	0%	55%	0%	0%
b. WA Basic Health	0%	90%	0%	0%	10%	0%	90%	0%	0%	10%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
c. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
d. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%
4. < 133% FPL																				
a. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
b. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
c. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
d. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – Low participation (9 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Medium participation (1 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Medium participation (2 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
b. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
c. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
d. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
2. 200% - 400% FPL																				
a. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
b. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
c. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
d. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
3. 133% - 200% FPL																				
a. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
b. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
c. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
d. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
4. < 133% FPL																				
a. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
b. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
c. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
d. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Medium participation (3 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Medium participation (4 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
2. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
3. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
4. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
b. 200% - 400% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
2. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
3. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
4. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
c. 133% - 200% FPL																				
1. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
2. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
3. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Medium participation (5 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%	90%	10%	0%	0%	0%
b. WA Basic Health	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
c. WSHIP	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%	60%	40%	0%	0%	0%
d. Uninsured	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%	0%	25%	0%	0%	75%	0%	26%	0%	0%	74%
2. 200% - 400% FPL																				
a. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
b. WA Basic Health	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
c. WSHIP	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%	35%	65%	0%	0%	0%
d. Uninsured	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%	0%	43%	0%	0%	58%	0%	44%	0%	0%	57%
3. 133% - 200% FPL																				
a. Individual insurance	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	38%	0%	63%	0%	0%	38%	0%	63%	0%	0%
b. WA Basic Health	3%	88%	0%	0%	10%	3%	88%	0%	0%	10%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
c. WSHIP	3%	98%	0%	0%	0%	3%	98%	0%	0%	0%	3%	0%	98%	0%	0%	3%	0%	98%	0%	0%
d. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	0%	55%	0%	45%	0%	0%	55%	0%	45%
4. < 133% FPL																				
a. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
b. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
c. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
d. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – Medium participation (6 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%
2. WA Basic Health	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
3. WSHIP	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
4. Uninsured	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%
b. 200% - 400% FPL																				
1. Individual insurance	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
2. WA Basic Health	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
3. WSHIP	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
4. Uninsured	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%
c. 133% - 200% FPL																				
1. Individual insurance	33%	68%	0%	0%	0%	33%	68%	0%	0%	0%	25%	0%	75%	0%	0%	25%	0%	75%	0%	0%
2. WA Basic Health	0%	95%	0%	0%	5%	0%	95%	0%	0%	5%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	63%	0%	0%	38%	0%	64%	0%	0%	37%	0%	0%	70%	0%	30%	0%	0%	70%	0%	30%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%
2. WA Basic Health	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
3. WSHIP	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
4. Uninsured	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%
b. 200% - 400% FPL																				
1. Individual insurance	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
2. WA Basic Health	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
3. WSHIP	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
4. Uninsured	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%
c. 133% - 200% FPL																				
1. Individual insurance	33%	68%	0%	0%	0%	33%	68%	0%	0%	0%	25%	0%	75%	0%	0%	25%	0%	75%	0%	0%
2. WA Basic Health	0%	95%	0%	0%	5%	0%	95%	0%	0%	5%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	63%	0%	0%	38%	0%	64%	0%	0%	37%	0%	0%	70%	0%	30%	0%	0%	70%	0%	30%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – Medium participation (7 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%
2. WA Basic Health	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
3. WSHIP	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
4. Uninsured	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%
b. 200% - 400% FPL																				
1. Individual insurance	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
2. WA Basic Health	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
3. WSHIP	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
4. Uninsured	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%
c. 133% - 200% FPL																				
1. Individual insurance	33%	68%	0%	0%	0%	33%	68%	0%	0%	0%	25%	0%	75%	0%	0%	25%	0%	75%	0%	0%
2. WA Basic Health	0%	95%	0%	0%	5%	0%	95%	0%	0%	5%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	63%	0%	0%	38%	0%	64%	0%	0%	37%	0%	0%	70%	0%	30%	0%	0%	70%	0%	30%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%
2. WA Basic Health	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
3. WSHIP	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
4. Uninsured	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%
b. 200% - 400% FPL																				
1. Individual insurance	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
2. WA Basic Health	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
3. WSHIP	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
4. Uninsured	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%
c. 133% - 200% FPL																				
1. Individual insurance	33%	68%	0%	0%	0%	33%	68%	0%	0%	0%	25%	0%	75%	0%	0%	25%	0%	75%	0%	0%
2. WA Basic Health	0%	95%	0%	0%	5%	0%	95%	0%	0%	5%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	63%	0%	0%	38%	0%	64%	0%	0%	37%	0%	0%	70%	0%	30%	0%	0%	70%	0%	30%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – Medium participation (8 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%	83%	18%	0%	0%	0%
b. WA Basic Health	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
c. WSHIP	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%
d. Uninsured	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%	0%	33%	0%	0%	68%	0%	34%	0%	0%	67%
2. 200% - 400% FPL																				
a. Individual insurance	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
b. WA Basic Health	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
c. WSHIP	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%	30%	70%	0%	0%	0%
d. Uninsured	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%	0%	53%	0%	0%	48%	0%	54%	0%	0%	47%
3. 133% - 200% FPL																				
a. Individual insurance	33%	68%	0%	0%	0%	33%	68%	0%	0%	0%	25%	0%	75%	0%	0%	25%	0%	75%	0%	0%
b. WA Basic Health	0%	95%	0%	0%	5%	0%	95%	0%	0%	5%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
c. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
d. Uninsured	0%	63%	0%	0%	38%	0%	64%	0%	0%	37%	0%	0%	70%	0%	30%	0%	0%	70%	0%	30%
4. < 133% FPL																				
a. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
b. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
c. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
d. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – Medium participation (9 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – High participation (1 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – High participation (2 of 9)

Baseline - 2010	2014-S-X-50					2014-M-X-50					2014-S-FBH-50					2014-M-FBH-50				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
b. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
c. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
d. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
2. 200% - 400% FPL																				
a. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
b. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
c. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
d. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
3. 133% - 200% FPL																				
a. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
b. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
c. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
d. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
4. < 133% FPL																				
a. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
b. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
c. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
d. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – High participation (3 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – High participation (4 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
2. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
3. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
4. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
b. 200% - 400% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
4. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
c. 133% - 200% FPL																				
1. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
2. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
3. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
d. < 133% FPL																				
1. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
2. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
3. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
4. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – High participation (5 of 9)

Baseline - 2010	2014-S-X-100					2014-M-X-100					2014-S-FBH-100					2014-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%
b. WA Basic Health	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
c. WSHIP	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%	40%	60%	0%	0%	0%
d. Uninsured	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%	0%	40%	0%	0%	60%	0%	41%	0%	0%	59%
2. 200% - 400% FPL																				
a. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
b. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
c. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%
d. Uninsured	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%	0%	60%	0%	0%	40%	0%	61%	0%	0%	39%
3. 133% - 200% FPL																				
a. Individual insurance	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	10%	0%	90%	0%	0%	10%	0%	90%	0%	0%
b. WA Basic Health	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
c. WSHIP	5%	95%	0%	0%	0%	5%	95%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
d. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	0%	75%	0%	25%	0%	0%	75%	0%	25%
4. < 133% FPL																				
a. Individual insurance	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%	50%	0%	0%	50%	0%
b. WA Basic Health	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
c. WSHIP	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
d. Uninsured	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%	0%	0%	0%	50%	50%

Individual take-up rates – High participation (6 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
1. Small employer (1-50)																				
a. > 400% FPL																				
1. Individual insurance	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
2. WA Basic Health	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
3. WSHIP	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%
b. 200% - 400% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%
c. 133% - 200% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	85%	0%	0%	15%	0%	86%	0%	0%	14%	0%	0%	90%	0%	10%	0%	0%	90%	0%	10%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%
2. Small employer (50-100)																				
a. > 400% FPL																				
1. Individual insurance	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
2. WA Basic Health	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
3. WSHIP	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%
b. 200% - 400% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%
c. 133% - 200% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	85%	0%	0%	15%	0%	86%	0%	0%	14%	0%	0%	90%	0%	10%	0%	0%	90%	0%	10%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – High participation (7 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
A. Employed households - no employer coverage																				
3. Large employer (> 100)																				
a. > 400% FPL																				
1. Individual insurance	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
2. WA Basic Health	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
3. WSHIP	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%
b. 200% - 400% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%
c. 133% - 200% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	85%	0%	0%	15%	0%	86%	0%	0%	14%	0%	0%	90%	0%	10%	0%	0%	90%	0%	10%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%
4. Public employer																				
a. > 400% FPL																				
1. Individual insurance	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
2. WA Basic Health	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
3. WSHIP	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
4. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%
b. 200% - 400% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
4. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%
c. 133% - 200% FPL																				
1. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
2. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
3. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
4. Uninsured	0%	85%	0%	0%	15%	0%	86%	0%	0%	14%	0%	0%	90%	0%	10%	0%	0%	90%	0%	10%
d. < 133% FPL																				
1. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
2. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
3. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
4. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – High participation (8 of 9)

Baseline - 2010	Ultimate-S-X-100					Ultimate-M-X-100					Ultimate-S-FBH-100					Ultimate-M-FBH-100				
	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured	Individual insurance		Federal Basic Health	Medicaid	Uninsured
	Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange				Outside Exchange	Inside Exchange			
B. Unemployed households																				
1. > 400% FPL																				
a. Individual insurance	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%	65%	35%	0%	0%	0%
b. WA Basic Health	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
c. WSHIP	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%	25%	75%	0%	0%	0%
d. Uninsured	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%	0%	50%	0%	0%	50%	0%	51%	0%	0%	49%
2. 200% - 400% FPL																				
a. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%
b. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
c. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%
d. Uninsured	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%	0%	75%	0%	0%	25%	0%	76%	0%	0%	24%
3. 133% - 200% FPL																				
a. Individual insurance	10%	90%	0%	0%	0%	10%	90%	0%	0%	0%	5%	0%	95%	0%	0%	5%	0%	95%	0%	0%
b. WA Basic Health	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
c. WSHIP	0%	100%	0%	0%	0%	0%	100%	0%	0%	0%	0%	0%	100%	0%	0%	0%	0%	100%	0%	0%
d. Uninsured	0%	85%	0%	0%	15%	0%	86%	0%	0%	14%	0%	0%	90%	0%	10%	0%	0%	90%	0%	10%
4. < 133% FPL																				
a. Individual insurance	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%	20%	0%	0%	80%	0%
b. WA Basic Health	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
c. WSHIP	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%	5%	0%	0%	95%	0%
d. Uninsured	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%	0%	0%	0%	80%	20%

Individual take-up rates – High participation (9 of 9)

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Navigator Report

(Draft)

December 30, 2011

Final report anticipated in Spring 2012

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Washington State Health Benefit Exchange: Potential Role and Responsibilities of Navigators

Summary
As the State of Washington builds its Health Benefit Exchange, identifying the role of Navigators is a central question. The following brief outlines the federal requirements for Navigators, reviews research conducted for the Health Care Authority to explore consumer and stakeholder opinions about the role of Navigators, and offers recommendations on (1) the ideal qualities or traits for Navigators and (2) the types of entities or organizations that are best suited to act as Navigators.

The recommendations are informed by key findings from a recent statewide survey on Washington residents and interviews with stakeholders from community organizations, health care associations, brokers, insurance carriers and consumer advocacy organizations.

Background
Finding health insurance can be a complex undertaking for individuals, families and small businesses. There are several options available and they differ significantly with respect to benefits and cost sharing, coverage standards, participating provider networks, eligibility requirements and more. Provisions in the 2010 Patient Protection and Affordable Care Act (ACA) seek to make the decision-making, eligibility and enrollment process streamlined and consumer friendly, with the ultimate goal of increasing access to quality health care for more Americans.

One cornerstone of the law requires states to develop a health insurance exchange by 2014, which will provide eligible individuals and small business owners a one-stop shop to more easily evaluate and purchase health care plans. The law also mandates states create a Navigator program, which would involve an array of entities charged with assisting the process.

Navigators will be critical to the success of the Exchange, and while the ACA outlines numerous functions and responsibilities, states have significant flexibility in establishing Navigator programs. This brief outlines the recommended traits and characteristics for Washington's Navigators and the types of organizations that are best suited to act as Navigators.

What is a Navigator?
Section 1311(i) of the ACA[1] requires that all health insurance exchanges establish a Navigator program that provides grants to entities that assist consumers as they seek services from an exchange. The ACA lists responsibilities of potential Navigators, a variety of groups that could serve the functions of Navigators and outlines certain eligibility requirements and standards including:

[1] Patient Protection and Affordable Care Act § 1311 (i): Navigators

Navigators will be **responsible** for:

- Conducting public education activities to raise awareness of plans provided on the exchange;
- Providing complete, fair, and impartial information during enrollment, including availability of tax credits;
- Facilitating health plan enrollment;
- Providing referrals for enrollees who have grievances, complaints, or questions regarding enrollment or coverage; and
- Providing information in a culturally and linguistically appropriate manner.

Eligible entities must have an existing relationship or the ability to easily create a relationship with potential users of the exchange, including employers, employees, consumers or self-employed individuals; and may include trade, industry and professional associations; organizations involved in fishing, farming and ranching industries; consumer-focused nonprofits; chambers of commerce; unions; Small Business Administration resource partners; and licensed insurance agencies and brokers. Other entities can be considered if they are deemed to be capable of such duties and meet all standards.

In order to **meet standards,** entities**:**

- Shall not be a health insurance issuer;
- Shall not receive any compensation from a health insurance issuer in connection with enrolling individuals or small business owners in certain plans; and
- Shall adhere to any forthcoming standards as set by the Secretary of Health and Human Services.

Recommendations and Key Findings

In addition to the guidelines and requirements detailed in the ACA, recent research conducted among Washington residents and a diverse group of stakeholders provides a number of insights that should be kept in mind as the Navigator program is developed and individual Navigators are selected. The findings are based on the following:

- A statewide online survey conducted among 570 adults, 18 and older, with varying incomes; and
- Stakeholder interviews with 16 representatives from several sectors, including community organizations, health care associations, brokers, insurance carriers and consumer advocacy organizations.

Please refer to Appendix A and B for a complete summary of findings from the online survey and stakeholder interviews.

The following are Navigator recommendations based on the research:

- **Ensure Navigators are knowledgeable about all aspects of the Exchange, including the benefits and costs of all plans offered and eligibility requirements for tax credits,**

subsidies, and Medicaid. Because Navigators will be in the position of helping consumers and small businesses compare plans and make the optimal choice based on personal circumstances, they will need a deep understanding of the benefits and costs of all plans offered through the Exchange, as well as the available tax credits and subsidies, and Medicaid. "Knowledgeable" was the top testing quality for Navigators in the survey of residents and was among the most frequently cited by stakeholders in the one-on-one interviews. Consistent, ongoing training will be key to ensuring Navigators are able to provide the most relevant and current information to individuals and small businesses. In the stakeholder interviews, brokers also cited the importance of requiring licensing, or some form of certification, to ensure Navigators begin with a minimum level of knowledge and maintain it over time.

- **Washington residents and small businesses are looking for clear, simple explanations and guidance.** Choosing health coverage can be a complex undertaking and many users of the Exchange will be signing up for insurance for the first time. It will be important for the Navigator system to be easy to access. Individual Navigators will need to be able to explain options in simple, lay-person terms and communicate in a way that is compassionate, non-judgmental and appropriate to the communities they serve. This applies across all audiences, including people from low-income or ethnic backgrounds and small business owners and employees. In fact, "clear, simple" explanations tested second in importance only to "knowledgeable" in the online survey.

- **Navigators must be viewed as trustworthy sources of impartial information.** Respondents uniformly cited the importance of Navigators being trusted and credible. In part, this is about familiarity and comfort. For example, stakeholders representing small businesses indicated that their constituents are used to working with brokers or representatives from their professional associations to find insurance. Similarly, consumer advocates noted that people from low-income and cross cultural backgrounds will likely want support from entities they currently come in contact with on health matters, like community health centers and community-based organizations.

  In addition, many consumers are wary of sharing the personal information required to enroll such as salary, social security number, and proof of residency. Navigators must be viewed as honest and reliable to overcome this barrier. Similarly, consumers want reassurance that Navigators have no financial stake in the insurance option they choose. Finally, many consumers and stakeholders, representing small business in particular, are wary of the Exchange being perceived as a government takeover of health care. Consequently, it is important that Navigators maintain and project independence from government control.

- **Navigators will need to offer support in a variety of ways and be easily accessible to the communities they serve during and after the enrollment process**. Consumers have varying levels of comfort with and access to technology and will want support in ways that are familiar to them. Nearly as many survey respondents indicated that they prefer receiving assistance online (38 percent), by telephone (31 percent), or in-person (30 percent). Accordingly, Navigators should not limit their availability to just one medium.

Further, Navigators should be conveniently located where people live and work and be available both during and after business hours.

- **A diverse array of Navigators will be necessary to serve the diverse array of consumers. Additionally, building on existing networks will be key to success.** The individuals and small businesses eligible to purchase insurance through the Exchange in 2014 will represent varying income, education and ethnic/cultural backgrounds. Some people will be familiar with the private insurance market or Medicaid, and some will be engaging for the first time. In order to engender trust and drive enrollment, Navigators will need to be as diverse as the people they serve.

  There are many organizations currently providing information and guidance to individuals and small businesses in an effective manner, and these existing networks should not be overlooked. Involving these entities in the Navigator program will ensure the benefit of past experience and leverage existing, trusted relationships.

  Recommended types of entities that many say will be well-suited to serve as Navigators include:
  - Community-based organizations (i.e., organizations that work with different ethnicities or specific populations)
  - Tribal councils/clinics
  - Insurance brokers
  - Local health departments
  - Community health centers
  - Nonprofit organizations that have successful outreach programs, such as those reaching diverse audiences
  - Health coalitions or associations
  - Chambers of commerce
  - Labor unions

- **Navigators must reach patients and consumers in settings where or when health care is top of mind.** Residents reported an interest in getting help from a navigator in places in which they receive their health care, such as a doctor's office or clinic, or directly from a health insurance plan. Navigators will need to be accessible in health-related locations and work in conjunction with providers to ensure some accessibility in non-emergency health care settings.

APPENDIX A

Findings from Statewide Online Survey

Lake Research Partners (LRP) conducted an online survey among Washington adults on issues related to Exchange Navigators. The purpose of the survey was to gain a better understanding of who residents want as Navigators, as well as what traits and characteristics are important in someone who would help them enroll in coverage.

The survey was conducted among 570 adults, 18 and older, statewide in Washington from November 9 through 12, 2011. The margin of sampling error is ± 4.1 percentage points.

The following are key findings from the poll:

- **The residents most likely to need help from Navigators include those with lower incomes, those with less education, and people 40 to 64 years old.** The following residents are most likely to say they are unwilling to apply for health insurance online:
    - Those under 400% of FPL (31% vs. 19%);
    - Ages 40 to 64 (26%) versus 18-39 year olds (15%);
    - Those with a high school degree or less (33%) or some college (26%), versus a college degree (16%); and
    - Those who infrequently use the Internet to email friends or family (35%).

- **Residents are split on whether they want help with the Exchange online, by telephone, or in person**. Nearly four in ten (38%) residents say that they would want to get help online if they needed assistance comparing plans or signing up for a plan. Of those who prefer online help, 42% say they would want the online help to be real-time chat compared to 29% who would want to email and 28% who would want to seek help from a Frequently Asked Questions (FAQ) page. The individuals most likely to want online help include adults under 40 years old and those with a college degree or at least some college.

  Close to three in ten (31%) would want help via telephone, and 30% would want help in person. Adults at or above 400% of FPL, ages 40 to 64, and women are more likely than their counterparts to want to get help by phone. Adults below 400% of FPL and those with less than a college degree are most likely to want to get help in person.

- **Residents are most interested in getting help from a navigator at a doctor's office/clinic or from a health insurance plan.** When asked how interested they would be in getting help from several potential navigator figures, "someone at a doctor's office or clinic" and "someone from a health insurance plan" receive the highest marks with mean ratings of 5.9 and 5.8, respectively, on a scale from 1 (not at all interested) to 10 (extremely interested). "Someone at a local organization in your community" and "a private health insurance agent or broker" are runners up with respective means of 5.6 and 5.5. The potential navigator receiving the least interest is "someone at your local

emergency room" with a mean interest score of 4.2. These preferences do not vary across demographic groups.

- **Residents place high importance on Navigators' accessibility and availability.** The vast majority – 86% – say it is important for Navigators to be available by phone. Another 78% say it is important for them to be available by email, and 68% say being available in person is important.

  There are some interesting differences by education. As education level increases, less importance is placed on in-person availability and more importance is placed on email availability.

- **Out of a list of potential navigator traits and characteristics, being knowledgeable and able to explain things clearly top the list in terms of importance to residents.** Respondents were asked to rate how important it would be for a navigator to have a variety of traits and characteristics on a scale from 1 (not important) to 10 (extremely important). The navigator characteristics receiving the highest mean importance scores are "knowledgeable" and "explains things clearly and simply" with 9.2 and 9.0, respectively. "Patient," "problem solver," and "non-judgmental" are also highly rated in terms of importance with mean scores of 8.2 each.

- **Concerns about sharing Social Security numbers with Navigators may be a potential barrier.** While a majority (58%) says they are comfortable sharing their Social Security number with a navigator, 42% say they are not comfortable with this idea. Individuals below 400% of FPL are less likely to be comfortable with this idea than those at or above 400% of FPL (52% vs. 65%). Also, adults under age of 65 are less likely to be comfortable with this idea than those 65 and older.

APPENDIX B

Findings from Stakeholder Interviews

To supplement the consumer survey, interviews were conducted with stakeholders in Washington who are invested in the Exchange and health reform at large. More than 20 stakeholders from various sectors were contacted, including community organizations, health care associations, brokers, insurance carriers and consumer advocacy organizations. GMMB, the Exchange's communication consultant, conducted the interviews from November 9 to 22, 2011. The questions addressed a variety of topics, including what the ideal qualities for Navigators are and what entities should be included in the program.

GMMB completed interviews with a total of 17 stakeholders. Based on these conversations, the following themes emerged:

- Many stakeholders strongly felt that Navigators will need a **deep understanding of the way both public and private insurance markets operate**, as well as the specific plans and tax credits offered through the Exchange. They should be able to **provide guidance** in comparing the different plans in terms of coverage and cost, as well as **understand all components of the Exchange and law requirements**.

- The majority of respondents expressed the need for Navigators to have **formal trainings and/or certification.** A few stakeholders noted that requiring a license would be the best way to ensure adequate training. Because the Exchange will be a complex, ever-evolving system, many felt Navigators should be required to undergo consistent, in-depth training before advising consumers and small businesses. In addition to initial training, a few stakeholders felt that continuing education was important since there will likely be changes in processes along the way.

- A few stakeholders felt that Navigators should not only listen to what consumers are looking for, but they should also be able to **effectively communicate the difficult-to-understand intricacies of insurance plans in a clear and concise way**. Further, the Navigator program at large should include entities that can effectively communicate with diverse audiences, including but not limited to:
    - Individuals of different ethnicities and/or language (cultural competency)
    - Individuals from low-income backgrounds
    - Small businesses

- Some stakeholders mentioned the sensitivities around buying health insurance, which requires people to provide personal information, including salary, social security number, and proof of residency. **Therefore, Navigators would need to be trustworthy sources.**

- Consistent with the ACA guidelines for Navigators, a few stakeholders noted that Navigators need to be able to **provide impartial information about the plans to consumers** – not receiving incentives in any way for guidance to a specific plan. In

particular, consumer advocates were adamant about the need for impartiality – ensuring there are no conflicts of interest for those who serve as Navigators.

- Most stakeholders expressed that the **Navigator program needs to include individuals/entities that offer help in a variety of ways – with personal assistance online, over the phone and in-person.** The process needs to be convenient, not cumbersome. There will be varying comfort levels among consumers with technology and comparing plans, so it is important to have options to suit different needs. Going online to buy insurance is not ideal for some individuals. For example, those who are less proficient with technology and have less access to the internet (often those from lower income and/or education backgrounds) may prefer more direct support. Similarly, **urban/suburban and rural businesses may have different navigator assistance preferences**. Urban and suburban businesses may have more advanced technology and thus may be more comfortable with online enrollment.

- The vast majority of stakeholders felt that **support would be necessary both during and after enrollment**. Inevitably, consumers will have questions about their coverage or need to understand how it could be adjusted if they have significant life or business changes, such as:
    - Becoming pregnant and needing health insurance for a future child,
    - Getting or losing a job and understanding how that affects what tax credits they qualify for,
    - Having a major health issue and understanding how their plan covers them, or
    - On the small business side, significant staffing changes.

- Several stakeholders noted that the **Exchange should build on existing networks**. Many consumers are already comfortable working with specific entities around health issues and the Exchange should leverage these existing relationships. For example, many small businesses are used to working with brokers and will continue to want to do so. Similarly, many individuals already have trusted relationships with community health centers and community-based organizations. Stakeholders suggested the Exchange should meet people where they already are.

- Stakeholders volunteered **many different types of organizations** when asked who would be best suited to serve as Navigators, including community organizations, insurance brokers, local nonprofits, local health departments, community health centers, health coalitions or associations, chambers of commerce and labor unions. **Several stakeholders noted that it would be important to have a range of organizations serve as Navigators in order to meet the needs of the diverse audiences.**
    - Most consumer advocates noted that, since there will be such a wide array of organizations serving as Navigators, there should be some sort of **central coordination to create statewide efficiencies and ensure that all are following the same rules.**

Five-Year Administrative Budget Projections and Self Sustainability Analysis

This report is scheduled to be released in Spring 2012

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Health Benefit Exchange Systems Integrator Services RFP

October 28, 2011

Appendices and Addendums are available online at http://www.hca.wa.gov/rfp/hbe

Appendix A Vendor Organizational Capabilities Requirements
Appendix B Project Management Requirements
Appendix C Business and Functional Requirements
Appendix D Technology Requirements
Appendix E Certs and Assurances
Appendix F Proposed Contract
Appendix G MWBE
Appendix H Protest Procedures
Appendix I Checklist
Appendix J References
Appendix K Financial Proposal
Appendix L Glossary of Terms, Abbreviations and Acronyms
Appendix M Model Deliverable Acceptance Criteria
Appendix N CMS Collaborative Environment and Life Cycle Governance
Appendix O Business and Functional Requirements
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Addendum 2 – Cover Letter
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Addendum 2 – Appendix A – Revision 1
Addendum 2 – Appendix B – Revision 1
Addendum 2 – Appendix C – Revision 1
Addendum 2 – Appendix F – Revision 1
Addendum 2 – Appendix K – Revision 1
Addendum 2 – Appendix P – Revision 1
Addendum 2 – Vendor Questions Answers Pre Proposal Conf
Addendum 2 – Pre Proposals Conference Attendees
Addendum 2 – Vendors Submitting Letters of Intent
Addendum 3 – Cover Letter
Addendum 3 – Appendix A – Revision 2
Addendum 3 – Appendix B – Revision 2
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Addendum 4 – RFP – Revision 2
Addendum 4 – Appendix A – Revision 3
Addendum 4 – Vendor Questions Answers
Addendum 5 – Cover Letter
Addendum 5 – Revision 3
Addendum 5 – Appendix H – Revision 1
Addendum 5 – Vendor Final Question – Answer
Addendum 5 – All RFP Questions Answers

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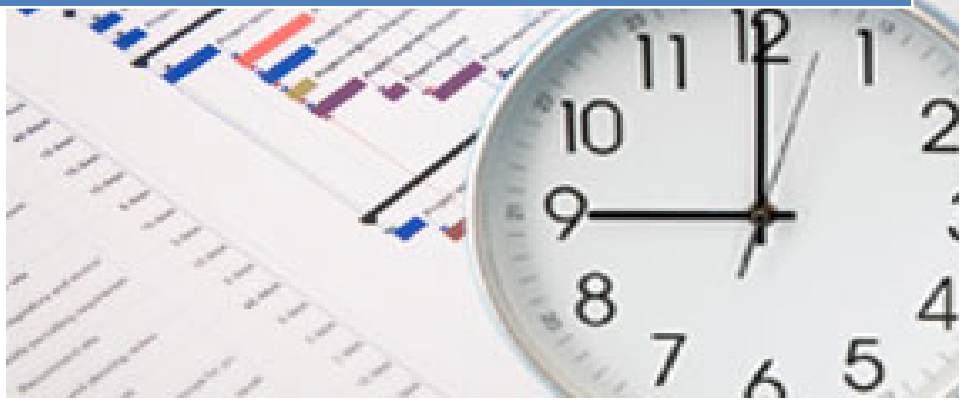
Washington State Health Care Authority
Health Benefits Exchange (HBE)

Request for Proposal Number K521
for
Health Benefits (Insurance) Exchange
Systems Integrator Services



Released Date: ***October 28, 2011***

Mandatory Pre-Proposal Conference November 8, 2011

Responses Due: December 8, 2011 3:00PM

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APPENDICES:

NOTE: All Appendices are provided as separate documents.

SECTION 1

1 Introduction

1.1 Purpose of Solicitation

The Washington State Health Care Authority ("Authority" or "HCA") is initiating this Request for Proposals (RFP) to solicit proposals from qualified vendors to provide development, implementation and hosting services to implement the Washington Health Benefits (Insurance) Exchange by December 2013. The Exchange solution must be a web-based solution hosted at a secure location in the United States proposed by the Vendor. The selected vendor will provide the following:

- A hosting solution meeting the requirements of the Exchange in terms of hardware, software, network, and infrastructure services
- An integrated Exchange solution based on a single Exchange portal encompassing the system capabilities to support Individual Eligibility and Enrollment, Plan Management, Financial Management, and Small Business Health Options Program (SHOP);
- Operations and Maintenance of the Exchange for one year; with provisions for extensions.

The solution being sought through this RFP competitive solicitation may consist of one or more commercial off the shelf (COTS) software product(s) or a custom-developed software offering or a combination.

The initial contract will be for design, development, and implementation of the Exchange Solution by December 2013 followed by a six month warranty period and then one year of Operations and Maintenance support with the option to extend the initial contract for an additional six years.

The proposal will include the following pricing elements:

- Detailed fixed priced costs for the development, verification, certification and deployment of all Exchange technical and functional components.
- Detailed fixed price costs for the operations and maintenance of the Exchange systems for the initial year.

The Exchange Portal provided by the vendor will use the State Eligibility Service offered by the state's Automated Client Eligibility System (ACES), Washington State Eligibility System, to determine eligibility for Medicaid, CHIP and Tax Credits. Details of the integration between the Exchange Portal and the State Eligibility Service and the boundaries for each system/service are further defined in Appendix P-Eligibility Service Requirements of the RFP.

As a contingency, in the event that the State Eligibility Service will not be available or the State decides to have the Exchange Vendor build out the State Eligibility Service, each proposing vendor is required to prepare a response in terms of how the requirements of the State Eligibility Service as described in Appendix P can be met.

Not included within the scope of this RFP are: third party administration of risk leveling functions, customer support and call center, and program operations staff of any kind outside the Operations and Maintenance of the Exchange solution.

Appendix C of this RFP, along with the Exchange Business Process Models and their supporting documents provide information regarding the Exchange business functions. Appendix D, the Technical Reference Model and the Security Blueprint, along with their supporting documents, provide insight regarding the technology services required for the Exchange.

1.2 Background

On March 23, 2010, President Obama signed into law the Patient Protection and Affordable Care Act. On March 30, 2010, the Health Care and Education Reconciliation Act of 2010 was signed into law. The two laws are collectively referred to as the Affordable Care Act (ACA). The ACA creates an opportunity to reform the health insurance marketplace in order to provide all Americans with quality, affordable health insurance coverage. A primary feature of the new law is the requirement that all states establish a Health Benefit Exchange (Exchange). In essence, the Exchange is an organized marketplace to help consumers and small businesses buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. By pooling people together, reducing transaction costs, and increasing price and quality transparency, Health Benefit Exchanges create more efficient and competitive health insurance markets to facilitate the offer of "qualified health plans" for individuals and small employers.

While ACA provides states with significant latitude in how reform is ultimately implemented, it also sets forth expectations around consumer-mediated enrollment processes, systems architecture and security, coordination amongst Medicaid, Children's Health Insurance Program (CHIP) and Health Benefits Exchanges and Plans, sharing of IT assets among states, and more. The guidance contained in ACA ultimately sets the foundational layer of requirements for states. For instance, as required by the ACA, the core functions of an Exchange include the following items, not all of which are included in the requirements for this RFP:

- Certification, recertification, and decertification of qualified health plans
- Call center
- Exchange website
- Premium tax credit and cost-sharing reduction calculator
- Quality rating system
- Navigator program
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Enrollment process
- Applications and notices
- Individual responsibility determinations
- Administration of premium tax credits and cost-sharing reductions
- Adjudication of appeals of eligibility determinations
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Outreach and education
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions

Under ACA, Washington is required to establish an operational Exchange to offer qualified health insurance plans to individuals and small businesses by January 1, 2014. Once implemented, Washington anticipates that the Exchange will serve 160,000 – 440,000 individual and group customers in 2014, consisting of 140,000 – 410,000 individuals in the non-group market and 20,000 – 30,000 employees of small businesses. Furthermore, the Exchange will support an estimated additional 180,000 - 190,000

new Medicaid customers. In order to meet the Department of Health and Human Services "readiness determination" deadline of January 1, 2013 and the Exchange "go-live" deadline of January 1, 2014, the Authority is focusing on three key areas:

- Analyzing the current Washington health care infrastructure, translating the federal requirements to the state's circumstances, and developing a strategy;
- Operations support founded on this strategy to provide the technology and program management support that will implement an effective Exchange addressing governance, eligibility determination, linkage to other major subsidized programs, customer support and educational outreach;
- Continuously evaluating program processes and outcomes to ensure that the technology/operational components of the Exchange and supporting systems are developed and deployed in an optimal manner, protecting consumer rights, and reviewing health plan and provider decisions for compliance with both federal and state requirements.

ACA establishes health insurance exchanges which are markets for individuals and small businesses to easily navigate the health care system and provides "one stop shopping" to assist consumers in their selection and purchase of health care. Health insurance exchanges may be run by states or by the federal government and must be operational by January 2014. Washington State SB 5445 established the intent of the State of Washington to establish and implement an Exchange.

To help leverage more efficient health care purchasing, and to address key priorities above, Washington merged two key agencies; the Washington State Health Care Authority (which managed the state's Public Employee Benefits Program, including managing health insurance plans) and the Medicaid Purchasing Administration (which managed Washington's Medicaid and medical assistance programs). Simultaneously, in Spring 2011, the Authority applied for and received a State Health Exchange Grant for planning an Exchange in Washington State. Authorizing legislation was also passed in 2011 (SSB 5445), which establishes the exchange as a "public private partnership separate and distinct from the state". The exchange will be established with a Board of Directors by March 15, 2012, so proposing vendors need to be aware of the transition of responsibility from HCA to the exchange in this timeframe. The grant was used to identify and document key business functions and policy decisions of a state-based Exchange. As part of the analysis of the information technology infrastructure necessary to support a state-based Exchange, the State conducted a detailed Information Technology Gap Analysis for the Health Benefit Exchange. The IT Infrastructure review and assessment report developed a high level understanding of the requirements of the Exchange and reviewed the State's current Medicaid technology investments and architecture. This included assessments of systems that could have potentially been leveraged for the new solution, such as:

- **Automated Client Eligibility System (ACES)**. Legacy eligibility system that supports eligibility determination for a large number of programs including cash, medical, and food assistance. (*Operated by Department of Social and Health Services*)
- **Washington Connection**. Statewide portal for self screening, application submission, renew benefits and report changes for Temporary Assistance for Needy Families (TANF), Supplemental Nutritional Assistance Program (SNAP), Medicaid and other medical programs. (*Operated by a collaboration between state, federal, local and community based organizations*)
- **ProviderOne.** The state's Medicaid managed information system (MMIS) used for claims processing and as a provider payment system. (Operated by Health Care Authority).

The assessment also developed a to-be architecture to support the Exchange, identified gaps in the Infrastructure needed to support the Exchange, assessed capacity requirements of new and existing

technology required for the Exchange, evaluated alternatives to meet the Exchange requirements, and provided a final Infrastructure Assessment that provided options for the State to consider and make a final decision. The Infrastructure Assessment can be found on the Authority website at http://www.hca.wa.gov/hcr/exchange.html.

Following the technology assessment, the Authority initiated this "Washington State Health Benefit Exchange Project" to develop and implement an integrated technical solution. Thus, the Authority is seeking proposals from qualified vendors to provide development, implementation and hosting services for the Exchange solution.

1.2.1 Solution Overview and Scope

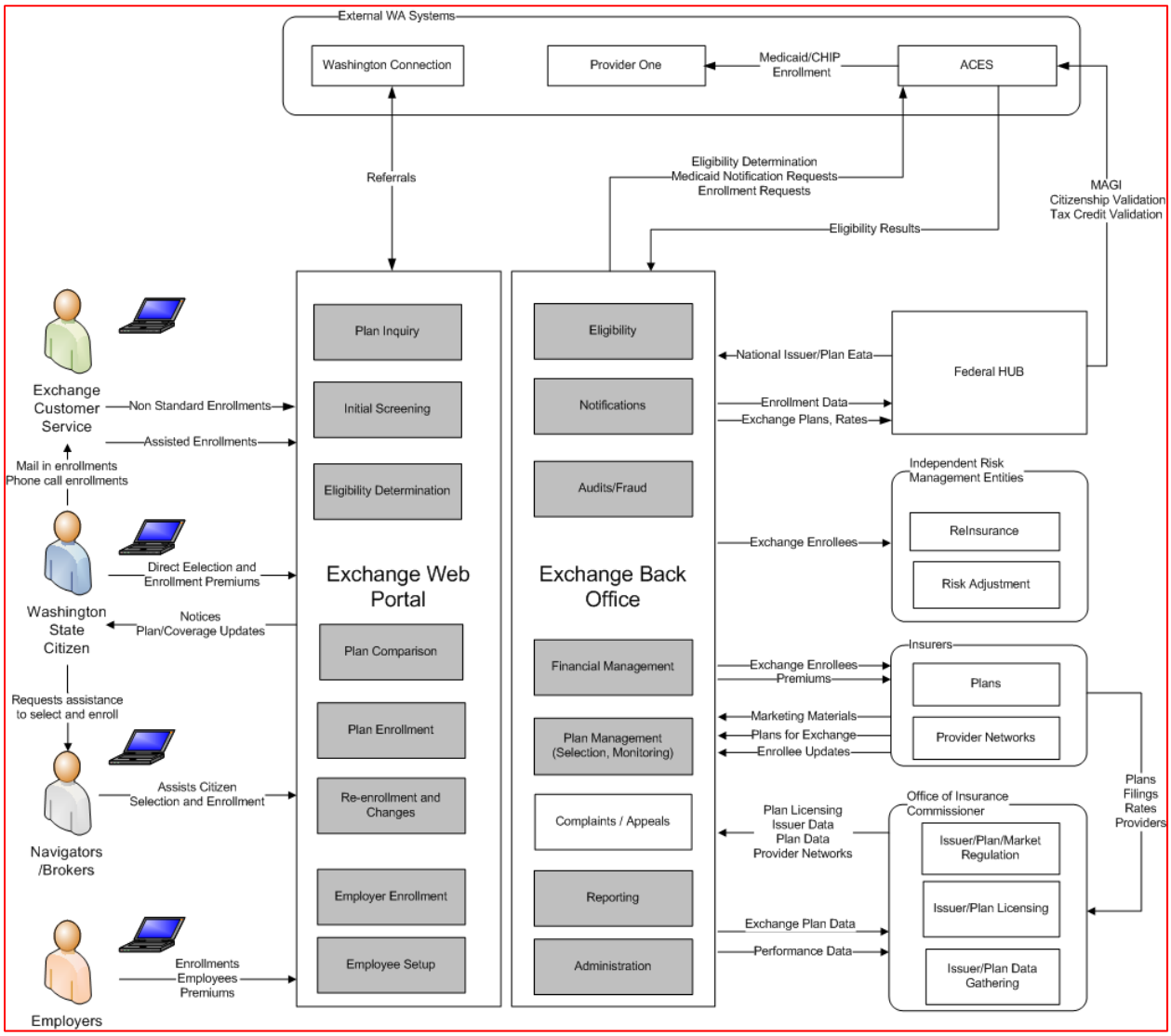
The vision for the new Exchange is a custom web-based portal solution that must be accessible by external Exchange customers and stakeholders, integrated with back office functionality to support Exchange staff, processing, and communication to the CMS Federal Data Services Hub (CMS Hub) which includes:

- An **intuitive web portal** through which residents can access subsidized and unsubsidized health insurance, including public insurance programs (e.g. Medicaid and CHIP), including:
  - Individual enrollment and plan selection
  - Small Business Health Options Program (SHOP) portal supporting plan selection and enrollment for small employers and their employees in qualified SHOP health plans
- **A consumer focus -** the portal will streamline health plan selection, offer real-time eligibility determination, and facilitate enrollment. Consumers must be able to, in a streamlined, single session, enter required information, receive an eligibility determination, compare insurance plans, select a plan and complete the enrollment transaction.
- **Automated interaction with stakeholders -** it is anticipated that Issuers, Navigators, third party administrators, Centers for Medicare and Medicaid Services (CMS), and the Office of Insurance Commissioner (OIC) will interact with the Exchange web portal and/or through data exchanges wherever possible to avoid manual transactions and re-keying information.
- **Integration with existing system –** it is the Authority's intent to utilize the existing ACES solution as an eligibility determination and notification services for the Exchange for Medicaid, tax credit and cost sharing eligibility functions. ACES will also continue performing notifications to ProviderOne for Medicaid and CHIP enrollments. The Exchange web portal must integrate with ACES to perform the services needed for the Exchange.
- **Back office** functions including:
  - Integration with a state eligibility service (provided by ACES) to determine eligibility for Medicaid /CHIP/Basic Health / Tax Credits
  - System components to facilitate enrollments into qualified health plans
  - System components to certify and manage insurance issuer, health plan and provider data
  - Financial management components (billing, receivables, general and subsidiary ledgers, premium aggregation, reporting, reconciliation)
  - Reporting and business analytics capability
  - Identity and account management
  - Document/content management
  - Notifications services

- **Hosting Services –** it is expected that the production solution and all supporting environments be hosted by the successful Vendor's recommended hosting environment.
- **Operations and Maintenance –** the Authority requests vendors to include on one year of operations and maintenance of the Exchange in their base Proposal, and to provide costs for six additional years.

Because it is expected that consumers will access the Exchange from their homes and other locations, the Exchange web portal is expected to generally be available to users in the field 24 hours a day, seven (7) days a week. The following conceptual diagram (Figure 1 below) illustrates the Authority's concept for how the Exchange will operate. Note that the Functional Areas within the scope of the RFP are shaded in gray.

Figure 1: Washington Exchange High Level Business Process Concept



The primary functional components of the Exchange that are within the scope of this RFP are defined in Appendix C. Please refer to Appendix C sections for more information on the solution vision for each function.

- **Individual Eligibility** - The Individual Eligibility business area consists of business processes and functional requirements for application intake and screening, determining eligibility, renewing eligibility, and handling appeals (Appendix C, Section 5.3.2.1).
- **Individual Enrollment** - The Individual Enrollment business area consists of business processes and functional requirements for enrolling participants, renewing enrollment, and conducting enrollment reports (Appendix C, Section 5.3.2.2).
- **Plan Management** - The Plan Management business area consists of business processes and requirements for acquiring, certifying, monitoring, renewing, and managing the withdrawal of qualified health plans and the issuers that offer these plans(Appendix C, Section 5.3.2.3).
- **Eligibility and Enrollment – SHOP** - The SHOP business area consists of business processes and functional requirements for enrolling SHOP employers and employees, renewing enrollment, and conducting enrollment reports (Appendix C, Section 5.3.2.4).
- **Financial Management** - Financial Management includes Advance Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR), Premium Processing (SHOP and Individual), Data Collection, and Issuer Payment Transfers (including the flow of funds for payments and charges for the risk-spreading programs) (Appendix C, – Section 5.3.2.5).
- **Exchange Portal/User Experience** – The Exchange portal will provide a customer experience similar to that experienced by internet customers of top commercial service and retail companies. The user experience will be based on the design produced by the Enrollment 2014 UX Project, and will include some mobile functionality (Appendix C, Section 5.3.2.6).
- **Administrative Functions -** include Audit and Program Integrity, Reporting, Business Intelligence capabilities and Notices(Appendix C, Section 5.3.2.7).

The business process flows and narrative to be supported by the Exchange are provided by the functional area in the Business-Functional Requirements folder of the Exchange Vendor Reference Library (available at the HCA Procurement Web Site; http://www.hca.wa.gov/rfp.html). Note that the process flows are draft and many business and operational decisions that impact the flow of work are still under development and will be throughout 2011. Proposing vendors need to be aware that requirements, process flows and other decisions affecting the Exchange solution are still under development, pending additional guidance from CMS, the Washington State Legislature and the Washington Exchange Board. The Authority advises proposing vendors to consider potential changes in requirements during the project when identifying resources and costs for developing and implementing the Exchange.

1.2.2 Technical Environment

The Vendor must propose a solution that meets all Authority requirements and is consistent with the standards and requirements outlined in the Technical Reference Model and the Security Blueprint requirements of this RFP. The Vendor's proposed solution must include provisioning the development, testing/verification, training, certification and production environments that will be used to develop, maintain and operate the Exchange.

The Exchange solution must be a web-based solution hosted at a secure location, in the United States, proposed by the Vendor. The Vendor also needs to provide hosting services for the Exchange development, testing/verification, training and certification environments. The vendor is required to host, maintain and operate the Exchange in production for one year. The selected Vendor will be

responsible for providing, installing and maintaining all hardware, software, network components and other infrastructure elements for the Exchange.

Vendors should note that the Exchange requires handling of Federal Tax Information (FTI), Health related data (HIPAA) and Payment Card Industry (PCI) data. The Security Blueprint document addresses some of the concerns related to the hosting and handling of these types of information.

Vendors are advised to review the Exchange Technical Reference Model (TRM) document, a key element of the enterprise architecture specification for the Exchange. The TRM and Security Blueprint documents are located in the Technology Requirements section of the Exchange Vendor Reference Library.

1.2.3 Security

The Exchange must comply with the requirements for security outlined in the Security Blueprint.

The Security Blueprint defines a complete set of management, operational and technical security controls to protect the confidentiality, integrity and availability of the Exchange functions and information. Once on board, the Vendor will work with the Exchange team to develop a detailed Security Plan for implementing and operating these controls. The Security Plan will ensure compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Payment Card Industry (PCI) Data Security Standard for payment card processing (electronic payments) and the federal tax information safeguarding requirements defined by the IRS in the Title 26 of the United States Code (U.S.C) section 6103.

The selected Vendor will be responsible for the implementation and operations of the Security Plan, which will address at a minimum all the controls defined within the Security Blueprint.

Vendors are advised to review the Security Blueprint document, a key element of the enterprise architecture specification for the Exchange. The Security Blueprint document is located in the Technology Requirements section of the Exchange Vendor Reference Library.

1.2.4 Planned Interfaces

The Exchange must have electronic interfaces to systems external to the Exchange organization. These interfaces may be file-based or real-time, depending on the Vendor's design approach, the Authority's business needs and business requirements, and the constraints and requirements of each system interfacing with the Exchange. Some examples of interfaces are as follows:

- State of Washington Agency Financial Reporting System (AFRS)
- ACES
- CMS Hub
- Office of Insurance Commissioner systems
- Insurance Company systems (Issuers)
- Washington Connection

1.2.4.1 AFRS

AFRS is the state-owned accounting system used by all state agencies and higher-education institutions in the state of Washington. AFRS is a legacy mainframe financial system that has been in production for over 25 years. The system performs all aspects of the accounting process: the general ledger, accounts receivable, accounts payable, balance sheets, etc. Accounting information is updated daily by most users of the system.

1.2.4.2 ACES

ACES will serve as the eligibility service for the Exchange, and continue handling the initiating transactions for enrollment of Medicaid and CHIP members to Provider one. As such ACES will receive the following requests from the Exchange.

- Eligibility determination requests
- Medicaid/CHIP enrollment requests
- Notice generation requests
- Requests to verify client information to the CMS Federal Data Services Hub (CMS Hub) and other State sources

The Exchange will also receive information from ACES including:

- Eligibility determination
- Record of eligibility notices provided to applicants
- Up-to-date Medicaid / CHIP managed care plan enrollment information
- Data from verification sources to add to individual accounts / data collection
- Notification of existing Medicaid / CHIP individuals whose circumstances have changed and require referral to the Exchange

It is important for bidding Vendors to note that ACES will be modified to handle these services concurrent with the Exchange development. The successful vendor will be working closely with the ACES modification team to successfully implement these interfaces and services.

ACES Profile: This system is used by the State of Washington's Department of Social and Health Services. ACES supports the operations of the department by integrating DSHS programs (including HCA/MPA Medicaid program) under a single, client-based, on-line system. The ACES system is a tool for determining eligibility, issuing benefits, management support, and sharing of data between agencies for Cash, Medicaid and Food Assistance programs. Other supporting functions of ACES include case management, generating letters and correspondence, address verification.

The ACES System was originally implemented on April 18, 1996. The system foundation was built using IBM IMS as a base and COBOL for the primary development language and runs on z/os. The system has evolved since inception, and now the legacy system is being decoupled and new functionality is being introduced under ACES Online, using technologies like Java, web services, DB2, WebSphere MQ, CICS Transaction Gateway. The new functionality being implemented takes advantage of Object Oriented Design principles, loose coupling, and separation of concerns. About 25-30% of the ACES functionality is now available using ACES Online. However, the eligibility determination function for all programs including Medicaid is in legacy COBOL code.

Going forward, to provide the eligibility service for the Exchange, ACES will implement a commercially-available business rules engine (IBM's ILOG) which will support eligibility determinations for current human services programs (e.g. TANF and SNAP) as well as the new Modified Adjusted Gross Income (MAGI)-based eligibility determinations for the Exchange. Additionally, the ACES eligibility service will also provide capability to the Exchange to query and exchange data with the CMS Hub for verification. Lastly, the ACES Eligibility Service will also generate notices to individuals and applicants as it relates to Medicaid / CHIP / Basic Health /Tax Credit eligibility determinations.

1.2.4.3 CMS Hub

The CMS Federal Data Services Hub (CMS Hub) will provide a central point of access to data services from diverse federal agencies. CMS plans to document and publish Hub integration with other federal stakeholders in the near future via a Business Architecture supplement. In general, the CMS Hub will:

Provide to the Exchange:

- Information on Issuers and Plans
- Plan Quality and silver ratings
- Validation of MAGI income and Citizenship to be provided via the ACES eligibility service

Receive from the Exchange:

- Exchange certified Issuer and Plan data
- Plan quality, performance and complaint data
- Enrollment
- Financial transactions related to tax credits, cost sharing and issuer reimbursements

Detailed requirements, data and design specifications will be provided by CMS at a future date, at which time, the interfaces with the CMS Hub can be further defined.

1.2.4.4 Office of Insurance Commissioner Systems

There are several Office of Insurance Commissioner (OIC) systems that house information about Issuers, rates, plans, provider networks and complaints. The selected vendor will work with the Exchange and the OIC to finalize a list of interfaces needed to share and receive electronic data with the OIC systems, and the type of interface. It is currently anticipated that interfaces will consist of file sharing vs. real time integration, but the vendor will assist in the final recommended approach for these interfaces.

1.2.4.5 Issuers

It is the Authority's intent to provide electronic methods for receiving data files and information from Issuers, with a priority on gathering higher volume data sets electronically (such as provider networks). The selected vendor will work with the Exchange to finalize a list of interfaces needed to share with and receive electronic data from the Issuers, and the type of interfaces required. It is currently anticipated that interfaces used between the Exchange and Issuers will consist of a combination of file sharing, data entry screens, and real time notifications. The vendor will assist in the final recommended approach for electronically interacting with and receiving data from Issuers. Information to be received from Issuers includes:

- Issuer data
- Plan benefit structure and rates
- Quality and Performance Data
- Monthly provider network updates

Information to be provided electronically to Issuers includes:

- Enrollment and disenrollment
- Aggregated premium payment and information
- Tax Credit information

1.2.4.6 Washington Connection

The Washington Connection portal is a collaborative effort between state, federal, local and community based organizations. Through this portal, the residents can easily and securely learn about and apply for available social services programs and benefits. Washington Connection has a screening tool that allows individuals/families to determine if they may qualify for benefits prior to submitting an application. Enhancements planned for 2011 include the ability to report eligibility changes and renew benefits online. The major software components of Washington Connection include WebSphere Application Server, WebSphere MQ Enterprise Service Bus, WebSphere iLog rules engine, DB2, SQL Server,

COGNOS, Infosphere server, and Tivoli Identity Management. The Washington Connection portal is based on an open architecture. This provides flexibility to integrate with other applications and or benefit providers in Washington State. Data Collected through Washington Connection is sent to ACES for eligibility determination. The portal is owned and maintained by the Washington Department of Social and Health Services, Economic Services Administration.

Interfaces between the Exchange and Washington Connection will consist of referrals.

- If a consumer provides information to Washington Connection for benefits application, and if the consumer needs health insurance from the Exchange, Washington Connection will electronically refer the consumer and provide relevant information to the Exchange.
- If a consumer provides information to the Exchange, and if additional benefits are available to the consumer through Washington Connection, the Exchange will electronically refer the consumer and provide relevant information to the Washington Connection.
- Data collected by either the WA Exchange or the WA Connection will be shared to minimize data entry and provide an integrated user experience and interoperability in terms of services coverage.

The successful vendor will work with the Washington Connection IT project team to determine the method for and implement a successful referrals process.

1.2.5 Phased Releases

The Exchange must be implemented in a series of phased releases that incrementally provide functionality to the Exchange consumers. Each release must be fully functional and provide a complete working set of features to the users. The requirements in Appendix C are organized by functional phase and describe the specific functionality required. Table 1 below summarizes the content of each release by functional module.

Table 1: Exchange Implementation Timeline

Phase	Deliverable Functionality	Preliminary Design Review	Final Detailed Design	Operational Readiness	Implementation
1	Plan Management	4/1/2012	9/1/2012	4/1/2013	7/1/2013
2	SHOP Employer Functionality	4/1/2012	10/1/2012	5/1/2013	8/1/2013
3	SHOP Employee Enrollment	4/1/2012	12/1/2012	7/1/2013	10/1/2013
4	Individual Eligibility	4/1/2012	12/1/2012	7/1/2013	10/1/2013
5	Individual Enrollment	4/1/2012	12/1/2012	7/1/2013	10/1/2013
6	Financial Management	4/1/2012	12/1/2012	7/1/2013	10/1/2013
7	Administrative Functionality	4/1/2012	3/1/2013	10/1/2013	1/1/2014

The implementation dates provided in Table 1 above are constrained by CMS requirements to ensure that individuals and small business employees can enroll and be protected by health insurance as of January 1, 2014. To accomplish this requires a staged implementation of functionality as follows:

- Plan Management available to issuers by July 1, 2013 to set up Qualified Health Plans (QHP)
- SHOP Employer Functionality available to employers by August 1, 2013 for employers to choose of QHP(s) and identify employees to Exchange
- SHOP Employee Enrollment and Individual Eligibility & Enrollments available to individuals and SHOP employees by October 1, 2013 to verify eligibility and enroll in a QHP prior to January 1, 2014.

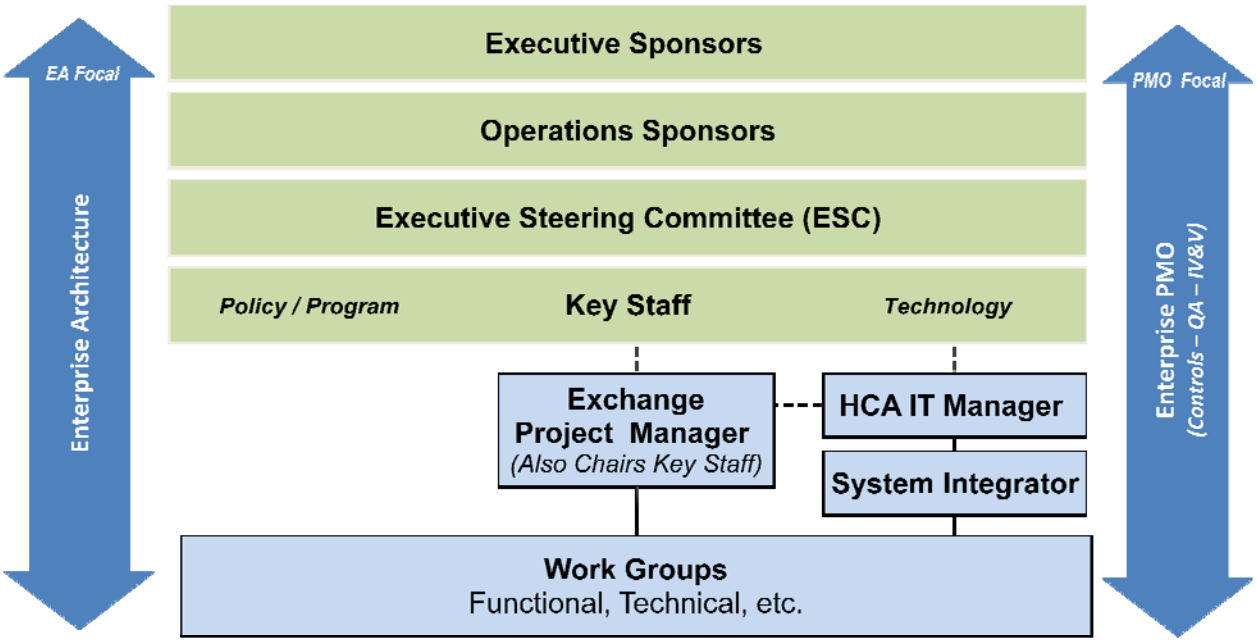
1.2.6 HCA Project Governance

To develop the state's Exchange, the Authority has deployed a project governance model that utilizes both state and industry best practices. Figure 2 below provides a graphic representing the current governance model which will be in place until March, 2012.

In addition to the Authority staff and Vendor, the Exchange project will involve stakeholders and support staff from multiple State Agencies:

- Department of Social and Health Services
- Office of Insurance Commissioner
- Office of Financial Management
- Office of Chief Information Officer

Figure 2: Project Governance Model Prior to March 2012



In March 2012, the Exchange Board will be established, and will put in place a new governance structure to guide the remainder of the Exchange project. The Exchange Board, a public-private partnership, will be authorized to apply for and administer grants, establish the Exchange information technology infrastructure, and undertake the administrative functions necessary to begin operation of the exchange by January 1, 2014.

The Board will consist of seven Governor appointed members as well as additional members including the Director of the Health Care Authority and the Insurance Commissioner or his designee (as a non-voting, ex-officio member). Once established, the board will also establish by-laws, ensure transparency and accountability of the entity, and hire an executive director and other staff members of the exchange. Until the Exchange Board is established, the Authority will continue to provide leadership in developing the Exchange.

1.3 Acquisition Authority

ESSB 5931 2011-12, an act reorganizing and streamlining central service functions, powers, and duties of state government, established the Office of the Chief Information Officer (OCIO). While the OCIO does not purchase for agencies, it regulates the manner in which state agencies may acquire information technology equipment, software, and services. In addition, because the Exchange Portal will be a major IT System that has significant statewide impact, the procurement and contract will be for personal services under the authority of the newly established Department of Enterprise Services. The Authority issues this Request for Proposal (RFP) pursuant to the rules of the OCIO and DES. The OCIO must approve the selection of the Apparently Successful Vendor and the award of this contract. This contract is also required to be filed with and approved by DES. Work shall not commence and payment shall not be made until a minimum of ten (10) working days after the date of filing, and, if required, until reviewed or approved by DES. In the event DES fails to approve the Contract, the Contract shall be null and void.

1.4 Contract Term

1.4.1 Contract—Initial Term

The initial term of the Contract resulting from this RFP will commence on the date listed in Section 2: Schedule and will extend through June 30, 2015.

The initial term will include: (i) the design, development and implementation phase; (ii) the initial operations and maintenance period; and (iii) the 6 month warranty period.

Because of the phased implementation approach, operations and maintenance will occur in parallel with the implementation of the Exchange Portal.

The operations and maintenance period will begin when the Exchange Portal has moved into production—when all Level 1, 2 or 3 deficiencies (as defined in Section 5.2.4.8.6 of Appendix B) have been remedied and retested.

Acceptance of the Exchange Portal will occur when all Deficiencies have been corrected. On the day after Acceptance, a 6-month warranty period will commence, during which time any deficiencies will be remedied to the Authority's satisfaction at no additional cost.

1.4.2 Contract—Renewal Terms

The Authority, at its sole discretion, may extend the Operations and Maintenance under the Contract for up to six (6) additional years. Such renewals may also include additional development as required by law changes or other circumstances related to the improved functioning of the Exchange Portal.

1.4.3 Software License

The term of any Custom Software Licenses resulting from this RFP shall be perpetual as to the License.

1.5 Definitions

Definitions for this Request for Proposal shall have the meanings assigned to them as provided in Appendix L.

1.6 Award

Only one (1) Apparently Successful Vendor (ASV) will be identified via this procurement. The Authority intends to award only one (1) Contract.

1.7 Overview of Solicitation Process

The solicitation process of this project is sanctioned and driven directly from federal law and mandated milestones tied to grants. Failure to meet mandated milestones puts the State in jeopardy of losing federal grant monies. From a State perspective, the procurement process has temporarily fallen in a gap between the former Information Services Board (ISB) [created by the State Legislature in 1987] being disbanded, and a newly formed Technology Service Board (TSB) that is in process of being formed. New legislation effective October 1, 2011, Engrossed Substitute Senate Bill 5931 (ESSB 5931) formed the TSB and the new Office of the Chief Information Officer (OCIO). The TSB focuses primarily on IT strategic vision and planning; enterprise architecture; policy and standards; and major project oversight, including procurement endorsements. The first TSB meeting is not scheduled until the week of November 28, 2011. Regularly scheduled quarterly meetings are planned after the initial meeting starting in January 2012.

Effective October 1, 2011, the OCIO adopted the policies and standards from the former Information Services Board in an interim status pending review by the OCIO and TSB. OCIO anticipates finalized policies being adopted by January 1, 2012.

With respect to this procurement, and the current gaps in timing of the TSB, the State plans to coordinate with the OCIO to ensure policy and strategic IT planning are adhered to as well as aligned and integrated with the Exchange program's federal requirements.

The procurement is initiated by this Request for Proposal (RFP). Vendors will compete to build/integrate, implement and operate the Exchange. After evaluation of the proposals (Section 7: Evaluation Process), the Authority and the ASV will enter into a fixed-price, deliverable based contract through which the Vendor will build/integrate and implement the Exchange.

This solicitation process will occur in two stages:

- Vendor Proposals will be evaluated based on Mandatory Requirements (pass/fail) and Mandatory and Desirable Scored Requirements; and
- The Authority will identify the three (3)*highest scoring vendors as finalists. Finalists will present their project management approaches, demonstrate their solutions and respond to Authority reviewer questions. The Apparently Successful Vendor will be selected from the finalists.

*The Authority reserves the right to increase the number of finalists if the scores are so close together so as to create a cluster of more than three at the top of the scoring range.

1.8 Authority Provided Resources

Vendors should assume that the Authority will provide the following resources to the Project:

- Technology Staff: IT Subject Matter Experts from the Authority's Information Technology Services Division will be available to help ensure policies, design intentions (EA / SOA), development, testing and implementation are adhered to as well as aligned and integrated with the Exchange program's federal requirements.
- Business Staff: Business staff from the Authority or other appropriate agencies will be available for design, development, testing, and implementation as requested in the Vendor's proposal and negotiated with the Authority.

SECTION 2

2 Schedule

This RFP is being issued under the following Schedule. The Proposal deadlines are mandatory and non-negotiable. Failure to meet any of the required deadlines (dates and times) will result in disqualification from participation.

NOTE: All times are Pacific Standard Time

Issue RFP	**10/28/2011**
Pre-Response Conference	**11/8/2011, 9:00 AM PST**
Vendor Letter of Intent Due	11/8/2011, 3:00 PM PST
Vendor Complaints Regarding Requirements Due	11/16/2011, 3:00 PM PST
Final Vendor Questions Due	11/22/2011, 3:00 PM PST
Publish Final Q & A	12/2/2011
Vendor Proposals Due	**12/8/2011, 3:00 PM PST**
Administrative Review	12/9/2011 – 12/13/2011
Written Proposal Evaluation Period	12/14/2011 – 1/9/2012
Schedule Oral Presentations/Demonstrations	1/10/2012
Conduct Vendor Oral Presentations/Demonstrations	1/18/2012 – 1/20/2012
Announce Apparently Successful Vendor	**1/25/2012**
Request for Optional Debrief Due	1/27/2012, 5:00 PM PST
Conduct Optional Debriefs	1/30/2012 – 1/31/2012
Contract Negotiations	**1/26/2012 – 2/7/2012**
File Contract with DES (10 Business day filing period)	2/8/2012
Contract Executed	**2/24/2012**

HCA reserves the right to revise the above Schedule.

The Authority recognizes that this is an aggressive schedule and expects the Apparently Successful Vendor (ASV) to be prepared for a short contract negotiation period. Failure to do so puts the project at risk of not being able to meet upcoming federal mandated milestones, thereby risking the loss of federal grant funds

SECTION 3

3 Administrative Requirements

3.1 RFP Coordinator (Proper Communication)

Upon release of this RFP, all Vendor communications concerning this solicitation must be directed to the RFP Coordinator listed below. With the exception of the Office of Minority and Women's Business Enterprises, unauthorized contact regarding this solicitation with other state employees involved with the solicitation may result in disqualification. Proposals should be based on the material contained in the RFP, any related amendments/addenda, and any questions and written answers directed through the RFP Coordinator. All oral communications will be considered unofficial and non-binding on the State. Vendors should rely only on written statements issued by the RFP Coordinator.

John Flanagan, RFP Coordinator
Health Care Authority
Telephone: (360) 923-2697
FAX: (360) 923-2835
E-mail: mailto:Contracts@HCA.wa.gov
(Please include RFP #K521 in subject line)

USPS Mail:

Post Office Box 42702

Olympia, WA 98504-2702

For any overnight, courier, hand-delivery, etc of the bids we need to use the following address:

Attn: John Flanagan
Health Care Authority
3819 Pacific Avenue SE, Suite A
Lacey, WA 98503

For official communications, the Authority may utilize:

- USPS mail;
- e-mail;
- the Authority's Procurement Web Site (http://www.hca.wa.gov/rfp.html);
- "**WEBS**" (Washington's Electronic Business Solution resource center for Vendors located at https://fortress.wa.gov/ga/webs/)

3.2 Procurement Web Site and Vendor Reference Library

The contents of this RFP, and all related documents, along with any amendments/addenda and written answers to questions will be available on the HCA web site at: http://www.hca.wa.gov/rfp.html

This Library includes supporting documents for the following:

- **Business/Functional Requirements**

- **Requirements Matrix** – contains the functional requirements that the vendor's proposal must respond to.
- **Documentation Providing Context to the Requirements** – The following documents are provided as additional context in order to understand the intent of requirements. These documents do not represent scope and are not finalized, but are provided to assist in scope determination and understanding the Authority's intent for the requirements.
  - ✓ **Business Process Flow Diagrams** – provides a high level indication of the Authority's current thinking on process flows for the functional requirements
  - ✓ **Business Process Descriptions** – provides narrative to support the business process flow diagrams, and context for the functional requirements
  - ✓ **Object Role Model (optional)** – provides a conceptual data view as context for understanding the functional requirements.
  - ✓ **System Context Diagram (optional)** – provides a conceptual system model showing actors, systems and the data flowing between the systems

- **Project Management Requirements**
  - Exchange Risk and Issue Management Plan
  - Sample Standard of Performance
- **Technology Requirements**
  - Technical Reference Model
  - Exchange Security Blueprint
- **CMS Artifacts** - Document templates defined by CMS for the deliverables necessary for the Exchange Stage Gate Reviews which are the basis for Vendor deliverable acceptance
- **CMS Blueprints** - Documents provided by CMS describing the activities required of the Exchange and offering technical guidance.
- **CMS NPRMs** – Notice of Proposed Rule Making for the Exchange

The document(s) will be available in Adobe Acrobat or Microsoft Word formats. Vendors are strongly encouraged to visit the Web Site and download the documentation from the Library.

3.3 (M) Letter of Intent; 11/8/2011, 3:00 PM PST

A letter indicating the Vendor's intent to respond to this RFP must be received by the RFP Coordinator at the address specified in Section 3.1: RFP Coordinator, no later than the date and time listed in Section 2: Schedule. The Vendor may submit the Letter of Intent by USPS mail, or courier, or e-mail. Failure to submit a Letter of Intent by the deadline specified in Section 2 *Schedule,* will result in Vendor disqualification and the rejection of any subsequent Proposal.

Each Vendor must include the following information in the Letter of Intent:

a) Name of Prime Vendor Organization;
b) Name of Prime Vendor Representative to serve as contact for RFP communications;
c) Prime Vendor Representative Title;
d) Prime Vendor Representative Address;
e) Prime Vendor Representative Telephone Number;
f) Prime Vendor Representative FAX Number;
g) Prime Vendor Representative E-mail Address;
h) Statement of Intent and Availability;
i) Certification that the Prime Vendor meets or exceeds the minimum requirements of this RFP;

j) Statement of Vendor's good faith belief in Vendor's ability to meet the Mandatory and Desired Requirements listed in this RFP document, and those in Appendices B: Project Management Requirements, C: Business/Functional Requirements, and D: Technology Requirements;
k) Statement of capacity and qualifications to perform a project of scope and duration of Exchange;
l) List by name the firms that the Prime Vendor anticipates using as sub-contractors;
m) Brief description of how your company meets the minimum qualifications set out in section 4.1: Minimum Qualifications.

3.4 (M) Pre-Proposal Conference; 11/8/2011, 9:00 AM PST

Vendors who wish to submit a Proposal to this RFP must participate in a Mandatory Pre-Proposal Conference on the date and at the time identified in Section 2: Schedule. Vendors who do not attend the Conference will not be eligible to submit a Proposal to the RFP. The Conference will be held at the following location:

Health Benefits Exchange Pre-Proposal Conference
General Administration Building
1ST Floor; Auditorium
210 11th Avenue SW
Olympia, WA 98501

http://www.ga.wa.gov/Park/visitor.htm

The purpose of this Pre-Proposal Conference is to provide Vendors an opportunity to address questions they may have concerning the RFP. Vendors are requested to submit their questions in writing to the RFP Coordinator at their earliest opportunity prior to the Pre-Proposal Conference. Verbal answers to additional Vendor questions at the time of the Pre-Proposal Conference will be nonbinding and unofficial. The Authority will attempt to provide a written response to significant questions to participating Vendors within three (3) Business Days after the Pre-Proposal Conference.

Attendance at the Pre-Proposal Conference is mandatory. Participation by teleconference will not be allowed. Attendance at the Pre-Proposal Conference is at the Vendor's sole expense.

We are also pursuing conducting this via a WebEx conference and thus avoiding the necessity to conduct this at one physical location. Further details will follow; however, until further notice attendance in person is still mandatory.

3.5 Vendor Questions

Vendor questions regarding this RFP will be accepted until the dates and times specified in RFP Section 2: Schedule. Early submission of questions is encouraged. Vendor questions must be submitted in writing via e-mail to the RFP Coordinator at contracts@hca.wa.gov. An official written response will be provided for Vendor questions received by the deadlines in the Schedule, Section 2 above.

Written responses to Vendor questions will be posted on the Authority's Procurement Web Site at: http://www.hca.wa.gov/rfp.html . The Vendor that submitted the questions will not be identified. Verbal responses to questions will be non-binding on the Authority. Only written responses posted to the Authority's Procurement Web Site will be considered official and binding.
Vendors are requested to use the following format when submitting their written questions

Question #	Document Name	Section # and Title	Page or Paragraph#	Question	Response

3.6 Vendor Complaints Regarding Requirements and Specifications

Vendors are encouraged to review the Mandatory Requirements of this RFP carefully. If Vendor believes that the document unduly constrains competition or contains inadequate or improper criteria, a complaint may be made to the RFP Coordinator before a vendor responds to a solicitation document. Where Mandatory Requirements appear to prohibit or restrict your firm's participation, an explanation of the issue with suggested alternative language should be submitted in writing to the RFP Coordinator by the deadline for Vendor Comments and Complaints in Section 2: Schedule.

Vendors are expected to raise any questions, exceptions, or additions they have concerning the RFP requirements early in the RFP process. The solicitation process may continue.

The Authority will immediately forward a copy of the complaint to the Department of Enterprise Services (DES) and the Office of Chief Information Officer (OCIO) The Authority will also reply to the Vendor with a proposed solution and advise DES and OCIO of its reply. If the Vendor rejects the Authority's proposed solution, DES may direct modification of solicitation requirements or the schedule, direct withdrawal of the solicitation, or may take other steps that it finds appropriate. The DES decision is final; no further administrative appeal is available.

3.7 (M) Proposal Contents

The Proposal must contain information responding to all Mandatory Requirements in the RFP document, and RFP Appendices B: Project Management Requirements, C: Business/Functional Requirements, D: Technology Requirements, P: Eligibility Service Requirements; and must include the signature of an authorized Vendor representative on all documents required in the Appendices.

Appendices A, B, C, D and P are an extension to RFP Sections 4 and 5. Specifically:

- Appendix A is supplemental to Subsection 4.4
- Appendix B is supplemental to Subsection 5.2;
- Appendices C and P is supplemental to Subsection 5.3, and;
- Appendix D is supplemental to Subsection 5.4.

Vendor's proposals must respond to all questions in both this RFP document and appendices A, B, C, D, E, K and P.

The Proposal must be submitted in three (3) volumes organized and containing the information listed below. This separation of documentation protects the integrity of the State's evaluation process. No mention of the Financial Proposal may be made in Volumes 1 or 3.

Volume 1:

- Vendor's Letter of Submittal (Section 4.2**Error! Reference source not found.**: Vendor Profile/Letter of Submittal) explicitly acknowledging receipt of all RFP amendments/addenda issued.

- The Response to Sections 4 and 5
- The Response to Appendix A: Vendor Organizational Capabilities Requirements
- The Response to Appendix B: Project Management Requirements
- The Response to Appendix C: Business/Functional Requirements
- The Response to Appendix D: Technology Requirements
- The Response to Appendix P: Eligibility Service Requirements

Volume 2:

- Financial Proposal (Section 6: Financial Proposal)

Volume 3

- Vendor's signed and completed Certifications and Assurances (Appendix E)
- Vendor's exceptions and/or proposed revisions to the Contract (Appendix F)
- Software Licensing terms for any proposed software that is not owned by Vendor (see Section 4.4)
- Vendor's Minority and Women's Business Enterprise (MWBE) Certification (Appendix G, if applicable)

3.8 (M) Number of Proposal Copies Required

- 1 CD-ROM of Proposal Volume 1, with one (1) true and correct printed original, plus four (4) complete printed copies, produced on 8.5 x 11 paper, punched and bound in separate three ring binders (Note: more than a single "binder" may be required for Volume 1).
- 1 CD-ROM of Proposal Volume 2, with one (1) true and correct printed original, plus four (4) complete printed copies, produced on 8.5 x 11 paper, punched and bound in separate three ring binders.
- 1 CD-ROM of Proposal Volume 3, with one (1) true and correct printed original, plus four (4) complete printed copies, produced on 8.5 x 11 paper, punched and bound in separate three ring binders.
- 1 copy of manuals, brochures, or other printed materials, if submitted, including any demonstration video or demonstration web site on CD-ROM.

3.9 (M) Proposal Presentation and Format Requirements

The following requirements are Mandatory in responding to this RFP. Failure to follow these requirements may result in Vendor disqualification.

3.9.1 The signature block in Appendix E: Certifications and Assurances must be signed by a representative authorized to bind the company to the offer.

3.9.2 Vendor must respond to each requirement contained in Appendix A: Vendor Organizational Capabilities, Appendix B: Project Management Requirements, Appendix C: Business/Functional Requirements, Appendix D: Technology Requirements, Appendix P: Eligibility Service Requirements, Appendix K: Financial Response and complete Section 6: Financial Proposal, and complete Appendix E: Certifications and Assurances.

3.9.3 Failure to submit any of the required documents may result in the Proposal being disqualified.

3.9.4 Each of the RFP requirements are numbered and titled. In each requirement title is a designation indicating how the Proposal will be evaluated:

a) For Mandatory Requirements **(M),** the Proposal must always indicate explicitly whether or not the Vendor's proposed services meet the requirement. A statement, "(Vendor Name) has read, understands, and fully complies with this requirement" is acceptable, along with any additional information requested.

b) For Mandatory Scored requirements **(MS)** and Desirable Scored **(DS)** requirements items, the Proposal must always indicate explicitly whether or not the Vendor's proposed services meet the requirement, and describe how the Vendor's proposed services will accomplish each requirement or are desirable as it relates to the service(s) proposed.

3.9.5 Proposals must be prepared on standard 8.5 x 11-inch loose-leaf paper and placed in three-ring binders with tabs separating the major sections of the Proposal. Pages must be numbered consecutively within each section of the Proposal showing Proposal section number and page number. Responses to numbered requirements must include the requirement number. Font size must be 11 or larger. Vendor may include oversize inserts in their submission.

3.9.6 Include Vendor name and the name, address, e-mail, facsimile and telephone number of the Vendor's authorized representative at the beginning of each volume of the Proposal.

3.9.7 Figures and tables must be numbered and referenced in the text of the Proposal by that number. Foldouts containing charts, spreadsheets, and oversize exhibits are permissible.

3.9.8 The Proposal, as well as any reference materials presented by Vendor, must be written in English and Vendor must provide all rates in United States dollars.

3.9.9 Files submitted on CD-ROMs must be in MS Word, MS Excel, MS Visio, MS Project or Adobe Acrobat format. Files must not be locked or protected. Failure to provide any requested information in the prescribed format may result in disqualification of the Vendor.

3.10 (M) Delivery of Proposals

It is Mandatory that Vendors submit all copies of their Proposals by the date and time in *Section* 2*: Schedule*, to the RFP Coordinator at the address specified in *Section 3.1: RFP Coordinator*.

Proposals must be **received** at the Authority by the date and time specified. Proposals arriving after the deadline will be returned unopened to their senders. A postmark by that time is not acceptable. **Proposals sent by facsimile or e-mail will not be accepted**. Vendors assume all responsibility for the method of delivery and for any delay in the delivery of their Proposal.

3.11 Cost of Proposal Preparation

The Authority will not reimburse Vendors for any costs associated with preparing or presenting a Proposal to this RFP.

3.12 Proposal Property of the Authority

All materials submitted in response to this solicitation become the property of the Authority, unless received after the deadline in which case the Proposal is returned to the sender. The Authority has the right to use any of the ideas presented in any material offered. Selection or rejection of a Proposal does not affect this right.

3.13 Proprietary or Confidential Information

The Authority is subject to the Public Records Act (chapter 42.56 RCW). Vendor's Response can be disclosed through the process set forth in this section. Portions of Vendor's Response may be protected from disclosure through the process set forth in this section.

- **Vendor cannot restrict its entire Response or entire sections of the Response from disclosure.**
- **Vendor cannot restrict its pricing from disclosure**

Any attempts to restrict disclosure through use of footers on every page and/or statements restricting disclosure will not be honored and may subject Vendor to disqualification.

If Vendor wants to protect any Proprietary Information that is included in its Response from disclosure, the information must be clearly identified by Vendor as Proprietary Information. Vendor must identify sections or pages claimed as proprietary in its Letter of Submittal (Section 4.2: Vendor Profile/Letter of Submittal). "Proprietary Information" is defined as information owned by Vendor to which Vendor claims a protectable interest under law. Proprietary Information includes, but is not limited to, information protected by copyright, patent, trademark, or trade secret laws.

The Authority will maintain the confidentiality of all information marked Proprietary Information to the extent consistent with the Public Records Act. If a public disclosure request is made to view Vendor's Proprietary Information, the Authority will notify Vendor of the request and of the date that the Proprietary Information will be released to the requester unless Vendor obtains a court order from a court of competent jurisdiction enjoining that disclosure. If Vendor fails to obtain the court order enjoining disclosure, the Authority will release the Proprietary Information, on the date specified.

The Authority's sole responsibility shall be limited to maintaining Vendor's identified Proprietary Information in a secure area and to notify Vendor of any request(s) for disclosure for so long as the Authority retains Vendor's information in the Authority's records. Failure to so label such materials or failure to timely respond after notice of request for public disclosure has been given shall be deemed a waiver by Vendor of any claim that such materials are exempt from disclosure.

3.14Waive Minor Administrative Irregularities

The Authority reserves the right to waive minor administrative irregularities contained in any Proposal. Additionally, the Authority reserves the right, at its sole option, to make corrections to Vendors' Proposals when an obvious arithmetical error has been made in the price quotation. Vendors will not be allowed to make changes to their quoted price after the Proposal submission deadline.

3.15 Errors in Proposal

Vendors are liable for all errors or omissions contained in their Proposals. Vendors will not be allowed to alter Proposal documents after the deadline for Proposal submission. The Authority is not liable for any errors in Proposals. The Authority reserves the right to contact Vendor for clarification of Proposal contents.

In those cases where it is unclear to what extent a requirement or price has been addressed, the evaluation team(s) may, at their discretion and acting through the RFP Coordinator, contact a Vendor to clarify specific points in the submitted Proposal. However, under no circumstances will the responding Vendor be allowed to make changes to the proposed items after the deadline stated for receipt of Proposals.

3.16 Amendments/Addenda

The Authority reserves the right to amend portions of this RFP at any time. The Authority may correct errors in the solicitation document identified by the Authority or a Vendor. Any changes or corrections will be by one or more written amendment(s), dated, and attached to or incorporated in and made a part of this solicitation document. All changes must be authorized and issued in writing by the RFP Coordinator. If there is any conflict between amendments/addenda, or between an amendment and the RFP, whichever document was issued last in time shall be controlling. In the event that it is necessary to revise or correct any portion of the RFP, a notice will be posted on the Authority's Procurement Web Site at: http://www.hca.wa.gov/rfp.html.

3.17 Right to Cancel

With respect to all or part of this RFP, the Authority reserves the right to cancel or reissue at any time without obligation or liability.

3.18 Contract Requirements

The Authority's Proposed Contract, based on the Model Information Technology Contract Terms and Conditions adopted by the OCIO, has been included as Appendix F.

To be responsive, Vendors must indicate a willingness to enter into a Contract substantially similar to the Authority's proposed contract, by signing the Certifications and Assurances located in Appendix E. Any specific areas of dispute with the attached terms and conditions must be identified in the Proposal and may, at the sole discretion of the Authority, be grounds for disqualification from further consideration in the award of a Contract.

A Vendor will be more favorably evaluated based on the degree of acceptance of the specified terms and conditions without exception, reservation, or limitation.

Vendors may, however, propose revisions to the Proposed Contract terminology for clarification and procedural purposes, and/or revisions based upon specific elements of their proposed solution.

Under no circumstances is a Vendor to submit their own standard contract terms and conditions as a response to this solicitation. Instead, Vendor must review and identify the language in Appendix F that Vendor finds problematic, state the issue, and propose the language or contract modification Vendor is requesting. All of Vendor's exceptions to the contract terms and conditions in Appendix F must be submitted within the Proposal, attached to Appendix E: Certification and Assurances. The Authority expects the final Contract signed by the ASV to be substantially the same as the Contract located in Appendix F.

The foregoing should not be interpreted to prohibit either party from proposing additional contract terms and conditions during negotiation of the final Contract.

The ASV is expected to execute the Contract within ten (10) Business Days of its receipt of the final Contract. If the selected Vendor fails to sign the Contract within the allotted time frame, the Authority may elect to cancel the award, and award the Contract to the next ranked Vendor, or cancel or reissue this solicitation (Section 3.17: Right to Cancel). Vendor's submission of a Proposal to this solicitation constitutes acceptance of these contract requirements.

The agreed-upon contract is subject to State and federal approval.

3.19 Incorporation of Documents into Contract

This solicitation document and the Proposal will be incorporated into any resulting Contract.

3.20 Best and Final Offer

Upon completion of the Vendors' oral presentations and demonstrations, the RFP Coordinator may issue to the Vendors participating in the presentations/demonstrations a request for Best and Final Offers. This request may include specific instructions as to the content and form of the Best and Final Offer and an invitation to submit a revised proposal.

The State reserves the right to select the Apparently Successful Vendor without requesting a Best and Final Offer. Therefore, Vendors should submit their proposal on the most favorable terms the Vendor can offer.

3.21 No Costs or Charges

No costs or charges under the proposed Contract may be incurred before the Contract is fully executed.

3.22 Minority and Women's Business Enterprises (MWBE)

In accordance with the legislative findings and policies set forth in RCW 39.19, the Authority encourages participation in all of its Contracts by Minority and Woman Owned Business Enterprise (MWBE) firms either self-identified or certified by the Office of Minority and Women's Business Enterprises (OMWBE). Participation may be either on a direct basis in response to this Solicitation or as a Subcontractor to a Vendor. While the Authority does not give preferential treatment, it does seek equitable representation from the minority and women's business community. Vendors who are MWBE or intend to use MWBE Subcontractors are encouraged to identify the participating firm on Appendix G: *OMWBE Certification*. For questions regarding the above, or to obtain information on certified firms for potential sub-contracting arrangements, contact Office of MWBE at (360) 753-9693.

3.23 No Obligation to Contract/Buy

The Authority reserves the right to refrain from Contracting with any and all Vendors. Neither the release of this solicitation document nor the execution of a resulting Contract obligates the Authority to make any purchases.

3.24 Non-Endorsement and Publicity

In selecting a Vendor to supply services to the state of Washington, the State is neither endorsing Vendor's products or services, nor suggesting that they are the best or only solution to the State's needs. By submitting a Proposal, Vendor agrees to make no reference to the Authority or the state of Washington in any literature, promotional material, brochures, sales presentation or the like, regardless of method of distribution, without the prior review and express written consent of the Authority.

3.25 Withdrawal of Proposal

Vendors may withdraw a Proposal that has been submitted at any time up to the Proposal due date and time (identified in Section 2: Schedule). To accomplish Proposal withdrawal, a written request signed by an authorized representative of Vendor must be submitted to the RFP Coordinator. After withdrawing a previously submitted Proposal, Vendor may submit another Proposal at any time up to the Proposal submission due date and time.

3.26 Optional Vendor Debriefing

Only Vendors who submit a Proposal may request an optional debriefing conference to discuss the evaluation of their Proposal. The requested debriefing conference must occur on or before the date

specified in Section 2: Schedule. The request must be in writing (e-mail acceptable) addressed to the RFP Coordinator.

The optional debriefing will not include any comparison between Vendor's Proposal and any other Proposals submitted. However, the Authority will discuss the factors considered in the evaluation of the requesting Vendor's Proposal and address questions and concerns about Vendor's performance with regard to the solicitation requirements. The debriefing conference may take place in-person or by telephone.

3.27 Protest Procedures

Vendors who have submitted a Proposal to this solicitation and have had a debriefing conference may make protests. Upon completion of the debriefing conference, a Vendor is allowed five (5) Business Days to file a formal protest of the solicitation with the RFP Coordinator. Further information regarding the grounds for filing and resolution of protests is contained in Appendix H: Protest Procedures.

3.28 Selection of Apparently Successful Vendor

All Vendors responding to this RFP shall be notified by mail or e-mail when the Authority has determined the finalist. The date of the announcement of the finalist shall be the date the announcement is postmarked.

One finalist will be selected as the ASV. The ASV will be the Vendor who: (1) meets all the requirements of this RFP; and (2) receives the highest ranking as described in Section 7: Evaluation Process.

SECTION 4

4 VENDOR REQUIREMENTS

Respond to the following "Vendor Requirements" in Section 4 as well as the supplemental "Vendor Requirements" in Appendix A: *Vendor Organizational Capabilities Requirements*, per the instructions in Section 3.9: Proposal Presentation and Format Requirements.

4.1 (M) Vendor Minimum Qualifications

Vendors must meet the following minimum qualifications:

a) Vendor must be licensed to do business in the State of Washington or provide a commitment that it will become licensed in Washington within thirty (30) calendar days of being selected as the Apparently Successful Vendor (ASV).

b) Vendor must have experience designing, developing and implementing a health related system (e.g., eligibility, enrollments, benefits, insurance, claims) in the last five (5) years of similar size and complexity and with a contract value in excess of $15 million **OR** must provide persuasive rationale why your organization is qualified to develop a Health Benefits Exchange.

c) Vendor must have a "good" or better financial strength rating on a Dun and Bradstreet business/credit report of Vendor's financial status dated not more than sixty (60) days prior to the submittal date of the proposal.

4.2 (M) Vendor Profile/Letter of Submittal

Vendor must provide a Letter of Submittal written on the Vendor's official business letterhead stationery that must be included in Volume 1 of Vendor's Response (Section 3.7: Proposal Contents) and must include:

a) The legal business name;
b) Type of business entity, (e.g., corporation, sole proprietorship, limited liability company.);
c) The year the entity was organized to do business as the entity now substantially exists;
d) Washington State Uniform Business Identification (UBI) number, if registered;
e) Proposal Primary Contact address, email address, telephone and FAX numbers;
f) A web site URL (if any);
g) An organizational chart of Vendor's principal officers, including names and titles;
h) A statement that the Vendor meets all the minimum qualifications and that the proposed solution meets all the Mandatory (M) and Mandatory Scored **(MS)** Requirements set forth in the RFP and its amendments/addenda, if any;
i) Identification of sections or pages of Vendor's Proposal claimed as Proprietary (see Section 3.13 Proprietary Information);
j) A statement that acknowledges and agrees to all of the rights of HCA including the RFP rules and procedures and the terms and conditions of this RFP, including any amendments/addenda;
k) A reference to all RFP amendments/addenda received by the Vendor (identified by amendment issue date) to represent that the Vendor is aware of all such amendments/addenda. If no RFP amendments/addenda have been received, the Vendor should so state;
l) Any other representations, assurances or warranties that the Vendor deems appropriate and wishes to convey to HCA.

The Letter of Submittal must be signed and dated by an individual with full authority to legally bind the entity submitting the Proposal to this RFP.

4.3 (M) Executive Summary

The Vendor's proposal must summarize the proposed project management approach and overall services, giving the evaluators a strong general overview of the Organizational, Management, Technical, and Functional proposals of the Vendor.

The Vendor's proposal must:

- State the Vendor's ability and willingness to work cooperatively with HCA and designees.
- State that the Vendor agrees to comply with the procurement process described in the RFP.
- State that the Vendor understands the scope and objectives of the project and agrees to meet the requirements specified in the RFP.
- State that the Vendor will perform the services described in the RFP.
- State that the Vendor's proposed solution will meet all Washington State Health Benefits (Insurance) Exchange – "Exchange" requirements.
- Identify any operational issues.
- Identify any unique or innovative features of Vendor's proposed solution.
- Provide an overview of the risks associated with this project, critical success factors, and actions HCA should consider during the major "Exchange" project stages.
- Explain how the proposed solution represents to HCA the best option for its Health Benefits (Insurance) Exchange project, and why HCA should select the proposed solution.

4.4 (M) Software Ownership

If Vendor is proposing a Software-Based Solution, Vendor's Response must include a statement indicating whether the Software is owned by Vendor or a third party. If the Vendor is not the owner of the Software, Vendor must agree to the following for each Software product included in Vendor's proposed solution (please indicate whether Vendor understands and agrees to each – failure to do so will result in disqualification from bidding on this RFP):

a) Vendor must identify the Software owner and provide contact information; and

b) Vendor must provide the Software owner's licensing terms in Volume 3 of the Response; and

c) Vendor must provide HCA's terms and conditions (Appendix F) to software owner; and

d) Software owner must agree to participate in contract negotiations with HCA.

4.5 (M) Single Point of Contact

Vendor will act as the Single Point of Contact for the Authority with the Vendor's subcontractors, Product manufacturers, and other relevant third-parties for the Services described in the Request for Proposal (RFP).

4.6 (M) Vendor Organizational Capabilities

Vendor must provide a response to the requirements included in the document Appendix A: *"Vendor Organizational Capabilities Requirements"* attached with this RFP. Vendors must respond within the appendix.

4.7 (M) Vendor Account Manager

Vendor shall appoint an Account Manager who will provide oversight of Vendor Contract activities under the Contract resulting from this RFP. Vendor's Account Manager will be the principal point of contact concerning Vendor's Contract performance.

4.8 (MS) Client References

4.8.1 **(M)** Vendor must ensure that on or before the date and time the Proposals are due (Section2: Schedule) the RFP Coordinator receives at least three (3) and no more than six (6) client references (Appendix J) from customers for whom the Vendor has implemented systems similar in size and scope .

- At least one reference must be from a customer for whom Vendor acted as the integrator for a large (e.g. $15M or more) health related project (e.g., eligibility, enrollments, benefits, insurance, claims).
- At least two references must be for a system implementation on which Vendor was the prime contractor.
- References must not be from a person, company or organization with any interest, financial or otherwise, in the Vendor organization. References that do not originate from a Client in an arms-length relationship with Vendor will be rejected.

The most relevant references are considered those that the vendor has provided services similar in type and scope to those requested within this RFP, RFP K521.

HCA reserves the right to be one of Vendor's client references based on HCA's prior experience with Vendor, and have HCA's Client Reference Form evaluated.

4.8.2 **(M)** The Vendor is responsible for providing the Client Reference Form to their identified customer references (see Appendix J: "Client Reference Form"). Vendor should select Client References that will respond in a timely manner. Each Client Reference must complete the Client Reference Form and either mail the original signed copy or email or FAX a PDF of a signed copy directly to the RFP Coordinator. The completed Client Reference Form must be returned directly from the customer, not the Vendor. All forms must be received by the RFP Coordinator no later than the time and date indicated in the Schedule (Section 2, Schedule).

4.8.3 **(M)** If the Client Reference Forms are not received by the RFP Coordinator on or before the indicated date and time, HCA will make one attempt to contact the Client references listed in Vendor's response to Subsection 4.8.4 to obtain a completed Client Reference Form. If contact cannot be made within one business day or the reference declines to submit the Client Reference Form, that Client Reference will not be included in the evaluation.

4.8.4 **(M)** Vendor must provide the following information about each customer reference.

1. Organization Name;
1. Type of Business
2. Contact name and title;

3. Telephone and E-mail address;
4. A brief description of the work done for the referenced client;
5. Start and end dates; and dollar amount of project; and
6. Date of system acceptance by the Client

4.8.5 **(M)**HCA may eliminate from contract award consideration any Vendor who receives an unfavorable report from a Vendor identified customer reference. HCA also reserves the right to contact other Vendor customers for additional references.

4.9 (M) Intellectual Property

Except as expressly provided in the Contract resulting from this RFP, Vendor agrees that all Software and documents that are developed as a part the Project will become of the property of the State of Washington, Health Care Authority.

4.10 (M) Financial Rating

Vendor must provide a copy of a Dun and Bradstreet business/credit report of the Vendor's financial status dated not more than sixty (60) days prior to the submittal date of the proposal that indicates a financial strength rating of "good" or better..

4.11 (M) Vendor Licensed to do Business in Washington

Within thirty (30) days of being identified as the ASV, Vendor must be licensed to conduct business in Washington. The Vendor must collect and report all applicable taxes. In order to receive payment from Washington state agencies, Contractors must be registered in the Statewide Vendor Payment Registration system maintained by the Office of Financial Management. To obtain registration materials go to http://www.ofm.wa.gov/isd/vendors.asp.

4.12 (M) Use of Subcontractors

The Authority will accept Proposals that include third party involvement only if the Vendor submitting the Proposal agrees to take complete responsibility for all actions of such Subcontractors. Vendors must state whether Subcontractors are/are not being used, and if they are being used, Vendor must list them in response to this Section. Any Subcontractors engaged after award of the Contract must be pre-approved, in writing, by the Authority.

Specific restrictions apply to contracting with current or former state employees pursuant to Chapter 42.52 RCW. Vendors should familiarize themselves with the requirements prior to submitting a Proposal.

4.13 (M) Prior Contract Performance

The Vendor's proposal must respond to the following:

4.13.1 Vendor must submit full details of all Contracts with the State of Washington within the last eight (8) years, including the other party's name, address, email address and telephone number.

4.13.2 Vendor must submit a brief description of any significant pending legal and administrative proceedings in any jurisdiction in which Vendor, its officers, directors, employees or principals or any of its subsidiaries or parent(s), their officers, directors, employees or principals is a party or of which any of their property is subject. Include the name of the court or agency in which the proceedings are pending, the date instituted, and the principal parties thereto, and a description of the factual basis alleged to underlie the proceedings. Notwithstanding the foregoing, Vendor

shall submit information concerning any claim or allegation which brings into question Vendor's performance or failure to perform.

4.13.3 Vendor must submit a brief description of any occasion in which Vendor, any officer or principal of Vendor with a proprietary interest therein, has ever been disqualified, removed or otherwise prevented from bidding on, participating in, or completing a federal, state or local governmental project because of a violation of law or a safety regulation.

4.13.4 Vendor must submit a brief description of any occasion in which Vendor has been in a position of default on a project, such that payment proceedings and/or execution on a letter of credit, payment, performance or bid bond have been undertaken.

4.13.5 Vendor must submit a list of all material threatened and/or pending claims, litigation and judgments or settlements, government enforcement actions.

4.13.6 Vendor must identify whether the Vendor or any of its officers refused to testify or waive immunity before any state of the federal grand jury relating to any public project within the last ten years. If so, provide details.

4.13.7 If multiple organizations are participating (e.g., subsidiaries, parent companies, and/or subcontractors), the information requested herein must be provided regarding each of the respective organizations.

4.13.8 The Authority will evaluate the information and may, at its sole discretion, reject the Proposal if the information indicates that completion of a Contract resulting from this RFP may be jeopardized by selection of the Vendor.

4.14 (M) Letter of Credit

Within 10 days of executing the Contract, Vendor must provide HCA with an Irrevocable Letter of Credit, naming HCA as the beneficiary, in a form and format acceptable to HCA in an amount of $5 Million. Irrevocable Letter of Credit (the "ILC") means a written commitment by a federally insured financial institution to pay all or part of a stated amount of money, until the expiration date of the letter, upon presentation by HCA (the "Beneficiary") of a written demand therefore. Neither the financial institution nor the Vendor may revoke or condition the Letter of Credit. The ILC securing Vendor's performance of its Contract obligations and other potential liabilities to HCA must remain in effect until the end of the Warranty Period.

4.15 (M) Insurance

The ASV will be required to obtain insurance to protect the State should there be any claims, suits, actions, costs, or damages or expenses arising from any negligent or intentional act or omission of the Vendor or its Subcontractor(s), or their agents, while performing work under the terms of any Contract resulting from this solicitation. Vendors will find a complete description of the specific insurance requirements in the proposed contract terms in Appendix F: *Proposed Contract.*

4.16 (M) Location of Vendor's Project Development Team

The Vendor's Exchange project development team will be based in the "Exchange Project Facility", in Olympia, Washington within reasonable proximity to the Authority's Cherry Street Plaza offices:

Washington State Health Care Authority
626 8th Ave.
Olympia, WA 98504

SECTION 5

5 Health Benefits (Insurance) Exchange System Requirements

Respond to the following "Vendor Requirements" in Section 5 as well as the supplemental "Vendor Requirements" in Appendix B, C D, and P per the instructions in Section 3.9: Proposal Presentation and Format Requirements.

5.1 (M) Risk Management

Risk Management will primarily be the responsibility of the Authority's Project Team and External Quality Assurance Contractor. Nevertheless, Vendor will be expected to identify and manage risks within its Project Management responsibilities in coordination with the Authority's Project Management Team, including:

a. Identification of risk areas;
b. Classifying criticality and probability of occurrence;
c. Planning potential contingency measures;
d. Identifying triggers to initiate contingency measures; and
e. Identification and monitoring of mitigation activities.

Vendor must agree to cooperate and work with HCA's Quality Assurance ("QA") and, potentially, Independent Validation and Verification ("IV&V") contractors in their efforts to provide independent assessment of Vendor's compliance with the Contract resulting from this RFP. Such cooperation includes agreement to cooperate with and make internal records, personnel, Project control systems and other support information available on a reasonable basis as requested by the Authority or the QA and IV&V contractors.

5.2 (M) Project Management Requirements

Vendor must provide a response to the requirements included in the document Appendix B: Project Management Requirements attached with this RFP. Vendors must respond within the appendix.

5.3 (M) Exchange Business/Functional Requirements

Vendor must provide a response to the requirements included in the documents Appendix C: Business-Functional Requirements and Appendix P: Eligibility Service Requirements attached with this RFP. Vendors must respond within the respective appendix.

5.4 (M) Technology Requirements

Vendor must provide a response to the requirements included in the document Appendix D: Technology Requirements attached with this RFP. Responses are expected to be documented within the appendix.

5.5 (M) Warranty

The Warranty period will begin on the day after the Exchange Portal has been Accepted. Acceptance will occur after the implementation of required functionality as defined in Appendix C: Business/Functional Requirements and Appendix D: Technology Requirements and when the entire Health Benefit Exchange is operating without deficiency, as defined in Appendix B, Section 5.2.4.9 and 5.2.4.10.

The Warranty Period will be for a period of six (6) months during which the Vendor will be responsible for the Warranty Services as described in Appendix F Proposed Contract at no additional cost to HCA**.**

(M) The Vendor must certify that they have read and understand the Warranty provisions as defined in Appendix F Proposed Contract.

SECTION 6

6 Financial Proposal

Respond to the following requirements per the instructions in *Section 3.9: Proposal Presentation and Format Requirements.*

6.1 (M) General Provisions

The Contract resulting from this acquisition will be a "fixed-price", deliverable-based Contract. In the Financial Proposal, Vendors will provide information regarding the deliverables, staff hours per deliverable, the delivery dates, and the cost of deliverables.

The Authority will pay for deliverables on the following basis as shown in the Deliverables Cost tab of Appendix K – Financial Proposal:

- 22.5 percent of the agreed, fixed price will be paid upon Vendor delivery (Vendor Delivery)
- 45 percent of the agreed, fixed price will be paid upon Authority acceptance (Authority Acceptance);
- 22.5 percent of the agreed, fixed price will be paid upon Federal certification and acceptance (CMS Check-in); and
- 10 percent of the agreed, fixed price will be paid at Turnover of the system at the end of the Warranty period (Holdback).

Operations and Maintenance charges will be paid upon receipt of a correct invoice for defined deliverables within 30 days of receipt of an invoice for services provided in the previous month as specified in the O&M tab of Appendix K – Financial Proposal.

6.2 (M) Financial Proposal Requirements

The Authority requires the following of the Financial Proposal:

- All Vendor costs (e.g., technical staff, management staff, travel, overhead) are to be included in the price of the deliverables.
- The deliverables must be the same as those in the listed in Section 5.2.6.2, Deliverable by Payment Milestone and in the Work Plan(s) for Project Management, Business/Functional, and Technical activities.
- The proposal must be free from mathematical error. (Minor rounding errors are not considered mathematical errors.)
- The proposal must include all costs as described in this section.
- The Financial Proposal must be accompanied by a copy of the Work Plan that includes all the deliverables specified in the Financial Proposal. HCA will not pay for products not described in this plan.

6.3 (MS) Financial Requirements "Health Benefits Exchange" Completion

All payments under the contract, except operations and maintenance services, will be for the delivery of tangible, completed products. The minimum work products are the Exchange Project deliverables identified in Appendix B: Project Management Requirements; Appendix C: Business/Functional Requirements; and Appendix D: Technology Requirements.

The Vendor is responsible for including all cost components in the proposed cost proposal.

Management costs as well as all other costs to the Contractor (including, but not limited to: facilities, computers, software, equipment, telecommunications, travel and living expenses/per diem, sales or use taxes and licensing fees) shall be included as overhead to the technical cost of completing Exchange Project deliverables, and will not be separately reimbursed.

To respond to the Financial Requirements set forth in this section, Vendor must utilize the Excel spreadsheets contained in Appendix K: Financial Response.

6.3.1 Vendor Pricing

Vendors must submit Appendix K, Financial Response, which is a multi-tab spreadsheet for the Vendor to enter their cost proposal in the individual worksheets as follows:

- **Deliverables Cost**: This worksheet summarizes the costs from all the other detail worksheets. There are four "yellow" highlighted cells on this worksheet for the Vendor to complete:
    - **Vendor**: Enter Vendor Name
    - **Basic Health Option**: Determining eligibility and coordinating enrollment for Washington citizens in the Federal Basic Health Option is within the scope of this RFP. The Federal Basic Health Option is a program that provides an additional low-cost health care coverage alternative for individuals who are between 133% and 200% of the Federal Poverty Limit. The Authority requests vendors to provide the estimated cost for the Basic Health program.
    - **Enrollment Transactions for Qualified Health Plans**: Generating enrollment transactions for Qualified Health Plans (non Medicaid/CHIP/Basic Health) is within the scope of the RFP. The Authority requests vendors to provide the estimated cost for generating enrollment transactions for the Qualified Health Plans.
    - **Optional Exchange Eligibility Services**: As defined in Appendix P, the Authority may request the Vendor to develop the required Exchange Eligibility Services

  All other cells on this worksheet are locked and are completed by formulas that reference the other worksheets.
- **O&M Costs**: Enter a list of proposed monthly deliverables and costs for the O&M services to be provided by the Vendor
- **CR Hourly Costs**: Enter the Role Name and Loaded Hourly Cost for the Vendor staff roles to be provided for the Exchange Project. At a minimum, this must contain all the key staff positions identified in Appendix A, Section 4.4.3.4
- **Enhancement Hourly Costs**: Enter the Role Name and Loaded Hourly Cost for the Vendor staff roles to be provided during the O&M period for Exchange system enhancements.
- **Infra – Project**: Enter the description of Hardware and Software components to be provided for the development of the Exchange, their unit costs and number of units to be provided for the five named environments (Development, System & Integration Test, Training, User Acceptance Test, and Production)

- **Infra – O&M**: Enter the description of Hardware and Software components to be provided for the Operations and Maintenance of the Exchange, their unit costs and number of units to be provided for the four named environments (Development, System & Integration Test, User Acceptance Test, and Production)
- **Worksheets 1 – Plan Mgmt to 7 – Administration**: These worksheets are provided for the Vendor to enter details concerning the main functionality breakdown of the Exchange and show estimated effort hours and cost. Two standard entries are provided:
    - **Exchange Web Portal / User Experience**: Enter estimated effort hours do design, develop, test and document the user interface for the functionality.
    - **Functionality**: Enter effort hours and costs for the functionality or break it down into sub-functions and enter effort hours and costs per line item.

  At a minimum, the vendor must enter one detail line containing the total cost for that functional area. The Authority prefers that the Vendors subdivide the main functionality into discrete pieces and provide both effort hours and cost.

6.3.2 Software and Equipment Costs

The Vendor must list all Software and Equipment necessary, and all associated costs to develop, test, and operate the Project. Equipment will include all servers, switches, racks, telecommunications, or any other equipment that will be used in the Exchange system. Software must include software used to support ongoing operations and maintenance initial costs and one-year maintenance/licensing costs. Vendors must submit Appendix K: Financial Response (Software and Equipment).

6.3.3 Operations and Maintenance

The Vendor must propose one (1) year of operations and maintenance of the Exchange. The cost for the one (1) year of Operations and Maintenance will be included in the cost evaluation of the Vendor's proposal.

At the option of the Authority, the contract resulting from this RFP for the Operations and Maintenance Services may be extended, on an annual basis, for up to six (6), one (1) year additional terms . The cost for each additional term shall be at the cost specified in the Vendor's proposal, adjusted annually by the "CONSUMER PRICE INDEX, SEATTLE AREA."

6.3.4 Total Cost of Project

The total cost of the Project is a summation of the above calculations. Vendors must submit Appendix K: Financial Response.

Vendors must supply supporting documentation for the deliverables and total Project cost.

6.4 (MS) Optional Tasks

This RFP includes optional tasks for which the Authority may choose to contract.

Proposals must include:

- Hourly rates for Pre-Implementation Change Requests (at multiple rates depending on the type of developer);
- Hourly rates for Post-Implementation Enhancement Requests; and
- Hourly rates and projected hours for post-Warranty Period Enhancement activity to maintain the Exchange at the levels indicated in Section 0 Warranty Period Service Levels.
- Hourly rates should include all Vendor activity, including management, for each activity.

SECTION 7

7 EVALUATION PROCESS

7.1 Overview

The solicitation and selection process will be staged:

- Vendors will submit Proposals in response to the requirements listed in this Request for Proposal.
- Mandatory Requirements (M) and Mandatory Scored Requirements (MS) will be screened for completeness. Proposals that fail to meet any Mandatory Requirements will be eliminated from further consideration.
- Mandatory Scored Requirements (MS) and Desirable Scored Requirements (DS) will be scored.
- The Vendors receiving the highest scores will be invited to present and demonstrate their solutions for the Exchange PROJECT and demonstrate their capabilities to meet the Authority's Exchange needs.
- The finalist candidates may be requested to submit a "Best and Final Offer" per RFP subsection 3.20
- An Apparently Successful Vendor (ASV) will be selected from among the finalists making presentations and demonstrations.
- The Authority will negotiate a contract with the ASV.

7.2 Administrative Screening

Proposals will be reviewed initially by the RFP Coordinator to determine on a pass/fail basis compliance with administrative requirements as specified in *Section* 3*: Administrative Requirements*. Evaluation teams will only evaluate Proposals meeting all administrative requirements.

7.3 Mandatory Requirements

Proposals meeting all of the administrative requirements will be reviewed on a pass/fail basis to determine if the Proposal meets the Mandatory requirements (Sections 4: Vendor Requirements; Section 5: Exchange Requirements; and Section 6: Financial Proposal and Appendix A: Vendor Organizational Capabilities, Appendix B: Project Management Requirements, Appendix C: Business/Functional Requirements, Appendix D: Technology Requirements, Appendix P: Eligibility Service Requirements, Appendix K: Financial Response). Only Proposals meeting all Mandatory requirements will be further evaluated.

The Authority reserves the right to determine at its sole discretion whether Vendor's response to Mandatory requirements is sufficient to pass. If, however, all responding Vendors fail to meet any single Mandatory item, the Authority reserves the following options: (1) cancel the procurement, or (2) revise or delete the Mandatory item.

7.4 Qualitative Review and Scoring

Only Proposals that pass the administrative screening and Mandatory requirements review will be evaluated and scored based on responses to the scored requirements in the RFP. Proposals receiving a "0" on any Mandatory Scored **(MS)** element(s) will be disqualified.

7.4.1 Vendor Client References

The RFP Coordinator should receive all Reference forms on or before the time and date of "Vendor Proposals Due" (reference RFP Schedule; Section 2). If more than three customer references are received, only three selected by the RFP Coordinator shall be considered during proposal evaluation. The Vendor Client References (Section 4.8) will be worth 50 points or 5 percent of the total points awarded in the scoring of the proposals.

The RFP Coordinator will assign scores for each set of Vendor references based on the following:

- The Vendor receiving the highest number of points will receive a score of 50.
- Other Vendors will receive a score based on the following formula:
  Vendor Score = (Vendor Points ÷ Highest Vendor Points) X 50

7.4.2 Administrative ,Project Management, Business/Functional and Technology Scored Requirements (MS, DS) Evaluation

Scored Requirements will be worth a total of 750 points or 75 percent of the total points awarded in the scoring of the proposals. Vendors will be evaluated on each Mandatory and Desirable Scored Requirement in previous sections of this document and in Appendix B: Project Management Requirements; Appendix C: Business/Functional Requirements and; Appendix D: Technology Requirements. Evaluators will assign points to each Mandatory and Desirable Scored requirement based on the effectiveness and completeness of the Proposal to each requirement.

Total points will be summed for each of the four requirements sections. The Evaluation teams will assign scores for each of these sections (Vendor Requirements; Project Management Requirements; Business/Functional Requirements; Technology Requirements) based on the following:

- The Vendor receiving the highest number of points for Vendor Requirements will receive a score of 150.
- The Vendor receiving the highest number of points for Project Management Requirements will receive a score of 200.
- The Vendor receiving the highest number of points for Business/Functional Requirements will receive a score of 200.
- The Vendor receiving the highest number of points for Technology Requirements will receive a score of 200.

Other Vendors in each of the four requirements sections will receive a score based on the following formula:

Vendor Score = (Vendor Points ÷ Highest Vendor Points) X score for the section (e.g., 150 for Vendor Requirements).

A score of zero by all evaluators on any Mandatory Scored Requirement will result in the Proposal being disqualified.

7.4.3 Financial Proposal Evaluation

The Financial Proposal will be worth 200 points or 20 percent of the total points awarded in the scoring of the proposals. The proposal will be evaluated based on Vendor's realistic pricing approach.

Vendor Price:

- The Financial Evaluation Team will score the Vendor's price for fixed-price deliverables and change request pricing, where:
  - The Vendor submitting the lowest Total Cost of Project will receive a score of 160.

- The Vendor submitting the lowest Change Request Evaluation Pricing will receive a score of 40. For calculation purposes, this will be based on the following:
  - 500 hours of project management services
  - 500 technical system architect services
  - 1000 hours of business analysis services
  - 3000 hours of developer services

  It should be noted that these four positions are predefined in the CR Hourly Costs worksheet.

- On both items, other Vendors will receive a score based on the following formula:

  Vendor Score = (Lowest Vendor Price ÷ Vendor Price) X maximum score for the item

7.5 Vendor Total Score

The Vendor Total Score will be calculated as follows:

Evaluation Category	Score
Vendor Requirements (Section 4)	150
Vendor References	50
Project Management Requirements	200
Business/Functional Requirements	200
Technology Requirements	200
Financial Proposal	200
Total Score	**1,000**

7.6 Oral Presentations/Demonstrations, Section of Apparently Successful Vendor

The Authority, after evaluating the written proposals, will schedule oral presentations/demonstrations for at a minimum the top three (3)* scoring finalists. The RFP Coordinator will notify finalists of the date, time and location of the oral presentation and demonstration. The dates in *Section 2: Schedule* are subject to change at the discretion of the Authority.

The Vendors making oral presentations and demonstrations will be grouped into an unranked pool of finalists. After the oral presentations/demonstrations, vendors will be ranked based on the overall quality of their oral presentations/demonstrations. Unless the Authority determines a "Best and Final Offer" process is necessary, the Authority will name the Vendor ranked first as the Apparently Successful Vendor .

*The Authority reserves the right to increase the number of finalists if the scores are so close together so as to create a cluster of more than three at the top of the scoring range.

7.7 Contracting Process

The Authority will enter into contract negotiations with the ASV. An ASV will be expected to execute the Contract within ten (10) Business Days of its receipt of a final Contract from HCA. If a selected Vendor fails to sign the Contract within the allotted ten (10) day time frame, HCA may declare negotiations at an impasse, elect to cancel the award, and award the Contract to the next ranked Vendor, or cancel or reissue this solicitation (see Subsection 3.17, Right to Cancel). Vendor's submission of a Proposal to this solicitation constitutes acceptance of these contract requirements. This process will continue until a Contract is signed, no qualified Vendors remain, or the Authority elects to cancel or reissue the solicitation.

The agreed-upon contract is subject to State and federal approval.

Resources and Needs Assessment

November 1, 2011

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Wakely
Consulting Group

Washington State Health Benefits Exchange Resources and Needs Assessment

November 1, 2011

One Constitution Center, Ste. 100, Boston, MA 02128

Table of Contents

I. Executive Summary

In July 2011, the HCA engaged Wakely Consulting Group, Inc. (Wakely) to assess Washington's current resources, capabilities, needs and gaps related to the development of the Washington Health Benefit Exchange. The assessment, the results of which are reflected in this report, was intended to identify which functional capabilities necessary to operate the exchange the state currently possesses, where gaps in functionality exist, and provide recommendations as to how these gaps can best be filled as well as to which aspects of existing capabilities might best be leveraged to support the exchange.

To assess the state's existing resources, Wakely conducted interviews with senior officials from a range of existing health care agencies in Washington, including representatives from the Health Care Authority; the Public Employees' Benefit Board (PEBB), the Health Insurance Partnership (HIP), the Basic Health program, and Medicaid. Outside of the HCA, Wakely interviewed staff from the Office of the Insurance Commissioner (OIC)). We also interviewed key vendors, such as third party administrators and consultants, where appropriate, and reviewed a range of publicly available information and documents provided by interviewees.

Wakely then compared Washington's existing infrastructure with the functional requirements of the exchange to identify where gaps in functionality exist that must be filled, as well as to identify existing capacity that may be useful to the exchange. We found that Washington State has a rich array of health care programs, each in possession of the infrastructure components to support its own population and administration, including eligibility determination, customer service, enrollment and billing, health plan procurement, and consumer outreach. In general, we found that, due to the specific requirements for exchange functionality specified under the ACA, most of the existing systems and capacities do not possess the full range of functionality and/or automation required to support the operations of the exchange without significant remediation. However, we did identify several smaller, more discrete instances of functions, processes, and expertise that warrant further study as potentially valuable assets for exchange development.

A summary of some key areas that warrant further study is included in the Table 1, below.

Table 1. Existing Exchange Related Resources, by Agency

Agency	Key Components Warranting Further Study
Basic Health Plan (BHP)	• MBMS system for premium billing and funds flow management
Health Insurance Partnership (HIP)	• Experience developing SHOP-specific functions related to employer billing, collection, and subsidy calculation

	• Experience with designating the health benefit plans offered by participating carriers • Experience marketing to small groups • Broker training and oversight
Medicaid	• Provider 1 MMIS system • Apple Health for Kids program for outreach organization management and performance evaluation to support Navigator program
Public Employee Benefit Board (PEBB)	• Infrastructure to support health plan procurement • Data warehouse • Benefit and product design and implementation
Office of the Insurance Commissioner (OIC)	• Regulatory oversight of health plans • Carrier data collection and review processes • Consumer protection, appeals, and outreach functions • Rate review and financial analytics

II. Introduction

Washington State passed legislation in April of 2011 authorizing the creation of the Washington Health Benefit Exchange. As indicated in the exchange's authorizing legislation, this report should include a discussion of the "administrative, fiduciary, accounting, contracting, and other services to be provided by the exchange", as well as discussion of whether and to what extent there will be "coordination of the exchange with other state programs."

In July 2011, the HCA engaged Wakely Consulting Group, Inc. (Wakely) to assess Washington's current resources, capabilities, needs and gaps related to the development of an exchange. The assessment is intended to identify what functional capabilities the state possesses, where gaps in functionality exist, and to provide recommendations about how to best utilize existing resources, as well as about how identified gaps can best be filled. While it does at times touch on information systems utilized by existing programs as they relate to exchange functionality, this review is separate from the information technology gap assessment that was performed by Cambria, which is focused more specifically on the needs and requirements of the exchange from an IT systems standpoint. Rather, this report will focus on existing business processes, programmatic functions, staff expertise, and other functional attributes of existing programs to assess their ability to support the required business functions of the exchange.

In this paper, we outline the capabilities and resources that will be needed to operate the exchange. We then assess the available resources and capabilities in the state's existing

coverage programs and agencies which parallel and could help meet the operating needs of the exchange. Finally, we identify options for Washington's new exchange to use existing state capabilities, and we discuss the pros and cons of filling the gaps by using existing resources and capabilities.

III. Key Functions and Requirements of the Exchange

Requirements for operating an exchange come from statutory requirements (stated in the Affordable Care Act (ACA)), regulatory requirements (based on guidance issued to date by federal agencies), and operational requirements (dictated by the functions needed for an exchange to carry out its operations). Taken together, the key functions for the exchange can be grouped into 16 core work processes. For convenience, we have further grouped these core work processes into five major business areas, as outlined in Table 1, below.

Table 2. Major Business Areas and Core Work Processes

Major Business Area	Core Work Processes
Exchange Governance & Administration	1. Governance & Oversight
	2. Internal Administration
	3. Financial Management
Operational Systems	4. Eligibility Determination
	5. Premium Tax Credit Administration
	6. Website & Online Shopping
	7. Enrollment, Billing & Collections
	8. Customer Service Call Center
	9. SHOP-specific Processes
Communications	10. Outreach & Marketing
	11. Broker and Navigator Management
QHP Certification	12. Qualified Health Plan (QHP) Certification
	13. Plan Rating System
Regulatory & Reporting	14. Reinsurance & Risk Adjustment Program
	15. Consumer Protections & External Reporting
	16. Exemption Certificates & Appeals of Eligibility

We will discuss each of these core areas in turn, and elaborate the requirements of the exchange in each area.

1. Oversight, Governance, and Program Evaluation

The exchange will be governed by a board, and exchange staff will need to manage board

relations so that the board is fully informed, works effectively, and maintains confidence and trust in the staff. Public board meetings often attract media coverage, so exchange governance structure and meetings communicate a lot about the exchange and reform more broadly. Coordination between the exchange and other state agencies will also be important to effective implementation of health reform across the various state agencies intimately involved in it. Once fully operational, the exchange should develop multi-year strategic plans, annual operating plans, and program evaluation tools to track performance over time, including take-up and enrollment levels of the target markets, and consumer satisfaction. Exchanges should also be able to monitor for unintended consequences such as crowd-out in the employer market or adverse selection.

2. Internal Administration

Washington's legislation creates the exchange as a "public-private partnership that is separate and distinct from the state". This means that, once established, the exchange must have a physical location to support operations as well as the administrative and financial infrastructure necessary to hire staff and operate its business functions. This will require the physical items needed to run the organization, such as office space, furniture, computers, data servers, and phones, as well as the administrative infrastructure needed for a new entity, including bank accounts, an accounting structure, payroll capabilities, as well as human resources policies and employee benefits.

3. Financial Management

An exchange must account for all activities, receipts, and expenditures and provide an annual report to the Secretary. An exchange will be subject to audits and investigations. In addition to strong accounting and financial management reporting systems, exchanges will need to be self-sustaining beginning in 2015. Specifically, SHOP exchanges will need to coordinate payments from employers to plans, brokers, and vendors. Exchanges are required by the ACA to publish the costs of licensing, regulatory fees, and any other payments required by the exchange. The exchange will also need to be self-sustaining. Exchanges will need data warehousing functions to manage these financial functions and be able to generate reports and receipts. Outsourcing and vendor management functions will also be needed. Periodically, the exchange will need to reconcile billing and collections with QHPs and possibly the Treasury as well.

4. Eligibility determination

The ACA requires an eligibility system that would determine an individual's eligibility for Medicaid, CHIP, and exchange premium and cost-sharing subsidies. The exchange would need to collect the information needed for eligibility determinations, transmit it to the federal hub for verification, and then return eligibility decisions in real-time (for most customers).

Federal guidelines indicate that customers should have the same, high-quality shopping experience regardless of which door (Medicaid, CHIP, or exchange) they utilize. The system should accommodate robust performance evaluation and management functions. The guidelines state that the federal government will establish an approach to verification from its agencies so that states will not have to independently establish their own interfaces and connections. The 1.0 version of the federal guidelines does not provide in-depth specifications for the technical architecture. However, the guidelines do identify several existing federal standards that exchange IT systems will need to comply with. These include HIPAA requirements, Section 6103 of the Internal Revenue Code, accessibility standards for people with disabilities, and the National Information Exchange Model (NIEM) to facilitate common data exchange. Depending on whether Washington elects to establish an eligibility determination system that is separate from the exchange website, the system will also require an accompanying call center and case workers.

States will need to consider the impact of using modified adjusted gross income (MAGI) for income-based eligibility determinations and non-income based eligibility determinations, such as for the elderly and disabled population, and when and how to conduct eligibility redeterminations.

5. Premium Tax Credit Administration

The exchange must determine individuals' eligibility for premium tax credits and cost sharing subsidies and include a premium tax credit calculator on its website that is integrated with the initial eligibility process and capable of providing subsidy calculations in real time. It also must coordinate the payment of these subsidies and integrate the determined level of subsidy with the billing and collections interface to QHPs offered through the exchange. Submitting information to Treasury and HHS will be necessary, especially for those individuals who request and receive an advance tax credit. Coordination and reconciliation with QHPs will also be necessary, as the exchange will be the source of record for enrollment, but the actual funds flow for tax subsidies will be from the US Treasury to the QHPs or to the exchange if Washington elects to have the exchange aggregate premiums.

6. Website & Online Shopping

Exchanges are required to establish a website that provides standardized comparative information on QHPs. Exchanges must inform consumers about the eligibility criteria for Medicaid, the Children's Health Insurance Program (CHIP), and other applicable state and local programs. The exchange must provide a cost calculator that calculates the cost of coverage after the application of a premium or cost-sharing tax credit. This means that the exchange must have a mechanism for "grabbing" rates from carriers. The internet portal must also provide information about enrollee satisfaction. In addition, the exchange should provide decision support tools to help consumers choose a plan.

While not explicitly described in ACA, SHOP exchanges will need to display for employees the coverage tier selected by their employer and the cost of plans to the employee taking into account the employer contribution.

7. Enrollment, Billing, and Collections

The exchange will need to be able to enroll both individuals and small groups into health plans. This should include a process for confirming and communicating about plan selection, enrollment date, premium subsidy level, monthly enrollee premium (subsidized or unsubsidized), dollar flows, effective date of coverage, and fulfillment of enrollment process and materials by carrier. There should be automated data exchange between the eligibility, enrollment, and billing systems, so that consumers do not need to re-enter or re-transmit basic information at each step. The exchange will need to generate bills, process electronic funds transfer and/or credit card payments, and generate receipts. Uniform policies should be established across carriers for enrollment, billing cycles, collections, late payments, and termination for non-payment.

Many of these functions apply to both the individual and SHOP exchanges. The SHOP exchange will also need to carry out a number of additional functions. For example, the SHOP exchange will need to establish an employer verification process, as well as a simple and streamlined employer application system that will expedite the collection of necessary data from employers, including an employee census. Employers must be able to select a tier of coverage and indicate their contribution to that coverage. Employees will need to be issued a passcode to access the exchange, and then be able to select among plans within the specified tier (employee-choice model). Although not entirely clear in the ACA, there is an interpretation of ACA that would also allow, in addition to the employee-choice model, a conventional health insurance offering in which employers select for employees the QHP, tier of coverage, and benefit plan on the tier (single-source coverage). Additional federal guidance is expected to clarify this issue. Exchanges will also need to develop a system for making mid-year additions/deletions as well as a system for administering COBRA coverage.

Exchanges are required to provide for open enrollment periods, including an annual open enrollment period as well as special enrollment periods for qualifying events. The NPRM contemplates rolling enrollment for SHOP, meaning that plan renewal occurs when the group's anniversary date comes up, with premiums fixed for a year from the employer's anniversary date. It is likely that Washington will have flexibility to establish its own small business enrollment process, including qualifying events. However, decisions on issues such as open enrollment cycles will need to be considered within the context of the existing small group market.

8. Customer Service

Exchanges are required to provide a toll-free telephone hotline to provide for consumer assistance in addition to the website described. Exchanges should consider the need for customer service to respond to individual, employer, and broker queries, any difficulties with website functionality or navigation, as well as problems in transmission of enrollment and premium information to plans.

To operate a customer service call center, the exchange will need customer service protocols (automated and in manuals) and customer tracking tools and databases. Telephone and in-person staff will need to be hired and trained. In developing customer service support, the exchange should consider accessibility of the exchange to people whose primary language is not English, and to people with disabilities.

9. SHOP Specific Functions

The SHOP exchange serving small businesses will need to provide a number of functions specific to the small group market and provide an efficient and administratively simple process for small employers similar to or better than the standards currently found in the commercial market. The SHOP exchange will need to provide online shopping services for employers, such as online premium quote generation, plan selection options, and employer account set up. Once an employer enrolls, the SHOP exchange must provide an employer verification process to confirm eligibility of employees, information on employer and employee contribution levels, an employee cost calculator, and employer invoicing and payment receptacles. The SHOP exchange must also be capable of providing aggregated payments to carriers; customer service protocols for employers, employees and brokers; and a calculator to assist employers in determining their eligibility for tax credits (actual determination is a function of corporate tax filings and determination by the IRS). With respect to brokers or other producers, the exchange must establish broker training and sales tools, broker reporting and analytics, and uniformity requirements among carriers.

10. Outreach & Marketing

Washington's exchange will need communications and outreach programs to explain the role of the exchange to Washington residents and small employers. In addition, the ACA specifies that exchanges must consult with stakeholders, including representatives of small businesses and self-employed individuals. For most people who are not sick, health insurance is a "grudge buy"—not something they like or want to spend a lot of time exploring, nor do they savor the purchase. Yet it is a major outlay, ranging from $3,000 to $15,000 per year, and carries great significance once the enrollee becomes ill. Therefore, effective communications to a large population of potential exchange customers is a critical function, and the relevant skillsets are far more typically available in the private than the public sector. This requires a marketing campaign, including branding, logo, paid and "earned" media strategies, etc.

11. Broker and Navigator Management

The Exchange has a range of options in structuring its relationship with health insurance producers, whether through a more traditional broker function or as structured as part of the ACA-required Navigator program, which is intended to supplement the exchange's outreach and educational functions. The role of navigators overlaps with brokers' traditional role in helping purchasers to pick plans and enroll, although the role and compensation for navigators (who the ACA suggests will be funded through grants) do not fit traditional producer compensation schemes. Navigators will also perform outreach, especially to hard-to- reach populations, provide information on reform to low-income populations, many of whom will qualify for Medicaid and CHIP, rather than tax credits in the exchange, and help clients through a sometimes daunting eligibility determination process. However, there is nothing to preclude brokers from fulfilling this role, and the state may elect to allow brokers to participate in this program.

For both traditional brokers and navigators, the exchange will need to provide training and certification, a dedicated portal to access exchange services, and dedicated customer service support. The broker support and oversight process is a complicated one. While working with brokers will be crucial to the success of the exchange, understanding brokers' roles and relationships with carriers is a skillset not readily available outside the world of agents and plans. The exchange does some things that brokers traditionally do—such as set forth plan options for buyers and provide comparative insights. Further, brokers typically work for and are paid by carriers as "producers," but this model may or may not fit Washington's exchange. The exchange will need to evaluate existing broker compensation methodologies to determine the appropriate model for Washington.

For navigators, whether inclusive of brokers or not, the exchange will need to both encourage navigators to pursue a broad range of outreach and educational services on health reform, as well as measure and provide oversight of navigator performance, including "productivity." While ACA defines a whole new role for "navigators," many states do have experience working with application facilitators and consumer advocates who play related roles with respect to Medicaid and CHIP. A critical consideration related to the navigator function is that federal grant funding is not available for this program, so the state will need to identify alternative revenue sources to support this program.

12. Qualified Health Plan (QHP) Certification

The ACA requires exchanges to certify, recertify, and de-certify plans as QHPs, based on standards that are established, in part, by the federal government. The ACA also directs exchanges to require health plans to submit justifications of premium increases. While not explicitly an exchange function, there will need to be close coordination between the exchange and the state regulatory agency responsible for such issues.

13. Plan Rating System

As required in the ACA and in coordination with HHS, the exchange must implement a plan rating system for Qualified Health Plans (QHPs) to evaluate QHPs on the dimensions of quality and value. Depending on the level of detail provided by HHS regarding the plan rating system, it may be necessary for Washington to develop state-specific metrics in which to compare plans. Or even if the HHS developed model is very detailed and requires little state customization, Washington may decide to develop a rating system that is reflective of the goals of its exchange and the implementation of any health care reforms specific to the state. Developing a rating system and any related decision support tools will necessitate access to large amounts of carrier information, meaning the exchange will require data storage and analytical capabilities as well as the ability to integrate plan quality and value information with the website.

14. Risk Adjustment

The ACA creates three kinds of risk adjustment programs: a temporary reinsurance program that assesses fees on all carriers and makes payments to individual plans enrolling high-risk individuals; a temporary risk corridor program for qualified health plans in the individual and small group markets; and a risk adjustment program for issuers offering plans in the individual and small group markets. Of these three, the risk corridors program will be administered at the federal level, while the state must administer the transitional reinsurance program. The state may or may not elect to perform the risk adjustment function, or choose to have this program administered, in whole or in part, by the federal government. These programs can be carried out by the exchange, or by another state entity. If housed outside the exchange, at a minimum, the exchange will need to be able to coordinate closely with these programs.

15. Consumer protections & External Reporting

The ACA requires exchanges to carry out a number of consumer protection functions. For example, exchanges are directed to require health plans that seek to become QHPs to submit justifications for any premium increases. The statute directs exchanges to collect and disclose information from plans seeking to be QHPs, including financial disclosures, data on enrollment and disenrollment, and data on denied claims. Exchanges are also required to post information about enrollee satisfaction on their websites.

Additional operational requirements include developing a reporting system to track buying patterns, enrollee satisfaction, and problems; developing a rating system for QHPs; coordinating with Washington's Office of the Insurance Commissioner on a host of licensure and market oversight issues; updating and monitoring QHP premium rates and underwriting; and addressing consumer complaints regarding QHPs. Beyond statutory requirements, each state exchange will no doubt exercise some discretion in deciding how proactive or interventionist it will be on consumer protections.

16. Exemption Certificates & Appeals of Eligibility

The ACA assigns the exchange responsibility for certifying exemptions from the individual mandate. While the Secretary is to establish an appeals process for eligibility determinations, it is likely that the exchange will need to be able to implement this process. The exchange will also need to be able to notify employers when an employee qualifies for subsidized coverage through the exchange, thus potentially triggering an employer penalty. Carrying out these politically sensitive tasks efficiently, effectively and with considerable flexibility will be necessary to maintain and build public support for the exchange and health reform.

IV. Survey of Existing State Resources

To understand the current state resources and capabilities that might be used to inform the development of Washington's exchange, we conducted interviews with senior staff in Washington during July and August 2011. Interviewees included representatives from Washington's Health Care Authority; including the Public Employees' Benefit Board (PEBB), the Health Insurance Partnership (HIP), the Basic Health program, and Medicaid. Outside of the HCA, we interviewed staff from the Office of the Insurance Commissioner (OIC). We also interviewed third party administrators and consultants where appropriate, and reviewed source documents identified by interviewees as being of particular importance or relevance. We are grateful to the interviewees for their candid and insightful thoughts on how their programs might relate to the Washington exchange, and for generously making time to contribute to this analysis, despite their many other responsibilities and commitments.

Based on these interviews, we identified existing resources within Washington that are relevant to the development and operation of an Exchange, including several capabilities that are especially robust.

As would be expected from examining multiple organizations engaged in a similar line of business, there is high degree of existing overlap in the functions performed by these agencies. Each has the administrative and operational infrastructure required to serve individuals falling under its jurisdiction and mandate, many rely on the same health carriers to service their members, and many interface with the same or similar populations as individuals move from one entity to another to seek health insurance benefits as their circumstances and demographic profile changes over time. For the sake of brevity and clarity, we have focused our discussion of key findings below on those elements of each organization we felt were most useful and/or relevant to the development of the exchange.

Public Employee Benefits Board

Washington's Public Employee Benefits Board (PEBB) administers benefits for approximately 350,000 state, K-12 school district, and local government employees and retirees. Employees can choose to receive their health care coverage from one of two fully insured managed care plans or through the self-insured Uniform Medical Plan (UMP), which PEBB administers in partnership with Regence Blue Shield, a contracted Third Party Administrator (TPA). Approximately 60% of members are enrolled in the UMP, while the remaining 40% are split between Group Health and Kaiser. Benefits are subject to overall spending levels set by the state legislature, and the cost of coverage is split between enrollees and PEBB, with PEBB paying about 85% of the cost. As the purchasing authority for 350,000 public employees, PEBB has a wealth of experience, expertise, and infrastructure related to procuring and administering publicly-subsidized commercial health benefits. Based on their scale and experience, the authority is able to both seek competitive rates for their members, as well as to engender changes and innovations in the design of benefits, product design, and care delivery.

PEBB works closely with its contracted health plans on the development of products and benefits, and seeks to leverage its buying power to play a leadership role in developing products and benefit designs focused on the improvement of care quality, consumer choice, and shared accountability. To broaden employee choice, and in partnership with its fully insured health plan vendors, PEBB has recently introduced lower-premium benefit designs, including designs available beginning in 2012 that are attached to a Health Savings Account, and is currently working to introduce a new benefit design slated for 2013 geared toward greater shared accountability for health behavior and cost trend management between the HCA, PEBB members, PEBB health plans, PEBB providers, and PEBB employers. Through changes to service utilization, payment, plan design, and the monitoring of health outcomes, PEBB hopes to improve health status, cost trend, member satisfaction, and health care quality.

The introduction of these products, which require a substantial investment on the part of participating carriers, as well as management and oversight on the part of PEBB to ensure consistency for their members, are examples of the opportunities available to purchasers with significant amount of membership scale.

To support their contracting and plan management functions, PEBB leverages their contracting, financial analysis, and data management capabilities, which exist partly within the agency, and partly in their contracted administrative vendors. Some key functions performed by PEBB include:

1. Health Plan Procurement and Annual Rate Renewal Process

   PEBB holds five year contracts with Group Health and Kaiser to provide member coverage in PEBB-specified product designs. Rates are renewed annually to reflect medical trend, population changes, and benefit design modifications. The procurement and rate renewal process requires significant financial and actuarial analysis, which is performed in part by in-house PEBB staff, and in part by consulting actuaries engaged by the agency. In addition to establishing rates and member premiums, this process involves risk-adjustment of carrier premiums to account for potential health status differences between plans.

2. Data Storage and Analysis

   For the self-insured product, PEBB contracts with a vendor called VIPS and operates a data warehouse called MCSource that supports modeling and analysis, claims and utilization reporting, quality assurance, and end-user training. Although MCSource is a robust system, staff expressed the desire to enhance the capabilities of the data warehouse to further support more detailed clinical and financial analysis. This desire may provide the exchange an opportunity to leverage the warehouse for its own data needs.

3. Member Services and Appeals

   PEBB staffs its own customer service center to provide support to enrollees and field questions and complaints regarding eligibility and enrollment. Plan specific questions are forwarded to the specific plan. PEBB employs a staff of 12 to field second-order member issues, take walk-in inquiries, and process account adjustments. This staff accepts 7,000 – 10,000 calls per month. In addition, the agency utilizes an online tool called FUZE, which allows for member and employer inquiries to be submitted online, responded to within a couple of hours, and stored in an accessible archive to provide answer to similar questions. Separate units within PEBB monitor enrollment and eligibility requirements, manage open enrollment, and support the personnel and payroll agency staff who manage the account accuracy of employees. These issues are mostly managed by HR staff in participating agencies with training and supervision from PEBB.

4. Member Communications

   PEBB employs a communications staff to manage member and agency communications related to the UMP, as well as overall PEBB open-enrollment information. (Communications specific to the fully-insured plans are handled by the individual carriers). This group drafts and reviews all published materials and correspondence, staffs benefits fairs, and generates member information, including detailed benefit and coverage publications.

The current IT systems that supports PEBB's benefits administration function is known as PAY1. The PAY1 system is a former payroll system that is now used for PEBB eligibility, paying carriers, and collecting monies from brokered agencies. Although Wakely was not charged with performing a detailed technical review of existing IT systems, feedback from staff indicated that PAY1 may not be able to meet the needs of the exchange due to its age and inflexibility. However, the system does support a total premium flow of approximately $1.8 billion annually, and is able to support flexibility to establishing benchmark premiums and varying contribution rates across agencies. The funds flow, particularly for brokered agencies, is complex and may have some applicability to the SHOP functions of an exchange. Thus, while PAY1 may not be the solution to support the exchange's SHOP functionality, the system's requirements documentation should be reviewed during the design and technology development phase, and the vendor may be a good, cost-effective source for WA's exchange.

The exchange will also want to review the UMP's TPA relationship with Regence BlueShield. While the state manages the plan, Regence BlueShield provides the operational features such as claims processing, customer service, online member support tools, and elements of the provider network. PEBB relies heavily on the state agencies to use online tools to educate and enroll their employees, so the Regence operated UMP call center is really their only robust customer service tool. Regence, Group Health, and Kaiser all offer members a chance to review their claims, provider search, health assessment, online chat with customer service representatives, hospital comparisons, and member submitted provider reviews.

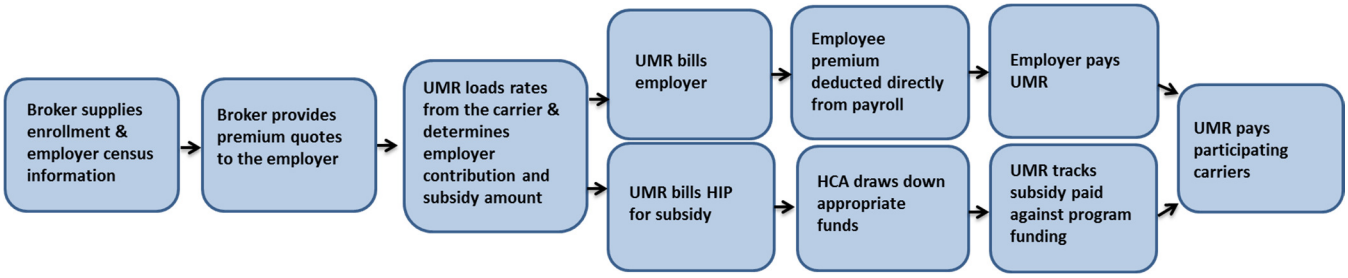
Health Insurance Partnership

Washington State's Health Insurance Partnership (HIP) allowed small employers with low-wage workers to have access to affordable health coverage in the small group health insurance market. HIP offered small employers a selection of the same health insurance plans available in the small group market with a lower employer contribution rate, and offered a premium subsidy to low-wage employees depending on their income. HIP was funded through a grant from the U.S. Department of Health and Human Services State Health Access Program (SHAP). There are currently 66 individuals, representing 16 small businesses, covered under the program. In May 2011 the program lost federal funding and is no longer accepting new members; benefits for existing members will continue through their existing plan year and then be discontinued. Although only operational for six months, HIP shared many design similarities that will be required for the SHOP exchange (including a tiered benefit design) and there are many areas of functional overlap with the primary exchange business areas that should be explored to inform exchange development. Wakely found particular promise in the relationships HIP had cultivated with its TPA, brokers, and the participating carriers.

HIP uses a third party administrator, UMR, for its application, employer eligibility, enrollment, and billing functions. UMR works directly with the employers, carriers, and brokers participating in HIP. UMR collects employer information and determines eligibility, monitors ongoing account activity, and also determines employee eligibility for subsidies. Once eligibility is determined, the employer is directed to a broker, who assists the employer in completing the enrollment process by providing quotes and assisting the employer to select a plan. Once they have selected a plan, ongoing billing, account management, and customer service are handled by UMR. Since not all employees qualify for subsidies, the billing and collections for HIP require a great deal of coordination. UMR uses enrollment information from the broker to determine a premium amount for each employee, bills the employer, and requests a subsidy from HIP. Employee premium is deducted directly from payroll. After HIP is billed for the subsidy, HCA will draw down the appropriate funds. UMR actively tracks the subsidy payout against total program funding.

While there is some procedural/process overlap, many of the eligibility and enrollment functions are part of a manual, broker driven process that does not seem to meet the level of automation needed by the exchange. The TPA infrastructure was designed to be scalable in order to support an anticipated growth in membership, but there are similar, more robust systems within the state that could perform similar functions. However, the funds flow between UMR, employers, HIP, and the carriers closely parallels processes that will need to be administered by the SHOP exchange, and should be closely examined by the exchange when developing this functionality. The business experience of HIP staff, as well as, potentially, the experience developed by UMR, may be important assets to leverage as the exchange designs and develops its SHOP components.

Figure 1. HIP Process Flow Diagram



Since HIP could not perform the quoting and rating functions necessary to facilitate enrollment, every participating employer had to work through a broker. Therefore, creating and maintaining relationships with participating brokers was critical to the success of HIP. HIP developed a detailed training program that brokers had to complete prior to being included on the preferred list of producers maintained by HIP from which employers could select brokers to work with once determined eligible. Broker commissions were paid by the carriers at the same rates as the commercial market. However, when the program was near implementation, most commercial carriers in Washington had recently cut commissions entirely to groups of five or fewer employees, which limited the willingness of some brokers to participate in the program. Others, however, continued to serve and support employer clients. The experience of HIP in working with brokers should provide a great deal of insight to the exchange as it develops its policies related to broker interaction and management. Concretely, through the HIP, the exchange can access a list of brokers that are already familiar with a SHOP-like model, as well as a smaller subset who are most likely to actually want to work with the exchange.

The HIP employed a number of features that mirror components of the SHOP exchange and that could help with the design and implementation of the exchange. For example, the HIP utilized online tools for employers, such as an online cost calculator and subsidy gauge, handled appeals of employer eligibility, and conducted stakeholder engagement as it relates to carrier participation. The relationships formed with carriers, small-business organizations, and public agencies, which were all heavily involved in the HIP development process, may help the exchange build engagement and acceptance of the SHOP exchange. Similarly, the experience of marketing the HIP to businesses should provide some valuable lessons that will help the exchange in their marketing efforts to small employers.

Basic Health Plan

The Basic Health Plan subsidizes private health insurance coverage for individuals, low-wage employees of private employers, and families with children in Medicaid (through Basic Health Plus) whose income is below 200 percent of the federal income guidelines and who are not eligible for Medicaid or Medicare. Basic Health enrollees pay a minimum monthly premium of $34, in addition to an annual deductible and coinsurance subject to an out-of-pocket maximum; the BHP subsidizes the remainder of plan costs. Basic Health enrollment peaked at over 100,000. Budget constraints led lawmakers to reduce BHP enrollment by 43 percent in the 2009-2011 budget cycle and introduce a waiting list. Now enrollment is at 37,000 with a waiting list of 252,000 people.

To support the financial management and premium billing functionalities required to collect money from enrollees and provide payments to participating health plans, Basic Health uses the Member Billing and Management System (MBMS). Basic Health is the only program that uses MBMS, which handles eligibility, enrollment, and billing needs, and leverages some components of the PAY1 system controlled by PEBB. While MBMS adequately supports the

Basic Health business needs, feedback from BHP staff indicated that it will likely not meet the ultimate goals of the exchange, which include web-based and self-service functionality. However, the financial model underlying this system may provide some important guidance to the exchange, particularly on the administration of premium tax credits.

The funds flow, eligibility interface, and billing functionality performed by MBMS are robust and apparently unique in the market place. After eligibility determination and enrollment is performed, a record is created in MBMS. MBMS then sends notification to PAY1, which will store the member account balance. MBMS automatically reads the account balance and sends the member an invoice. After payment, PAY1 sends the 820 to the carrier and MBMS sends the 834. This system allows Basic Health to bill individuals, participating employer groups, and also pay carriers all at the same time. Dual system interaction would allow the exchange to bill an individual for buying up from the benchmark plan and bill the group simultaneously. The MBMS system could be modified to perform this function, but staff expressed concern over whether the system would really meet the needs of the exchange. Basic Health staff also expressed their frustration over the unavailability of a similar system in the IT marketplace. Basic Health has put their billing system out to bid multiple times, but have never found a vendor that was able to design a premium billing system to meet their model. Exchange leadership should consult with Basic Health staff on MBMS to inform their design and thinking about an exchange billing system.

For 2012, the BHP is currently preparing a joint procurement with Healthy Options (Washington's Medicaid MCO program). While the purchase will jointly cover both programs, each program will constitute its own risk pool.

In addition, since changes in the program structure mean that premium cost is no longer an enrollment driver in the program, Basic Health is experimenting with using creative provider network/capacity strategies to incentivize enrollment in participating health plans.

Medicaid and Apple Health for Kids

Medicaid is a program that provides health coverage to low-income Washington residents, including families with children, pregnant women, medically needy individuals, the elderly, and people with disabilities. Washington's Medicaid program was recently moved from The Department of Social and Health Services (DSHS) to the Health Care Authority (HCA). The program serves over 1 million recipients, 50 percent of whom are enrolled in managed care. Medicaid FFS expenditures in Washington for the state fiscal year totaled $4,200,000,000. Medicaid offers the exchange capabilities in the areas of navigator management, eligibility determination, enrollment, customer service, and outreach.

Medicaid, in its Apple Health for Kids program, has significant experience with navigator-like enrollment assistance. This program was created to compensate selected community groups for assisting families with enrollment into the program. Compensation was tied in part to the number of children the community group successfully enrolled into the program. Enrollment

assistance was provided by one designated community partner or public health official per county. Staff members were able to track where applications came from through a barcode attached to all electronic and paper applications. Medicaid used population surveys to measure effectiveness of the program. Although supervising staff felt there could be improvements in the compensation model, they felt the program did enhance accountability for community outreach efforts, and both the program and the community groups were happy to have information on application status and ultimate determination of a case.

More can be learned through interviews with the community partners that participated in this program, as these groups may be able to provide valuable insight on what worked, what didn't, and particular geographic and demographic factors for the exchange to consider when developing a navigator program.

The customer service platform for Medicaid members (post-eligibility) and providers is built from the state's MMIS system – Provider 1. Staff mainly handles application, card, and FFS issues from members, as well as full provider customer service including credentialing and claims. This platform offers very sophisticated IVR and CRM tools. Provider 1 also offers flexible reporting, data management, and carrier functionality. However, the billing/financial capabilities of the system still need to be assessed. Medicaid does not currently use the system for its billing/collections needs, but rather utilizes the Aquity system at the Division of Child Support (a system that does not offer the varied means of payment needed by the exchange). Provider 1 is also not designed to receive any provider network information from carriers. More analysis would need to be done in order to completely understand which functions Provider 1 could assist with. Also, based on staff feedback, it was apparent that integrating customer call center functionality between Medicaid and the exchange would be challenging. Should the state elect to rely on Provider 1 for some functions of the exchange, whether and how the exchange should centralize call center functions across health programs would require further analysis. One option would be to utilize the IVR functionality and one centralized toll free number that would direct the customer to specialized call centers (including at the exchange).

Department of Social and Health Services

The Washington State Department of Social and Health Services (DSHS) determines eligibility for Medicaid using the Automated Client Eligibility System (ACES). ACES is a legacy system that determines eligibility for cash, medical, and food assistance programs. ACES appears to be one option to achieve integration and operability between Medicaid, the exchange, and social services. However, staff from the exchange, DSHS, and Medicaid will need to carefully assess the required timeline, functionality, and competition for internal business and technical resources that are needed to make the required technological enhancements to support the exchange.

DSHS is also developing a web portal called Washington Connection that helps low-income families and individuals apply for and access a variety of subsidized programs. Through Washington Connection, residents can learn about and apply for food, cash, and medical assistance; child care subsidies; long-term care services and support; and drug and alcohol treatment. The portal allows existing members to report changes in their circumstances, initiate eligibility reviews, and access their benefit account (where members can review application status and manage their account information). Washington Connection currently links with ACES, but a separate rules engine is being developed for use on the site. The goal of Washington Connection was to offer one unique member portal for state services, including health care. Because of the "no wrong door" requirement of the ACA, the exchange must evaluate whether and how they will need to link to Washington Connection.

The Office of the Insurance Commissioner

The Office of the Insurance Commissioner (OIC) performs a wide range of regulatory, oversight, and consumer protection functions that touch on multiple aspects of the commercial insurance industry. The agency works to protect consumers, collect and distribute information, monitors the solvency of insurance companies, and oversees insurance product development and pricing. The OIC is funded through an administrative fee assessed on insurance companies and revenue generated from broker licensure fees. Because the OIC already performs extensive regulatory and oversight functions for the health insurance market, and also holds responsibility for the implementation of several aspects of the ACA in Washington, the exchange will need to work closely with the OIC to coordinate the implementation of reform, minimally, to ensure the two bodies are working in coordination at not at cross purposes. In addition, as the agency possesses significant regulator infrastructure, there may be additional opportunities to leverage this asset more specifically through collaboration on some consumer or regulatory functions. In particular, Wakely believes the exchange should further explore opportunities to collaborate with OIC as a resource on broker credentialing, consumer protections and outreach, plan rating and product review, risk adjustment, and transitional reinsurance.

Activities performed by the agency include:

- Company Supervision and Market Oversight: This function includes the licensing, certification, and auditing of the 56 insurance companies based in Washington State, and monitoring the other 2,144 authorized to do business here. The OIC must assess the financial solvency and provider networks of each carrier as part of the licensing process. The OIC also conducts an annual analysis of the entire insurance market.
- Producer Oversight: The OIC controls the licensing and education of all agents and brokers in Washington.
- Product Oversight and Rate Review: The OIC reviews and approves specific plan and rates filed by the insurance carriers. This analysis includes a rate review process staffed by on site actuaries.

- Consumer Protection: Through a network of community groups, volunteers, and in-house staff, the OIC monitors complaints/appeals from consumers and also performs consumer education.
- Enforcement: The OIC has a legal unit charged with the investigation of producers and carriers. They also recover money for consumers with insurance disputes (the agency recovered $9 million in 2010).

As the entity charged with overseeing Washington's insurance market, the OIC performs a number of information gathering, analytical, and reporting functions that are analogous to the more "regulatory" aspects of the exchange's business requirements. For example, the OIC collects and reviews a significant amount of information from carriers as part of their licensure, rate review, and product review processes that would be similar to the "credentialing" or "qualification" aspects of the QHP certification. It also makes public a significant amount of information related to plan activities, products, and financial position of health plans that is similar to the type of public reporting and quality reporting that will be required of the exchange. Similarly, the agency, as part of its rate review process, collects and subjects to actuarial analysis plan pricing, premium, and financial performance information that, while not encompassing the full scope of functionality that would be required to operate a state-run risk adjustment program, has many similar features.

The OIC also holds responsibility for licensing and overseeing the activities of the state's insurance producers, including brokers. The OIC has an online self-service portal for brokers to apply and pay for their licenses online. This web tool also contains links to all associated training materials brokers need to review in order to operate in Washington State. A list of certified brokers is available on the web as a comparison tool for consumers and carriers to use. The OIC also provides broker oversight and enforcement, which includes a consumer protection function as well as intensive work and relationships with brokers, carriers, and consumers. This structure and expertise may be valuable to the exchange as it develops a strategy and approach to working with and managing this important stakeholder community. Feedback from OIC staff indicated that their experience would not lend itself to contributing to the management of navigators (another type of producer for the exchange) but that their broker oversight and enforcement team could certainly provide the exchange with the knowledge base needed to work with the broker community.

In addition to its analytical and licensure activities, the OIC oversees several consumer outreach, information distribution, and grievance support functions to help consumers navigate the insurance market. One such program is SHIBA, a statewide network of volunteers that provides assistance to residents accessing health services and was started primarily to assist individuals gain access to Medicare benefits. The program is funded by an administrative fee on carriers and supplemented with federal funding. The program operates with the assistance of 400 volunteers, who are recruited, trained, and managed by a network of 20 community organizations located around the state. SHIBA's network of volunteers could potentially be trained to be navigators. The program may also provide a model for performance measures for navigators. The OIC uses a web application to obtain data from volunteers and organizations to send to CMS as part of their reporting requirements, but the agency also uses the data to measure consumer satisfaction.

In addition to SHIBA, the OIC has 8 analysts in house that staff a call center for consumer questions about insurance and appeals. These analysts use a detailed case management system to track consumer interaction, which is also used by the OIC to measure satisfaction. Future outreach plans include a system that notifies consumers via email when their plan files new rates. The OIC was the recipient of a consumer assistance grant from CCIIO. Staff is using that grant money to organize an IT infrastructure to create a stronger referral process between different programs and agencies. SHIBA, the OIC call center, and/or consumer assistance program may provide valuable insight for the exchange as a model. Due to the regional and geographic differences in Washington, having these existing community resources could prove vital. Also, the consumer satisfaction data compile by the OIC will have to be shared with the exchange to assist in the measurement and rating of QHPs.

V. Summary of Key Findings by Core Work Process

Based on Wakely's review of existing state health programs, the following section will highlight the key elements identified that warrant further study to determine whether the existing capacity will be able to support exchange functionality. The section is organized by core work process to identify elements from the agencies examined that will potentially support each process.

Table 3. Summary of Key Findings by Core Work Process

Core Work Process	Existing Washington Resources Warranting Closer Examination
1. Oversight, Governance, and Program Evaluation	• The exchange will establish its own independent governance and oversight structure, but will work closely with associated agencies and existing workgroups. • A number of independent boards and authorities exist in the state and they may provide a template for governance model and board practice.
2. Internal Administration	• The HCA currently provides the exchange with payroll and human resources services, as well as employee benefits, IT infrastructure, office space, and furniture and fixtures. Once the exchange becomes independent, it may elect to continue using some state elements, such as employee benefits and HR functionality. Relying on the state for some of these functions may be cost- effective in the short term while exchange staffing needs remain uncertain. • The exchange may want to use existing HCA policies and procedures as a template for administrative and HR practices.
3. Financial Management	• Although the exchange will establish financial independence and hold custody of its own funds, leveraging existing state banking relationships or investment funds may provide a cost effective means to manage exchange cash and investments. • Currently, the exchange is reliant upon HCA for accounting, financial reporting, and internal financial control functions. Existing state policies and procedures could provide a starting point for the development of similar protocols within the exchange.
4. Eligibility Determination	• PEBB, HIP, Basic Health, and Medicaid all determine enrollee eligibility separately. The systems utilized differ in scale and level of complexity, but none currently has the functionality needed to provide the full scope of exchange eligibility needs without substantial remediation. However, feedback from staff identified the ACES system under DSHS as an asset that could be modified to support exchange eligibility requirements. • Administration of the premium tax credit is a function unique to the exchange and is not performed by other health care agencies.
5. Premium Tax Credit Administration	• The MBMS system under BHP may provide guidance for the design phase and/or requirements definition with respect to administering funds flow, one component of the tax credit administration functionality. • No existing web portal currently exists that provides the full scope of exchange-required service, including eligibility determination, automated plan comparison, decision support, and rating mechanism. However, certain elements that are similar to discrete functions required for the exchange web portal exist in a number of different areas.
6. Website & Online Shopping	• PEBB displays plan benefits and costs online for its members, and provides enrollees with online account management and customer self- service tools, such as the FUZE inquiry interface • HIP provides online services that help employees find a qualified broker, lists different plan designs for comparison (without a price comparison), and provides some online decision support tools including a subsidy estimator.

	• The OIC provides a wide range of information for consumers related to brokers, carrier, and insurance coverage
7. Enrollment, Billing, and Collections	• PEBB, Basic Health, and HIP all perform enrollment and billing functions similar to the exchange. However, this infrastructure is geared toward the operation of each individual program and would require substantial remediation to support the exchange. Also, because these systems are currently supporting exclusively individuals or groups, the exchange would need to assess the ability of any individual or combination of systems to support both the SHOP and the Non Group exchange. • Of existing billing systems, the billing and enrollment functionality employed by HIP, as well as the MBMS system utilized by BHP, offer the most comparable functionality to what would be needed for the exchange. • Although it is not currently used to perform billing and collection functions, feedback indicated that Provider 1, the state's MMIS system, possesses the functionality to support these activities.
8. Customer Service	• While all programs operate some form of call center/customer support, none seem to meet the requirements of the exchange. It is critical to the exchange's commercial success that it establishes a brand and reputation for high customer service for a diverse population. An important component of this is to create a sophisticated and real time referral mechanism with any existing state call centers to ensure that the exchange meets the federal "no-wrong door" requirement for seamless customer service between Medicaid and the exchange. • A number of agencies contract vendors to provide this service, including HIP (UMR) and PEBB (Regence). Current contracts with UMR and Regence should be reviewed as models for customer service and/or performance measures. • Given the multitude of entry points, particularly for individuals accessing subsidized coverage, Wakely recommends a thorough analysis of customer service functions and customer interfaces to help the exchange better understand the customer service entry points currently available for consumers and options that exist to ensure the consumer experience is as simple as possible across agencies.
9. SHOP Specific Functions	• The enrollment, billing, and employer/carrier interfaces developed by HIP and UMR are most similar to the functionality that will be required to operate the SHOP. However, key functions, such as the automatic generation of quotes, employer account management, and automated broker interface, do not currently exist. • PEBB performs some employer benchmarking and contribution adjustments, as well as rate compositing functions. The MBMS system operated by BHP performs billing, collection, and interface to eligibility that is similar to operations performed by the SHOP.

10. Outreach & Marketing	• PEBB has a communications staff that manages the creation of member materials, open enrollment publicity, and benefit guides. • HIP has developed strong stakeholder relationship with small businesses, carriers, and the broker community, as well as experience, through a vendor in developing information and marketing materials for small businesses. • The SHIBA program, operated by the OIC, includes a network of volunteers and community organizations that would be a useful asset to help spread the message about the exchange to the uninsured. The OIC also holds data on insurance take up around the state that could be useful for the exchange to target Outreach/resources to the places their most needed. • Medicaid and DSHS have strong existing relationships with community organizations and local entities throughout the state. This community presence and experience will be valuable to support exchange outreach efforts.
11a. Broker Management	• The OIC performs credentialing and oversight for brokers and other producers that the exchange may be able to draw upon. • HIP developed a broker training program and materials to support the programs SHOP-like functions. They also developed (a) a list of qualified brokers and (b) a shorter list of brokers with a strong interest in participating in a state-subsidized program.
11b. Navigator Management	• Medicaid's experience working with community groups and tracking enrollment performance with Apple Health for Kids can provide important lessons and specific tools. Washington is one of the few states who have experimented with compensation and evaluation of its community groups in this way and this experience could be a valuable asset to the exchange.
12. Qualified Health Plan (QHP) Certification	• PEBB, Basic Health, Medicaid, and HIP all have experience procuring health benefits for public programs, and PEBB, BHP, and Medicaid are currently active purchasing agents interfacing with carriers in the market. PEBB has extensive experience working with carriers on benefit design and product development, as well as analytical infrastructure to assess plan bids and rates. HIP engaged in an extensive benefit design and plan tiering exercise to select plans and benefit designs to offer to small employers. The exchange will want to understand existing carrier relationships with other health programs, as well as utilize their contracting and management experience/expertise. • The OIC collects and reviews a large amount of data from carriers as part of their rate review, market oversight, and consumer protection functions, including premium cost, financial solvency, medical trend, provider contracting, and customer satisfaction. As this data collection and plan assessment will be an important element of the certification process, their capacity and/or expertise may be valuable assets of the exchange.
13. Plan Rating System	• PEBB has data warehousing and information analysis capabilities specific to the UMP that is a common source for reporting and benchmarking activities.

	• The OIC collects and reviews a large amount of data from carriers as part of their rate review, market oversight, and consumer protection functions, including premium cost, financial solvency, medical trend, provider contracting, and customer satisfaction. They also publish a significant amount of public information related to plan performance and key statistics. • Again, a common plan rating system could prove useful and efficient.
14. Reinsurance and Risk Adjustment Program	• PEBB performs basic risk adjustment, but it is specific to its own, captive risk pool and limited to the three health plans offered by the agency. • The OIC performs a portion of the duties that would be required to operationalize a risk-adjustment program, including a collection of carrier premium information, benefit level, and loss ratios. However, they lack some of the more detailed analytical capacity, such as a claims warehouse and risk adjustment model, which will be required to manage such a program, should the state elect to do so. • The OIC performs a wide range of consumer protection and public reporting functions related to health insurance coverage and consumer experience. The entity not only has the experience, but also many of the data collection and review processes necessary for adequate analysis and tracking. Therefore, the exchange may want to link or populate this information on theirs.
15. Consumer Protections & External Reporting	• There is a component to the reporting function that will be highly exchange specific (i.e., related to the operations and performance of the exchange and its target population) for which no current capacity exists outside the exchange. • In their capacity as regulator and consumer oversight bureau, the OIC has multiple groups tasked with collecting, reviewing, and disposing of consumer grievances and appeals related to their health insurance coverage. As the appeals function is a primarily process-driven endeavor, coordinating with or leveraging the OIC's expertise with respect to this regulatory function should be strongly considered.
16. Exemption Certificates & Appeals of Eligibility	• Similarly, Medicaid has an appeals process related to eligibility determination that is relevant for individuals seeking coverage through the Non Group exchange. • Although not encompassing near the scale that will be required for the exchange, HIP does have some experience dealing with the type of employer related appeals concerning eligibility that will be filed and developed plans for scaling this function up based on anticipated growth.

Appendix 1. Conceptual Framework for Exchange Decision Making

Discussion of Key Considerations

Washington State has a large number of publicly sponsored health care and health oversight programs. As would be expected from multiple organizations engaged in a similar line of business, there is certain degree of existing overlap in the functions performed by these agencies, as each has the administrative and operational infrastructure required to serve individuals falling under its jurisdiction and mandate, many rely on the same health carriers to service their members, and many interface with the same or similar populations as individuals move from one entity to another to seek health insurance benefits as their circumstances and demographic profile changes over time.

By bringing three major health care programs under the umbrella of the HCA, Washington has taken steps toward consolidating the governance and operations of some of the major health care programs in the state. As the integration between Medicaid, BHP, and PEBB matures, we would expect the state to gradually increase the level of operational integration between these three programs. Some current efforts, such as the joint procurement of Medicaid and BHP managed care plans, suggest that the state is already moving in the direction of enhanced collaboration and integration between health insurance programs. The introduction of the exchange, therefore, raises important questions related to how the new organization will or will not relate to existing state programs.

While we have identified several existing and highly functional administrative and operational systems, processes, and areas of expertise that relate to required functions of the exchange, the extent to which these elements can or should be incorporated into the state's efforts to develop the exchange is dependent not only on whether these items exist, but on several additional factors that must be carefully considered. We have outlined some of these considerations below, as we believe they are central to identifying which components, if any, can or should be incorporated, shared, or repurposed for assistance in meeting the requirements of the exchange. We also share the following considerations to highlight the criteria we used to develop our recommendations, which are presented in the next section of this report.

1. Opportunities for Administrative Efficiency

   The most obvious reason to consider leveraging existing infrastructure is to achieve administrative efficiencies in not having to re-create functions from scratch, or to achieve greater scale efficiencies from the state's existing fixed costs. To assess the level of efficiency, the state must perform a cost/benefit analysis to weigh the pros and cons of remediating existing systems or processes to serve the needs of the exchange, which should include an assessment of how close the component is to being able to service

the exchange, what functionality will be gained or sacrificed to repurpose or adopt the element, as well as the non-financial considerations, described in part below.

2. Functional Criticality, and/or Uniqueness

How critical and/or unique a function is to the exchange will have a strong impact on whether the organization seeks to re-use, share, or rely on an existing entity to help support the function. To help structure the assessment of different components, it is useful to group functions into one of three categories as illustrated with examples in the figure below. Functions deemed as critical to the exchange, while unlikely to be shared with an outside government entity, may still be outsourced to a Third Party Administrator or another vendor contracted to the exchange.

Figure 1. Criticality and Uniqueness of Exchange Functions

Critical Function, Unique to the Exchange	Critical Function, Similar to Other Programs	Secondary Function, Similar to Other Programs
• Tax Credit Administration • Broker Compensation • Carrier interface for SHOP Functions	• Eligibility Determination • Customer Call Center • Health Plan Certification and Benefit Design	• Transitional Reinsurance • Producer Credentialing

Items that fall on the left-hand side, such as tax credit administration, are both critical functions of the exchange and unique to exchanges, and therefore unlikely to be found in existing programs. Items at the far right are less critical business functions of the exchange, and therefore strong candidates to share or rely on existing programs if available. Those in the middle will require careful consideration, as they are both critical to the program, yet similar to functions performed by existing programs. Thus, while potentially technically capable of being used in some way, the exchange will need to identify on a case-by-case basis which should or should not be utilized.

3. Potential for Market Confusion and/or Frustration

For many functions, mostly related to QHP certification, but also including regulatory interfaces with businesses and individuals, and data acquisition to support exchange analytics and risk adjustment, the exchange will interface with the same parties and for similar purposes as other current programs. Finding ways to consolidate, coordinate, or streamline these interactions may prevent market confusion or frustration on the part of businesses or carriers now interfacing with several different state agencies.

4. Autonomy vs. Integration

Although less conducive to empirical analysis than other dimensions, finding the appropriate balance between autonomy and integration will be one of the most critical considerations for the exchange as it moves down the challenging timeframe towards ACA implementation and develops a strategy for positioning itself within the state and in relation to both the market and existing programs. As illustrated under consideration (2), above, the exchange is likely to seek greater levels of autonomy relative to items situated on the left-hand side of the criticality scale, as well as for items related specifically to key strategic and governance components of the exchange.

Recommendations

Based on Wakely's review of existing state infrastructure and review of relevant state agency capacity, as well as the key considerations outlined in the previous section, we offer the following recommendations as areas for further exploration and consideration by the exchange. Please note that these recommendations are draft and preliminary, and will be further refined and developed in collaboration with exchange staff as this document is prepared for final review.

Table 1. Criticality and Uniqueness of Core Work Processes

Major Business Area	Core Work Processes	Critical Function & Unique to HIX	Critical Function, Similar to Other Programs	Secondary Function, Similar to Other Programs
Exchange Governance & Administration	1. Governance & Oversight	✓		
	2. Internal Administration	✓		
	3. Financial Management	✓		
Operational Systems	4. Eligibility Determination		✓	
	5. Premium Tax Credit Administration	✓		
	6. Website & Online Shopping	✓		
	7. Enrollment, Billing & Collections		✓	
	8. Customer Service Call Center		✓	
	9. SHOP-specific Processes	✓		
Communications	10. Outreach & Marketing	✓		
	11. Broker and Navigator Management	✓		
QHP Certification	12. Qualified Health Plan (QHP) Certification		✓	
	13. Plan Rating System		✓	
Regulatory & Reporting	14. Reinsurance & Risk Adjustment Program			✓
	15. Consumer Protections & External Reporting			✓
	16. Exemption Certificates & Appeals of Eligibility			✓

Note: Each core work process consists of several activities and processes. Within any given process, there are some functions that are unique and critical, while others could be done in coordination with a separate entity. Additional refinement is required to assess these functions at a more detailed level.

Regulatory Functions

The most salient issue that emerged from our review of existing state programs is related to the need on the part of the exchange to determine how it should balance its role as a market actor and business partner with the regulatory requirements specified in the ACA. In particular, this issue touches on the potential relationship between the exchange and the OIC, which, while potentially complex, may be important to the success of the exchange, as well as potentially fruitful for both agencies if they are able to harness and coordinate their complementary capacities.

The major business functions required of the exchange encompass both business and administrative functions more analogous to a private company, as well as public-facing and reporting functions more similar to a government agency. This is true at the level of core work processes, as well as within each core work process. For example, the broker management function involves a credentialing and oversight function familiar to government oversight authorities, as well as a business relationship similar to that which exists between a company and its commission-based sales force. Similarly, the QHP certification process blends the regulatory functions of compliance verification and credentialing with the business functions of strategy and market positioning. Although at times advantageous to play both roles simultaneously, doing so can also create challenges for the exchange in its interactions with the market and other authorities.

The determination of how to appropriately balance these two roles should include a consideration of the ways the exchange may choose to collaborate with the OIC, which currently performs some similar functions to items required of the exchange and is currently tasked with implementing some additional key components of the ACA. Regardless of whether the exchange elects to leverage the OIC in the performance of its duties, the two agencies will need to work closely together on a host of issues on an ongoing basis and the OIC's regulatory expertise and capacity may be an important resource for the exchange. Although a detailed review of the ways in which the two agencies could potentially collaborate is beyond the scope of this document, we will provide some specific examples of areas and ways that such a partnership could be handled by focusing on QHP Certification and Broker Management. Other potential areas to explore include Risk Adjustment and Reinsurance, Consumer Protections and Reporting, and Exemption Certificates and Appeals of Eligibility.

In certifying, decertifying, and recertifying Qualified Health Plans to participate in the exchange, the exchange performs a both a compliance monitoring role in approving plans for sale through the exchange as well as a vendor role in providing a sales outlet for the sale of insurance and providing related administrative functions. There are a number of critical components that go into the QHP certification process, but a few of the major functions include a strategic vision, goal setting, and decision making function; an operational and technical interface component; and a credentialing function that involves significant amounts of data collection, review and analysis. Based on the OIC's existing infrastructure to support data collection and analysis, as well as its existing regulatory role in monitoring health plan performance, the agency could provide

assistance in relation to the third of these functions, while its work would be an input to support the development of the first two. This would also prevent the duplication of effort on the part of carriers by maintaining a single flow of information, and clearly delineate the regulatory vs. operational responsibilities performed under the program.

A similar distinction in roles could be applied to the oversight and management of brokers participating in the exchange. This function again involves both a credentialing and oversight role as well as a market-facing, business relationship focused on selling insurance. Following a similar logic to that employed relative to QHP certification, the exchange could rely on the OIC's existing credentialing and oversight capabilities to certify and credential qualified brokers, while maintaining internal management of its own broker management, outreach and operations.

Regardless of how closely integrated the exchange seeks to become with the OIC, we believe it to be one of the organization's critical relationships, and one that necessitates close coordination.

Core Systems

Regardless of the approach elected by Washington for the development of its exchange systems, these systems must interface with and be integrated into existing state programs to comply with eligibility requirements of ACA. Approaching the systems in an integrated fashion (e.g., running the exchange and Medicaid through the same eligibility system) makes sense from a cost standpoint, as the state should realize economies of scale from leveraging the same technical infrastructure for a larger population. However, the opportunities for administrative efficiencies must be balanced against the criticality and uniqueness of the functions being discussed. Given the strategic and operational important of core IT systems for the exchange, as well as the new and unique functionality required to operate the exchange, we recommend that the exchange maintain a high level of control, ownership, and oversight of its core IT systems. In areas where joint operation is employed (e.g., eligibility), the exchange should maintain a strong voice in the design and operation of the system to ensure it is structured in a way that meets the requirements for exchange functionality.

An additional issue the exchange may wish to consider is whether or not to integrate the SHOP and non-group exchanges from a systems and/or vendor perspective. Because the SHOP exchange in Washington will likely be quite small, this may provide scale economies for the SHOP exchange.

Based on our experience running an exchange, as well as observations of the market, we have found a particular lack of solution related to a billing system that is able to interface cleanly with a dynamic eligibility system and provide the type of solution required by the exchange or similar state programs. These observations were echoed in our discussion with BHP, which has significant experience in working through some of the relevant issues.

Customer Service

There are a large number of customer call centers currently run or managed by health programs within Washington, and the connectivity and overlap between these programs is extensive and complex. At the same time, customer call center functionality is widely available from vendors in the market, with a wide array of firms able to provide high quality product on a cost effective basis. Thus, while we would suggest that the exchange seek to outsource this function, given the extensive overlap between populations and functions across state agencies, developing a detailed strategy for how these numbers and/or call centers relate to each other will be critical to providing streamlined, high-quality customer service across programs within Washington.

Appendix 2. Staff Consulted for Resources and Needs Assessment

Staff consulted for Needs and Resources Assessment		
PEBB	• Mary Fliss • Barb Scott • Renee Bourbeau	
HIP	• Beth Walter • Shannon Hannan (UMR)	
Basic Health	• Preston Cody • Christy Vaughn • Eileen Harris • Bob Longhorn	
Medicaid	• Manning Pellanda • Mary Wood	
OIC	• Barb Flye • Leslie Krier • Gayle Pasero • Jeff Baughman • Dave Marty • Carol Sureau	• John Hamje • Janis LaFlash • Mary Childers • Lichiou Lee • Andrea Philhower
HCA	• Beth Walter • Molly Voris • Richard Campbell • Cathie Ott • Andrew Cherullo • Annette Meyer	• Karen Glabas (Cambria) • Jason Leung (Cambria)

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Information Technology Infrastructure Review and Assessment

July 22, 2011

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Washington State Health Care Authority

Information Technology Infrastructure Review and Assessment

Final Assessment

July 22, 2011

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Objectives of IT Infrastructure Review & Assessment

- Conduct IT Gap Analyses for a Health Insurance Exchange (HIX) in Washington State.

- Evaluate various solution alternatives against key criteria including the identification of System Assets that can be leveraged for the Exchange.

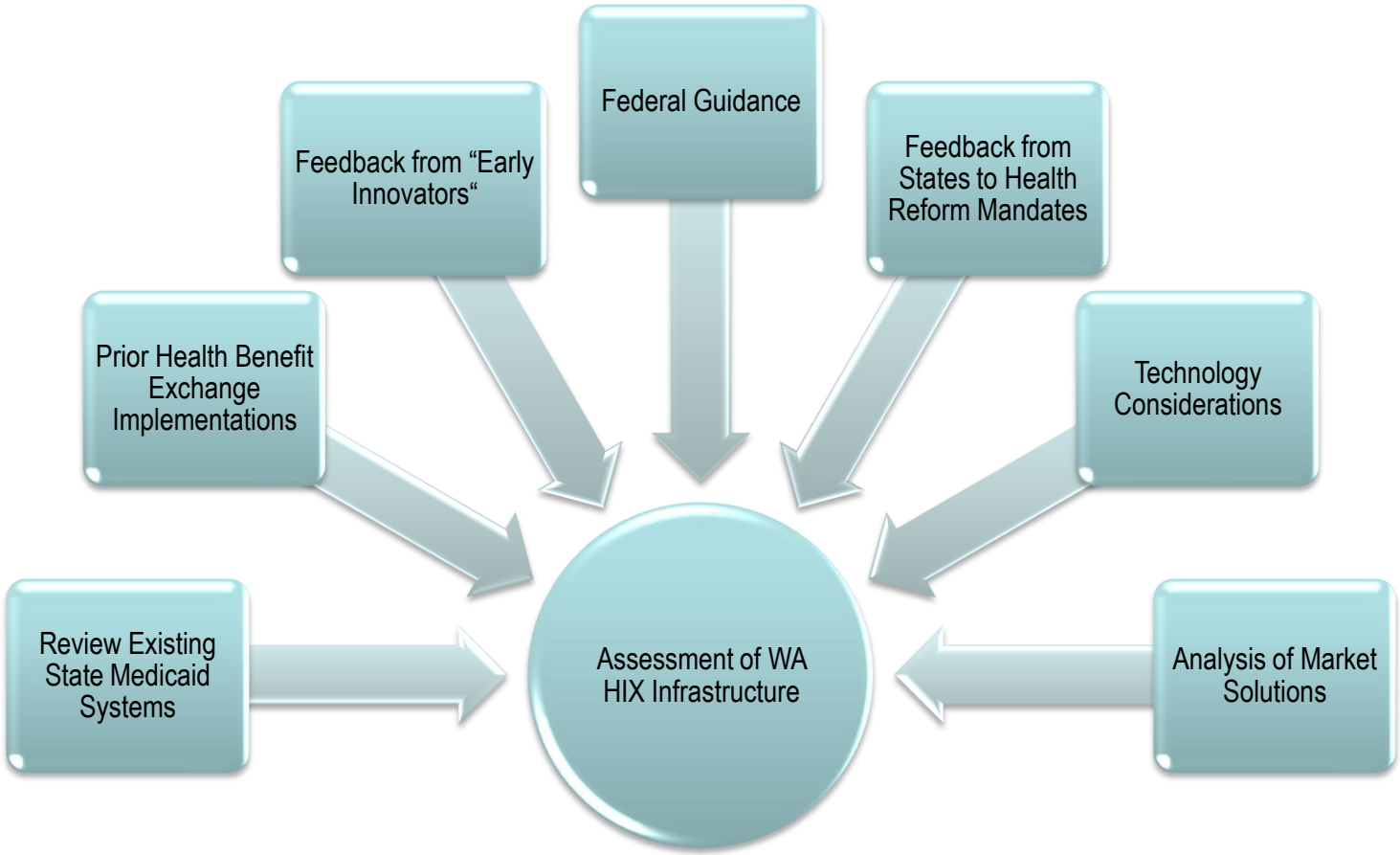
Key Topics

1. IT Assessment Guiding Principles
2. IT Assessment Approach
3. Washington State Systems Reviewed
4. HIX Overview
    - 4.1 Key Benefits of HIX
    - 4.2 HIX Requirements Overview - Core Component Areas
    - 4.3 HIX Conceptual Solution Overview
    - 4.4 HIX Capacity Requirements
5. CMS Guidance for Exchange and Medicaid Information Technology (IT) System
    - 5.1 CMS Guidance Highlights
    - 5.2 CMS - Technical Architecture Guidance Framework
    - 5.3 CMS - Technical Architecture Principles
    - 5.4 CMS - Technical Architecture Standards
6. Washington State Systems Review – Analysis and Findings
    - 6.1 Overall Findings
    - 6.2 Existing Systems – Functional Requirements Fit Gap Analysis
    - 6.3 Existing Systems – Non-Functional Requirements Fit Gap Analysis
    - 6.4 Technical Requirements
7. IT Review and Assessment - Summary Findings
8. HIX Solution Options
    - 8.1 Enterprise Architecture Recommendations
    - 8.2 Objective and Key Criteria for Alternatives Evaluation
    - 8.3 Solution Options
9. Appendices

IT Assessment Guiding Principles

- Business needs must drive technology solutions
- Leverage existing state investments in technology where feasible
- Cost Efficient
- Flexible and Scalable to meet changing regulatory environment
- Consistent with State Enterprise Architecture and IT Standards
- Conform with HIPAA, State Security and Privacy policies
- Minimize changes to existing legacy state systems
- Minimize implementation related risks
- Easy to use for consumers
- ADA compliant
- Sustainable

IT Assessment Approach



A comprehensive approach was used to conduct the assessment and validate the findings.

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Washington State Systems Reviewed

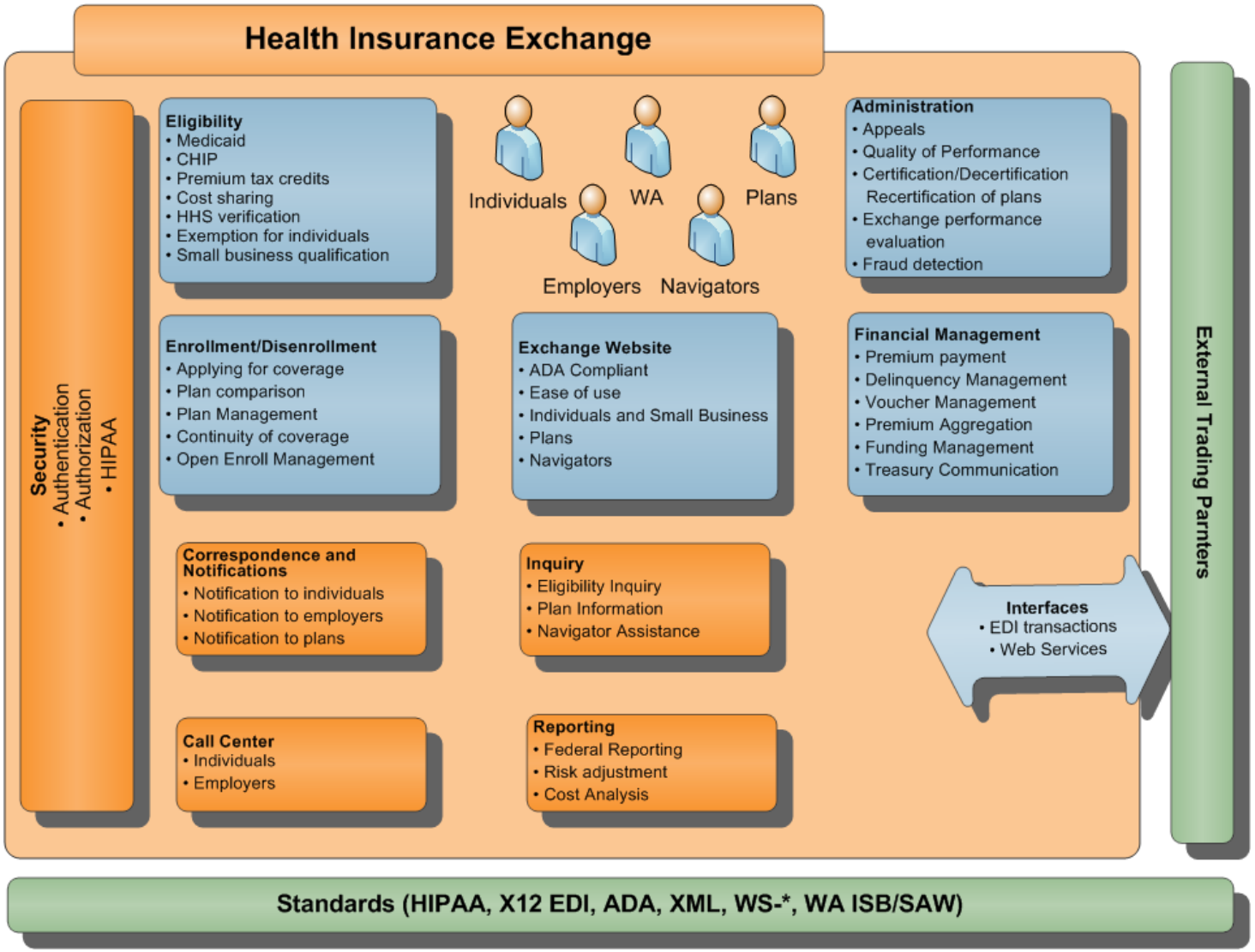
ID	System Name	System Description	System Owner	Status
1.	ACES	ACES supports eligibility for a large number of programs including cash, medical, and food assistance	DSHS, ESA	In Production
2.	Washington Connection	Statewide Portal for self screening, application submission, renew benefits and report changes for TANF, SNAP, Medicaid and other medical programs	DSHS, ESA	In Production
3.	ProviderOne	Claims Processing and Provider Payment System	HCA /MPA	In Production
4.	OneHealthPort	Community that facilitates sharing of information and implementation of Health Information Exchange	OneHealthPort – State Designated Entity	In Design and Development
5.	Client Hub*	Provides a unique identifier for clients(including Medicaid) across multiple programs and systems	DSHS/ISSD	In Design and Development
6.	Provider Hub	Provides a unique identifier for all Medicaid Providers	HCA/MPA	In Design and Development

Note: Client Hub – Is a planned project under ProviderOne Phase 2 that enables tracking of clients that receive various health care services*

Key Benefits of HIX

- Provides an organized and competitive marketplace to purchase health insurance
- Provides information to help individuals understand available options and compare plans
- Provides a set of common rules regarding plan offering and pricing
- Creates an administrative mechanism and facilitates enrollment into health plans
- Assists individuals in determining if they are eligible for public health programs or premium tax credits or cost sharing subsidies
- Provides choice of health plans for employees of small businesses

HIX Requirements Overview - Core Component Areas



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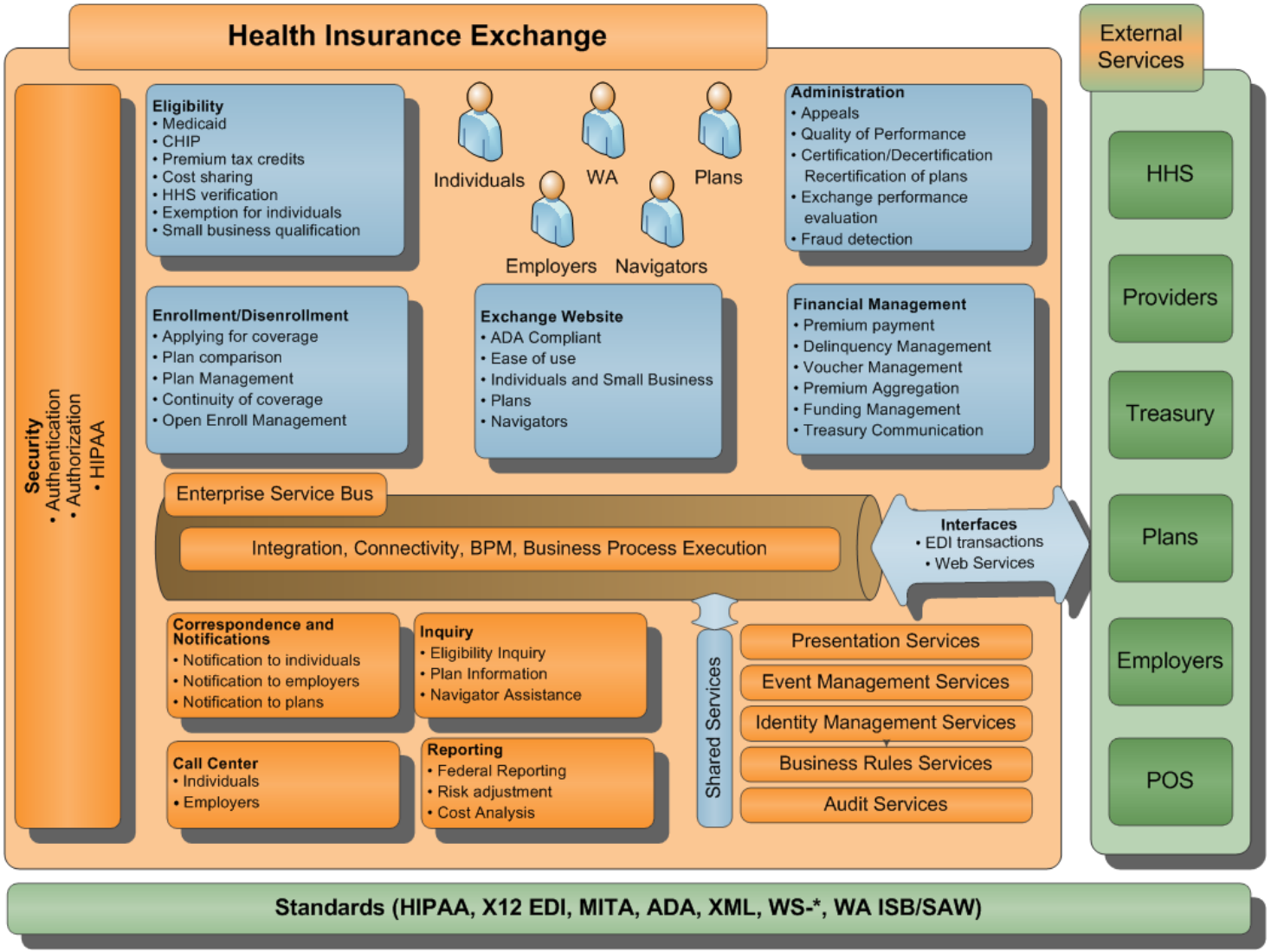
HIX Conceptual Solution - Overview



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CMS Guidance for Exchange and Medicaid Information Technology (IT) Systems Version 2.0 May, 2011

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CMS Guidance Highlights

- IT Systems should be simple and seamless in identifying people who qualify for coverage through the Exchange, tax credits, cost-sharing reductions, Medicaid, and CHIP. States should aim to provide the same customer experience to all individuals seeking coverage, regardless of source or amount of financial assistance for which they may qualify or whether they enter the process through the Exchange, Medicaid, or CHIP.

- Most individuals will be evaluated for eligibility in the Exchange, tax credits, Medicaid, and CHIP using a coordinated set of rules. As a result, we expect the use of a common or shared eligibility system or services to adjudicate placement for these individuals.

- States should not assume that they will have to operate a “shadow eligibility system” for the purpose of claiming appropriate match for Medicaid individuals based on whether they were eligible under the state rules in effect prior to 2014 or are “newly eligible”.

- States will need to allocate costs of their IT systems proposals, considering OMB Circular A-87 between Exchanges, Medicaid and CHIP. The services or functions necessary to adjudicate eligibility for premium tax credits and reduced cost sharing, Medicaid, or CHIP based on MAGI must be cost allocated among those programs.

CMS - Technical Architecture Guidance Framework

Systems developed or enhanced to support functions of the HIX should adhere to these architecture framework when possible

- Exchange Architecture Guidance Framework
  - Exchange Reference Architecture: Foundation Guidance: provides the business architecture, information architecture, and technical architecture for the nationwide health insurance exchange(s).
  - Collaborative Environment and Governance Approach – Exchange Reference Architecture Supplement: provides the collaborative environment and governance approach for the nationwide health insurance Exchange(s) and federal data services hub
  - Harmonized Security and Privacy Framework – Exchange TRA Supplement: introduces and defines a risk-based Security and Privacy Framework for use in the design and implementation of the Exchanges and the data services hub
  - Eligibility and Enrollment Blueprint – Exchange Business Architecture Supplement
  - Plan Management Blueprint – Exchange Business Architecture Supplement
  - Financial Management Blueprint – Exchange Business Architecture Supplement
  - Customer Service Blueprint – Exchange Business Architecture Supplement
  - Communications Blueprint – Exchange Business Architecture Supplement
  - Oversight Blueprint – Exchange Business Architecture Supplement

CMS - Technical Architecture Principles

Systems developed or enhanced to support functions of the HIX should adhere to these architecture principles to the fullest extent possible

Systems Integration

- Provide high-level integration of process flow and information flow with such business partners as Navigators, health plans, small businesses, brokers, employers, and others.
- Apply a modular, flexible approach to systems development, including the use of open interfaces and exposed APIs, and the separation of business rules from core programming, available in both human and machine-readable formats.
- Ensure seamless coordination between the Exchange, Medicaid, and CHIP , and allow interoperability with health information exchanges, public health agencies, human services programs, and community organizations providing outreach and enrollment assistance services.

Service Oriented Architecture

- Employ Web Services Architecture/Service-Oriented Architecture methodologies for system design and development and to ensure standards-based interfaces to link partners and information at both federal and state levels.
- Employ common authoritative data sources and data exchange services, such as but not limited to, federal and state agencies or other commercial entities.
- Employ open architecture standards (non-proprietary) for ease of information exchanges

Isolation of Business Rules

- Use standards-based business rules and a technology-neutral business rule repository.
- Consistent with the recommendations issued pursuant to section 1561 of the Affordable Care Act, clearly and unambiguously express business rules outside of transactional systems.
- Enable the business rules to be accessible and adaptable by other states.
- Submit business rules to a federally designated repository.

CMS - Technical Architecture Principles - Continued

Security and Privacy

- Support the application of appropriate controls to provide security and protection of enrollee and patient privacy.

Efficient and Scalable Infrastructure

- Leverage the concept of a shared pool of configurable, secure computing resources (e.g., Cloud Computing)

Transparency, Accountability and Evaluation

- Produce transaction data and reports in support of performance
- Leverage Commercial Off-the-Shelf business intelligence functionality to support the development of new reports and respond to queries.

System Performance

- Ensure quality, integrity, accuracy, and usefulness of functionality and information.
- Provide timely information transaction processing, including maximizing real-time determinations and decisions.
- Ensure systems are highly available and respond in a timely manner to customer requests.

CMS - Technical Architecture and Standards

- Federal Data Services Hub – to verify citizenship, immigration, and tax information from Social Security Administration, Department of Homeland Security and Internal Revenue Service
- Standards
  - Comply with all relevant HIPAA Standards including those for protection of protected health information (PHI)
  - Fully comply with National Information Exchange Model (NIEM) – Data Standards defined for 11core data elements (eligibility and enrollment related)
  - Encourage States to follow Section 508 guidelines or guidelines that provide greater access to individuals with disabilities
  - Security and Privacy (HIPAA Privacy and Security Rules specify privacy and security requirements that HIPAA covered business associates must follow).

HIX Capacity Requirements

ID	Program	Baseline	Low Participation	Medium Participation	High Participation
1.	Medicaid**	1,131,418	1,319,418	1,323,418	1,326,418
2.	Medicaid Increase		188,000	192,000	195,000
3.	Exchange - Individual (between 133% and 400% FPL for subsidized coverage and others who buy through the exchange)		135,000	259,000	382,000
4.	Exchange - Employees of small businesses		14,000	31,000	47,000

Note:

*** Medicaid baseline data extracted from Medical Assistance Eligible Persons Report, June 2010 and excludes those individuals that are covered by State-Only funds. It includes dual eligibles and those who have other primary coverage.*

The Exchange Participation Data for various categories is extracted from the draft Milliman Client Report titled "Planning Washington's Health Benefit Exchange"

Washington State Systems Review– Analysis and Findings

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Overall Findings

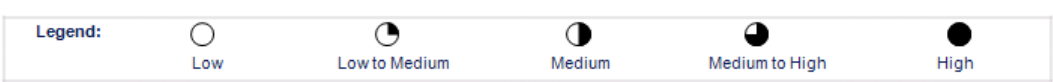
- ACES and ProviderOne are the two primary Medicaid Systems that have more of the functionality that was a Potential fit for the Exchange. The following slides provide a breakdown of the fit gap for these systems. In addition, key functional and technical assets of Washington Connection that were considered for the Exchange are summarized and their findings described under ACES. It is to be noted that Washington Connection currently functions as a portal for public assistance benefits and data captured is sent to ACES for final eligibility determination.

- “Client Hub “ and “Provider Hub” are being developed as enterprise wide assets that could be leveraged for identifying clients and providers uniquely for the Exchange.

- OneHealthPort, a community that facilitates sharing of information and implementation of Health Information Exchange (HIE), via implementation of Axway technologies, enables trading partners to Exchange electronic health information including Eligibility, e-Prescribing, Continuity of Care Document and Lab Results. Provider Directory is limited to providers participating in HIE. Only components that can be leveraged for the Exchange include Security design and concepts.

Existing Systems – *Functional Requirements* Fit Gap Analysis

HIX Components	Relevant Systems/Alternatives		
	ACES*	P1	Findings
Enrollment/Disenrollment • Applying for coverage • Plan comparison • Plan Management (enrollment/disenrollment/changes) • Continuity of coverage • Open Enrollment Management			• ProviderOne currently has enrollment transactions to plans for Medicaid and CHIP clients This functionality can be extended for new Medicaid, other subsidized clients and non-subsidized clients. • ProviderOne has a client facing component that could be extended for comparison of plans and enrollment. • None of the existing systems allow for review and comparison of plans. • While ACES Online and Washington Connection have functionality to support application for eligibility/benefits, the rest of the functions need to be rebuilt – very little is reusable.
Eligibility Determination • Medicaid • CHIP • Premium tax credits • Cost sharing • HHS verification (citizenship and income) • Exemption for individuals • Small business qualification			• ACES eligibility rules for Medicaid and CHIP is in COBOL code. This will need to be rewritten to comply with the new eligibility requirements – ability to leverage is very limited. • Existing ACES interfaces with external systems are batch or near real time including ACES-ProviderOne interface. New web services will need to be implemented to support the verification interfaces and real time eligibility determination. • Premium Tax Credits, Cost Sharing, Small Business Qualification, Verification Interfaces are all new functionality • If ACES is used for eligibility determination and/or System of Record of new Medicaid clients, there may be capacity to handle a 30% increase as many of the clients may already be known to ACES through other social service programs. ACES is also in the process of acquiring a new mainframe for additional capacity.
Correspondence and Notifications			• Both ACES and ProviderOne support correspondence generation in nine different languages. The technology of either system could potentially be leveraged for HIX. However, new correspondence templates have to be designed and logic developed to generate and print the correspondences.
Call Center			• Both ACES and ProviderOne have an IVR system that is integrated to the core application. Ability to leverage the technology is also dependent on the potential call volume for HIX – pending additional capacity analysis.



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Existing Systems – *Functional Requirements* Fit Gap Analysis *(Cont:)*

HIX Components	Relevant Systems/Alternatives		
	ACES*	P1	Findings
Financial Management • Premium payment • Delinquency Management • Voucher Management • Premium Aggregation • Funding Management • Treasury Communication			• Neither ACES nor ProviderOne has any functionality related to premium aggregation, voucher management, delinquency management, and treasury communication that can be leveraged. • ProviderOne fund management and claiming functionality could potentially be extended for funding and claiming. • Business Rules Engine from either WA Connection or ProviderOne could be used for some elements of premium aggregation, voucher and delinquency management.
Administration •Appeals •Quality of Performance •Certification/Decertification/Recertification of plans •Exchange performance evaluation •Fraud detection			• Quality of performance, Plan Management, and Exchange performance evaluation are new requirements – limited ability to reuse, if any, functionality from existing systems. • Both Washington Connection and ProviderOne have fraud detection capabilities through business analytic solutions that can be used as a starting point to build from.
Reporting •Federal Reporting •Risk adjustment •Cost Analysis			• Both ACES and ProviderOne have reporting infrastructure that can be leveraged for reporting, but will potentially require additional licenses. • ProviderOne related business analytics (Ingenix Solution) can be more of a functional fit for the reporting needs of the exchange.
Inquiry •Eligibility Inquiry •Plan Information •Navigator Assistance			• ProviderOne currently provides information on plans. This could potentially be extended. • ProviderOne provides eligibility inquiry. However, this would need to be extended for the new Medicaid and non-Medicaid individuals eligible for subsidies. • While ACES does not have any eligibility inquiry function for clients, WA Connection recently implemented the ability for clients to report a change and/or renew benefits online. WA Connection is implementing the ability for client to view eligibility information online in Aug 2011.

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Existing Systems – *Non-Functional Requirements* Fit Gap Analysis

HIX Components	Relevant Systems/Alternatives		
	ACES*	P1	Findings
Exchange Website •ADA Compliant •Ease of use •Individuals and Small Business •Plans •Navigators			• WA Connection can be leveraged if the state plans on integrating the HIX horizontally with other social service programs. There is a risk of being perceived as "government " look and feel with a cumbersome process that is contrary to the Exchange customer experience that is envisioned based on the IT Guidance. It also blends the public assistance benefits into the private marketplace. All these factors may negatively impact the ability to attract non-Medicaid consumers to buy through the Exchange. • ProviderOne has a client and provider facing portal that could be leveraged.
Interfaces •EDI Transactions •Web Services			• WA Connection, ACES Online and ProviderOne all have web service capabilities. • ProviderOne generates the EDI Transactions today (270/271, 834, 820) that can be leveraged.
Security •Authentication •Authorization •HIPAA			• The security of both systems is centric to each. WA Connection is integrated with SAW and could potentially be extended to support internet facing UI components of the HIX. • Neither system supports WS-* web service security standards, something that may be a requirement of the federal interfaces.

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Technical Requirements

Technical Component	Relevant Systems/Alternatives			
	ACES	WA Connection	P1	Comments
Enterprise Service Bus				• Transformation • Workflow Management • End Point Management • WS-* support • ACES, WA Connection, and ProviderOne both have Websphere MQ ESB
Business Rule Engine				• WA Connection BRE supports Rete Algorithm • Flexible • WA Connection supports IBM iLog BRE while ProviderOne has custom BRE
Data Exchange Standards				• X12 EDI • XSD • HL7
Correspondence and Notifications				• Multiple Language Support • Automated • Physical/Electronic
Call Center				• IVR • Integrated
Document Management System				• Blob file indexing • P1 DMS is newer than what is available in ACES
Business Intelligence				• Data Warehouse • Operational Data Store • Reporting capabilities with Cognos for both WA Connection and ProviderOne

Note: As the technology components for ACES and WA Connection are vastly different, they have been identified seperately. Also, items taken into consideration in the preceding table include: additional licensing, maintainability, functionality, staff knowledge base, and extensibility.

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IT Review and Assessment – Summary Findings

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Summary Findings

- To date, no vendor has built all IT components of the Exchange.
  - Solutions exist in the marketplace for Plan Comparison and Enrollment
  - Solutions exist for Medicaid and CHIP eligibility determination
  - Solutions for Plan Comparison and Enrollment are not integrated with Medicaid and/or CHIP eligibility. Furthermore, eligibility for tax credits and subsidies are not built into any of these systems.

- Early Innovator States are not as far along as originally planned in terms of solutions development. Ability to leverage fully-built component(s) from other Early Innovator States are not promising, given the integration requirements with Washington State Systems.

- It is likely that the Solution for Washington HIX will be a combination of building some new components, buying a few components, leveraging existing State Assets and borrowing components/design from other States.

HIX Solution Options

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Enterprise Architecture – Recommendations for any HIX Solution Option

Data Services	Comments
Provider Hub	▪ Provides a central repository for Provider Management ▪ Provider look-up ▪ Provider registration ▪ Provider Hub can be used for generating unique identifiers for all plans
Client Hub	▪ Provides a unique identifier for all clients ▪ Phase 1 implementation, anticipated to be completed in six months will contain all ACES clients ▪ Client Hub can be used to generate identifiers for all individuals coming through exchange

Infrastructure Services	Comments
Service Oriented Architecture	▪ Loose coupling ▪ Distributed System ▪ Agile environment to meet the ever changing needs of the HIX ▪ Aligns with the MITA framework
Server Virtualization	▪ Server capacity management ▪ Resources can almost be allocated dynamically ▪ Server consolidation ▪ Ease of infrastructure support
Server Farms - Web and Application	▪ Scalability to match demand ▪ Redundancy ▪ Separation of concerns ▪ Ease of deployments ▪ High Availability
Federated Security	▪ Single Sign On support ▪ Non-repudiation support ▪ Option should facilitate SAML Assertions
Certificate Management	▪ Centralized store ▪ Non-repudiation support

Objective and Key Criteria for Alternatives Evaluation

In addition to conducting an IT Gap Analysis for HIX, the objective is to evaluate various solution alternatives against key criteria including the identification of System Assets that can be leveraged for the Exchange.

#	Criteria	Detail
1	**Funding**	▪ Ability to maximize federal Exchange and CMS funding during DDI ▪ Funding impact on Maintenance and Operations
2	**Governance**	▪ Ability to influence and control the solution long term ▪ Competing priorities long term
3	**Requirements Fit** *"Which System better fulfills the requirements"*	▪ % fit with HIX requirements – one that would require less overall change ▪ Easily integrates with other enterprise wide assets ▪ Includes functional, non-functional, and technical requirements.
4	**Integration with Medicaid/CHIP**	▪ Simple and seamless in identifying people who qualify for coverage through the Exchange, tax credits, Medicaid, CHIP ▪ Seamless coordination of Exchange with Medicaid/CHIP ▪ Coordinated set of eligibility rules for Medicaid/CHIP; Common or shared system for eligibility determination and placement
5	**Schedule Risk** *"How quickly can it be implemented?"*	▪ Earliest implementation date ▪ Other competing priorities ▪ Risk of schedule delays
6	**Flexibility**	▪ Flexibility of solution to respond to changing federal guidance and regulations
7	**Sustainability**	▪ Ability to minimize operational costs after implementation
8	**Procurement**	▪ Procurement Complexity

Common for all Solution Options

ID	Description	Criteria								Rationale
		Funding	Governance	Requirement Fit	Medicaid/CHIP Integration	Schedule Risk	Flexibility	Sustainability	Procurement	
1.	Leverage Client Hub and Provider Hub enterprise assets for generating unique client and provider identifiers Leverage ProviderOne for plan enrollment/disenrollment EDI Transactions ACES will continue to determine eligibility for certain Medicaid groups including blind, disabled population and be the System of Record for eligibility Use an Enterprise Service Bus, Business Rules Engine, Document Management System and Business Intelligence technologies as solution components	●	●	●	●	▲	●	●	●	Reduced Exchange M&O costs by leveraging existing enterprise wide assets ProviderOne and Provider Hub components under HCA High degree of Requirements fit for selected components; Cost efficient and Reduces redundancy Achieves integration with Medicaid/CHIP by using common data services for Client and Providers and common enrollment services Delay in Client Hub and Provider Hub Implementations could impact Exchange Schedule Extend Provider Hub to track all Plans participating in the Exchange (Medicaid, CHIP, Individual and SHOP)
2.	Leverage and Incorporate Early Innovator State Solution Requirements, Design, Architecture, Best Practices and learnings' to gain efficiencies and reduce overall build and integration efforts	●	●	●	●	●	●	●	N/A	Early Innovator States like Wisconsin are further along in Requirements and Solution design. Washington can benefit by using Wisconsin solution models and concepts as a starting point to get a jumpstart on the solution build. Availability, timing and dependencies will need to be factored in to minimize impact to Washington Exchange Implementation Schedule.

KEY: ■ Least Favorable ▲ Moderately Favorable ● Most Favorable

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Option A -
Build New Exchange Portal

ID	Option Description	Criteria								Rationale
		Funding	Governance	Requirement Fit	Medicaid/CHIP Integration	Schedule Risk	Flexibility	Sustainability	Procurement	
A.	Develop New Exchange Portal whose Technology Architecture is compliant with Federal Guidance and State Standards to perform a large majority of the Exchange Functions Use Common Rules Engine Framework with coordinated set of rules to determine Eligibility for Exchange Tax Credits, Subsidies, Exemptions and Medicaid Eligibility that is shared by both Exchange and ACES Use "No Wrong Door" that allows for WA Connection and Exchange Portal to integrate with each other for individuals who comes through different channels	●	●	●	●	▲	●	●	●	Maximizes 90-10 funding available for Medicaid related system changes during DDI and provides 75-25 funding for Medicaid eligibility rules maintenance that will also be shared by Exchange and helps with overall sustainability Minimizes risk of competing priorities across other Human Services programs impacting Exchange implementation schedule in the short term and enables quicker implementations for enhancements long term Integrates Medicaid/CHIP eligibility into Exchange; Achieves seamless coordination with Medicaid/CHIP *Separates Exchange from Human Services Programs* Compliant with CMS and CCIIO vision Extracting Medicaid eligibility business rules from ACES into a Business Rules Engine by 2014 is a significant effort and can potentially delay overall schedule

KEY: ■ Least Favorable ▲ Moderately Favorable ● Most Favorable

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Option B1 –
Use Washington Connection as Exchange Portal

ID	Option Description	Criteria								Rationale
		Funding	Governance	Requirement Fit	Medicaid/CHIP Integration	Schedule Risk	Flexibility	Sustainability	Procurement	
B1.	Use Washington Connection technology architecture as the base architecture to build the New Exchange Portal and perform a vast majority of the Exchange functions Use Common Rules Engine Framework with coordinated set of rules to determine Eligibility for Exchange Tax Credits, Subsidies, Exemptions and Medicaid Eligibility that is shared by both Exchange and ACES	●	■	▲	●	■	■	●	▲	Maximizes 90-10 funding available for Medicaid related system changes during DDI and provides 75-25 funding for Medicaid eligibility rules maintenance that will also be shared by Exchange and help with Exchange Sustainability Increases risk of competing priorities across other Human Services programs impacting Exchange implementation schedule in the short term *More integrated with human services programs and consequently be a risk to getting non-Medicaid consumers to buy through the Exchange* *High "government" look and feel* *Blends public assistance programs into private marketplace* Achieves Exchange integration with Medicaid and CHIP Complex procurement as Washington Connection is maintained by an integrator Extracting Medicaid eligibility business rules from ACES into a Business Rules Engine by 2014 is a significant effort and can potentially delay overall schedule

KEY: ■ Least Favorable ▲ Moderately Favorable ● Most Favorable

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Option B2 - A Variation:
Use Washington Connection as Exchange Portal

In this option, the Medicaid eligibility rules are **NOT** built into the Common Rules Engine framework that manages the rules for Exchange Tax Credits, Subsidies, and Exemptions.

ID	Option Description	Criteria								Rationale
		Funding	Governance	Requirement Fit	Medicaid/CHIP Integration	Schedule Risk	Flexibility	Sustainability	Procurement	
B2	Use Washington Connection technology architecture as the base architecture to build the New Exchange Portal and perform a vast majority of the Exchange functions Use Common Rules Engine Framework with coordinated set of rules to determine Eligibility for Exchange Tax Credits, Subsidies, and Exemptions. (*Medicaid eligibility rules are not built into the Common Rules Engine Framework*) Keep existing eligibility rules for Medicaid in ACES on existing platform	▲	■	▲	▲	▲	■	▲	▲	Does not leverage 90-10 funding available for Medicaid system changes. Maintenance funding stays at 50-50 and does not help Exchange Sustainability Increases risk of competing priorities across other Human Services programs impacting Exchange implementation schedule in the short term *Potentially more integrated with human services programs and consequently be a risk to getting non-Medicaid consumers to buy through the Exchange* *High "government" look and feel* *Blends public assistance programs into private marketplace* *Eligibility determination for Medicaid through the Exchange will be less seamless and real-time* Achieves Exchange integration with Medicaid Complex procurement as Washington Connection is maintained by an integrator As Medicaid eligibility business rules continue to stay in ACES, the impact to the overall schedule is less than option B1.

KEY: ■ Least Favorable ▲ Moderately Favorable ● Most Favorable

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Option C1 -
Use ProviderOne as the Exchange Portal

ID	Description	Criteria								Rationale
		Funding	Governance	Requirement Fit	Medicaid/CHIP Integration	Schedule Risk	Flexibility	Sustainability	Procurement	
C1	Use ProviderOne technology architecture as the base architecture to build the New Exchange Portal and perform a vast majority of the Exchange functions ✓ Build on the Client and Provider portal for the Exchange Website ✓ Use the ProviderOne ESB, BRE, Business Intelligence tool, Transaction Validation, and Correspondence Architecture for the Exchange Use Common Rules Engine Framework with coordinated set of rules to determine Eligibility for Exchange Tax Credits, Subsidies, Exemptions , Medicaid and CHIP Eligibility that is shared by both Exchange and ACES Use "No Wrong Door" that allows for WA Connection and Exchange Portal to integrate with each other for individuals who comes through different channels	●	●	●	●	▲	●	●	▲	Maximizes 90-10 funding available for Medicaid related system changes during DDI and provides 75-25 funding for Medicaid eligibility rules maintenance that will also be shared by Exchange and help with Exchange Sustainability ProviderOne currently managed by HCA/MPA *Separates Exchange from Human Services Programs* Integrates Medicaid/CHIP eligibility into Exchange; Achieves seamless coordination with Medicaid/CHIP Compliant with CMS and CCIIO vision Complex procurement as ProviderOne is maintained by an integrator Major system enhancements planned for ProviderOne may conflict and compete with Exchange development Extracting Medicaid eligibility business rules from ACES into a Business Rules Engine by 2014 is a significant effort and can potentially delay overall schedule.

KEY: ■ Least Favorable ▲ Moderately Favorable ● Most Favorable

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Option C2 – A Variation:
Use ProviderOne as the Exchange Portal

In this option, the Medicaid eligibility rules are **NOT** built into the Common Rules Engine framework that manages the rules for Exchange Tax Credits, Subsidies, and Exemptions.

ID	Description	Criteria								Rationale
		Funding	Governance	Requirement Fit	Medicaid/CHIP Integration	Schedule Risk	Flexibility	Sustainability	Procurement	
C2	Use ProviderOne technology architecture as the base architecture to build the New Exchange Portal and perform a vast majority of the Exchange functions ✓ Build on the Client and Provider portal for the Exchange Website ✓ Use the ProviderOne ESB, BRE, Business Intelligence tool, Transaction Validation, and Correspondence Architecture for the Exchange Use Common Rules Engine Framework with coordinated set of rules to determine Eligibility for Exchange Tax Credits, Subsidies, Exemptions . (*Medicaid eligibility rules are not built into the Common Rules Engine Framework*) Use "No Wrong Door" that allows for WA Connection and Exchange Portal to integrate with each other for individuals who comes through different channels									Does not leverage 90-10 funding available for Medicaid system changes. Maintenance funding stays at 50-50. ProviderOne currently managed by HCA/MPA *Separates Exchange from Human Services Programs* *Eligibility determination for Medicaid through the Exchange will be less seamless and real-time (as Medicaid business rules are still maintained in ACES)* Compliant with CMS and CCIIO vision Complex procurement as ProviderOne is maintained by an integrator Major system enhancements planned for ProviderOne may conflict and compete with Exchange development As Medicaid eligibility business rules continue to stay in ACES, the impact to the overall schedule is less than option C1.

KEY: Least Favorable | Moderately Favorable | Most Favorable

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Appendices

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HIX Early Innovators - (Point In Time Information)

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Early Innovator Research Findings

HIX Topic	Comments
Solution Strategy	The Exchange Technical Solution for Wisconsin, Oklahoma, and Oregon were all different and influenced by their existing IT infrastructure, gaps between the existing infrastructure and the Exchange requirements as well as other initiatives currently underway. While Wisconsin decided to leverage its web portal ACCESS, Eligibility System CARES and MMIS System Interchange, Oregon decided to use a commercially available framework in Oracle or Curam as the foundation for building the Exchange. Oklahoma planned to use its MMIS system as the foundation architecture for building the Exchange components. Takeaway: There is not a single IT solution that is available in the Marketplace today that can meet all of the Exchange functions. While frameworks are available commercially that will meet the Exchange framework architecture, much work needs to be done to build the Exchange and integrate it with existing state systems.
Implementation Schedule	States are still in the early stages of their requirements development efforts. Full functioning solution components are not expected to be available in a timeframe that will allow for Washington to leverage and customize one or more solution components for their specific needs. Takeaway: Washington will need to build its own solution now rather than waiting and increasing the risk of not having a solution in time by Jan 2014.
Sharing Work Products and Best Practices	Some of the Early Innovator States like Wisconsin have been planning for the Exchange for quite some time and are further ahead in defining the vision for the Exchange, designing prototypes and developing requirements. Takeaway: Washington should collaborate with the Early Innovator States as much as possible and try to leverage their work products from Requirements to Design and Development. Many of the Exchange related issues are common to all States and Washington would benefit by knowing how other States are solving similar problems.

Wisconsin

HIX Topic	Comments
Technology System Overview	Medicaid eligibility system: ▪ The legacy system (CARES) is still being used, which also includes other social service programs. They continually deprecate legacy mainframe functionality, but the legacy system still supports eligibility functionality. ▪ The system has a web façade front-end, ACCESS, that provides client facing access. MMIS system: ▪ Java based front end system. ▪ With the addition of HP Interchange system in 2008 the state was awarded MITA certification.
Enhancement to Current Systems	▪ One major factor culminating in the decision to modify their existing systems was that the Interchange system currently enrolls beneficiaries into plans. Some portions can not be expanded, like the eligibility piece that is being ported to a rules engine. ▪ To help define a road map to implement the exchange and choose a vendor, Wisconsin had 17 vendors bid on how they would address modifying the current systems. They also developed a prototype top facilitate a vision and provide it as a guide. They also had a two year effort prior to ACA to plan for an exchange.
To-be Business Processes	▪ Wisconsin has started the development of the "to-be" business processes by both elaborating on what the exchange will need to accomplish and by developing working prototypes. ▪ Work groups have been formed and they have begun to break down the processes that need to be in place in order for them to move forward with the implementation.
Overview of IT Implementation Plan	▪ The first phase of the plan is to work out the enrollment for Medicaid individuals. ▪ The next two phases focus on employer and individual enrollment that are outside the Medicaid boundary, with plans to incrementally move to the larger population. ▪ They are trying to be in front of the greater policy decisions by making practical assumptions regarding MAGI and enrollment rules.

Wisconsin

HIX Topic	Comments

Major Challenges	▪ Besides dealing with a new administration, Wisconsin has identified the following challenges:
	  ▪ There has yet to be any clear guidance with any level of fidelity from the federal government
	  ▪ The scope of the HIX combined with other health related challenges, 5010 and ICD10.
	  ▪ Leverage as many existing items they can in order to not duplicate efforts.

MAGI Impact to Eligibility	▪ Wisconsin is currently reviewing how the foreseen requirements will affect their eligibility rules. ▪ They are attempting to define who falls into which group and the income rules around specific groups. ▪ They are identifying situations and conditions when human intervention will be required. To complete eligibility determination.
HIX Artifacts	▪ Wisconsin is planning to offer products and tools that they develop to the greater HIX community; the idea being that the artifacts could be used by other states to facilitate their implementation. ▪ Wisconsin is also planning to share the source code for their exchange web site. Although this may be a generous offer, the source code may or may not be able to be used to support the WA HIX website. A detailed technical analysis will need to occur prior to attempting to port it over.
HIX Staffing Overview	▪ For the exchange there is a state lead, and vendor leads from HP and Deloitte. Deloitte is acting as the prime consultant for the exchange effort.
Key Findings	▪ Wisconsin is clearly the furthest along regarding all “early innovator” states. They are facilitating the shaping the federal requirements and anticipating what the impacts of the exchange will be. It is evident that if there are any truly “reusable” artifacts to come from any “early innovator” state, that they will most likely come from Wisconsin.

Oregon

HIX Topic	Comments
Technology System Overview	▪ Oregon has plans to automate and refactor their current Medicaid eligibility system in parallel with their HIX implementation. ▪ Oregon has not selected a vendor but the platform for the Exchange will be either Oracle or Curam.
Enhancement to Current Systems	▪ Oregon is going to do a full scale replacement of their eligibility system while implementing their HIX. ▪ The plan is to implement both in a coordinated fashion and use the same "framework". ▪ After a bake off between Curam and Oracle, Oregon will select an integrator to implement the exchange. ▪ All changes and new development will occur over two years.
To-be Business Processes	
Overview of IT Implementation Plan	▪ The implementation plan that was submitted in the early innovator grant is the same plan that Oregon is currently using. ▪ Their plan follows a standard waterfall approach to Software Development Lifecycle.
Major Challenges	▪ Oregon has identified the aggressive implementation time frame and the coordination between their MMIS and HIX implementations as being their major challenges that they will face.
MAGI Impact to Eligibility	▪ Oregon stated that is was a bit too early to give detailed consideration that MAGI will have in determining eligibility.
HIX Artifacts	▪ Oregon has no artifacts or immediate plans to share artifacts for the exchange. When distributable artifacts become available they will arrange to share them.
HIX Staffing Overview	▪ Oregon is undergoing the process for procuring vendors that will implement the exchange. Once a vendor has been chosen they plan to solidify their staffing plans.
Key Findings	▪ Oregon has undertaken a great deal of work considering that they are replacing their entire eligibility system in the same timeframe that they are going to implement the exchange. Since the nascent projects have yet to shape concrete artifacts, it is recommended that a future meeting be scheduled after Oregon has made more progress on implementation.

Oklahoma – returned their grant April 14th, 2011

HIX Topic	Comments
Technology System Overview	▪ Oklahoma's latest version of their MMIS system went live on September 7th of 2010. A majority of the social service population goes through their online system for enrolment, which is built in ASP.NET on top of the standard Microsoft stack. ▪ The MMIS system uses a business rule engine based on InRule to facilitate eligibility and enrollment.
Enhancement to Current Systems	▪ Oklahoma planned to leverage their current MMIS system as they foresaw the Medicaid expansion as having a significant impact to the system. ▪ The current system is supported by HP and built on a Microsoft .NET Foundation, which they planned to integrate with the exchange.
To-be Business Processes	▪ Many of the "to-be" processes were defined in their grant application. They had plans to build a member portal using the .NET Framework. The system would have provided a pre-eligibility determination, eligibility navigation, and validate the applicant upfront. ▪ Oklahoma planned to allow their Provider Index to be accessible to participants. ▪ Oklahoma also had plans to integrate their HIE with the exchange and support access to personal health records in a future phase.
Overview of IT Implementation Plan	▪ Oklahoma planned on taking a phased approach to implementation of the exchange; tentatively the first phase was to build out the member portal. Subsequent phases would have incorporated a master provider index, integrated with federal systems and existing MMIS system, and finally integrated with the state's HIE system.
Major Challenges	▪ The state of Oklahoma foresaw governance of the exchange as being the most immediate challenge and the aggressive timeline set by the federal government. ▪ Other major challenges included staffing for the HIX, IT planning and expertise, and reaching out to the greater business community regarding health plan modifications.
HIX Artifacts	▪ Oklahoma had no HIX artifacts to share at the time of the meeting, but responded that they would have shared requirements with the state of Washington.
HIX Staffing Overview	▪ Oklahoma had staffed the HIX project with twenty-one analysts (QA, Business, and Technical). They also had brought on three project managers (Technical, Operations, and Project). Oklahoma had an HIX steering committee comprised of the Governor, HCA, PMs, and cabinet members.
Key Findings	▪ Oklahoma had planned to build a member portal that would provide pre-eligibility determination and would validate the person as they navigated through the eligibility process. ▪ Governor Mary Fallin succumbed to pressure from state GOP lawmakers to return the $54.6 million grant.

HIX Technology Solutions – Market Analysis

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HIX Technology Solutions - Market Analysis

- eHealthInsurance and VIMO
  - Online source of health insurance for individuals, families and small businesses
  - Enables online comparison and purchase of health insurance products
  - Licensed to sell in all 50 States
  - Electronic communication with Health Plans
  - Integrated back office operations and customer support
  - Not integrated with Medicaid and/or CHIP
- bSwift
  - Business Process Outsourcing vendor
  - Enables Employers to use their SaaS model to register employees and provide an ability for the employees to choose plans and complete enrollment
  - Call center capabilities
  - Potential solution for SHOP component of Exchange
  - Technology Partner for Utah
- Healthequity
  - Technology Partner for Utah
  - Provides premium collection and aggregation service

One Health Port – Key Findings

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OneHealthPort – Key Findings

System Component	Comments
ESB	▪ The Axway "ESB" provides a flexible and secure solution for workflow and data transport management ▪ Provides a solid limited set of transformation services, centered around eligibility currently. ▪ Provides an excellent security model that protects data in transit and supports non-repudiation. ▪ The scope of the ESB is primarily used to support the eligibility inquiries and is relegated by market adoption.
Security Services	▪ OHP has implemented a solid federated security model including SAML assertions. ▪ Support Two-Factor Authentication ▪ Provides a solid foundation that could potentially be leveraged for external trading partners.
Provider Directory	▪ OHP has a provider directory that is used to facilitate the HIE ▪ The provider directory does not include all providers in the state, only providers that participate in HIE.