Update on the Hawai'i Health Connector

Statement of

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Subcommittee on Economic Growth, Job Creation and Regulatory Affairs and
Subcommittee on Energy Policy, Health Care and Entitlements

Hearing: Examining ObamaCare's Problem-Filled State Exchanges

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Introduction

Chairman Issa, Ranking Member Cummings, and Members of the Committee and Subcommittees,

My name is Tom Matsuda, Interim Executive Director of the Hawai‘i Health Connector (the "Connector"), speaking on behalf of the Connector and its Board of Directors.

The Connector, established as a non-profit organization, is an online health insurance marketplace, created to help individuals and small businesses take advantage of the health insurance choices available to them. Our mission is to help the people of Hawai‘i live happier, healthier lives by making sure that health insurance is not only easier to purchase, but also, easier to understand.

Background

Hawai‘i has long been a leader, ensuring that our residents have access to quality, affordable health insurance. In 1974, Hawai‘i enacted the Hawai‘i Prepaid Health Care Act, which generally requires that most employers in Hawai‘i provide health care coverage to employees who work more than twenty hours per week for at least four consecutive weeks. As a result of Hawai‘i Prepaid Health Care Act requirements, which are generally stricter than those of the Affordable Care Act (ACA), Hawai‘i has a lower uninsured rate than all but one other state (Massachusetts), estimated at about 8%[1]. The Hawai‘i Prepaid Health Care Act has also resulted in benefits being offered that are more generous than benefits available[2] to employees in other states' small employer markets[3]. Finally, Hawai‘i Prepaid established an affordability test for employer-based coverage that is stricter than that required by the ACA. The State's priority has been to establish a State-based Marketplace and harmonize the Hawai‘i Prepaid Health Care Act requirements with those of the Affordable Care Act.

Because of the Hawai‘i Prepaid Health Care Act, the Aloha State embraced the option to build our own Exchange in order to remain directly involved with protecting and enforcing the requirements of this groundbreaking state law. In 2011, the State Legislature passed Act 205[4], which created the Hawai‘i Health Connector to implement Section 1311 of the ACA. On June 27, 2012, Governor Abercrombie became the first Governor to submit a letter of intent to establish a State-based Marketplace.

I came to the Hawai‘i Health Connector as interim executive director on December 9, 2013. Since starting in this new role, I have established several priorities: increasing enrollment of consumers who want to obtain health insurance plans, assisting the board of directors with developing a sustainability plan for future years, improving the IT systems in the Connector's portion of the exchange to enable faster, more user-friendly applications and enrollments and contributing to the State's efforts to preserve the protections of the Hawai‘i Prepaid Health Care

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[1] See Kaiser Family Foundation, State Health Facts, Health Insurance Coverage of the Total Population, available at: http://kff.org/other/state-indicator/total-population/

[2] See Oliver Wyman Analysis, enclosed.

[3] Defined in Hawai‘i as employers with fifty or fewer employees. Hawaii Revised Statutes §431:2-201.5.

[4] Act 205, 2011 Legislative Session, is codified in Hawaii Revised Statutes §435H.

Act for employees of small employers in Hawai‘i. Prior to taking on this role, I served as the Affordable Care Act implementation manager for the Governor’s Office.

I welcome the opportunity to share more information with you about the Connector and answer any questions you have. To hopefully address some of your questions, I would like to take this opportunity to address four issues: 1) enrollment through the Connector, including factors that have uniquely impacted enrollment, 2) ensuring the Connector is self-sustaining in 2015, 3) expenditures in support of exchange implementation, and 4) our priorities going forward.

Enrollment

As of Sunday, March 30:

- 7,242 individuals have enrolled in commercial health insurance through the Connector (Individual and SHOP);
- 281 employers are participating in the SHOP Marketplace; and
- In total, 23,692 applications have been completed.

If one views the Hawai‘i State-Based Marketplace as a combined effort between the state’s Medicaid Program and the Connector, from October 2013 to February 2014, the state Medicaid program has processed, approved and enrolled over 28,800 Medicaid eligible people. The Connector has processed 7,242 QHP enrollments for individuals with and without financial assistance and SHOP Employees as of March 30, 2014. The combined total of enrollments in our State-Based Marketplace is over 36,042.

Unfortunately, we face some significant issues which delay enrollment as well. For example, there is currently a backlog of roughly 11,000 financial assistance applications within the Individual Marketplace that have been processed by our state Medicaid program and must be evaluated by the Connector for other premium assistance eligibility. We are working to make the necessary eligibility determinations in order to process the applications that remain “in queue” at this time. We have more than tripled the number of call center representatives and are making as many as 1,000 outbound calls each day to collect information from consumers so we can process their applications.

You can find all of this information – as well as data on the total number of calls received by our customer support center, the number of in-person assisters and certified application counselors, and the number of unique visits to our website - at www.HawaiiHealthConnector.com. We update these figures every week so that the public can see our progress and hold us accountable.

Regarding the demographics of enrollees, enrollment is split roughly evenly across males and females. While we understand there is interest in the number of our enrollees who were previously uninsured, this data is not captured in the applications and, therefore, is not available to us.

Prepaid Health Care Act: Impact on the State’s Insurance Market

The Connector’s total enrollment, to date, is low – especially as compared to other State-based Marketplaces. I believe there are several reasons for this. The Hawai‘i health insurance marketplace is unique, as noted above. We have a small total population of roughly1.4 million

residents, with only 8% uninsured, or about 100,000 lives. Hawai‘i’s Prepaid Health Care Act has existed for 40 years and is largely responsible for the low number of uninsured individuals.

In addition to requiring most employers to offer coverage to employees who work more than twenty hours per week, the Hawai‘i Prepaid Health Care Act also prescribes certain other requirements that are generally more stringent than the ACA. For example, under the Hawai‘i Prepaid Health Care Act, employees can be required to contribute up to the lesser of 50% of plan cost or 1.5% of income; for most employees, contributions will almost always be capped at 1.5% of income. Therefore, anyone whose employer complies with the Hawai‘i Prepaid Health Care Act is extremely unlikely to qualify for tax credits in the Connector. Insurance benefits offered under the Hawai‘i Prepaid Health Care Act are often more generous than benefits typically available to individuals in other states.

Consequently, Hawai‘i’s priority has been to harmonize Hawai‘i Prepaid Health Care Act requirements with the ACA requirements. The ACA included a specific carve out for the Hawai‘i Prepaid Health Care Act so that the state law’s more generous requirements would be maintained. We are proud of our State’s history with respect to ensuring coverage for the vast majority of our residents. However, because Hawai‘i’s Prepaid Health Care Act has been well established for 40 years and virtually all small employers that could use the SHOP Marketplace already purchase insurance for their employees, generating SHOP enrollments is a challenge in Hawai‘i. In the Individual Marketplace, excluding the uninsured eligible for Medicaid, there are not enough likely participants to enroll at a volume necessary to sustain the Connector’s operations unless we have substantial SHOP enrollments as well.

Hawai‘i Demographics and Geography

Also impacting the insurance market is Hawai‘i’s diverse population and geography. Out of a population of roughly 1.4 million, about 10% identify as Native Hawaiian or other Pacific Islanders[5]. There are at least 45 different Asian and Pacific Island languages spoken in the state[6], with one quarter of our population speaking a language other than English at home and just over half of the population is able to speak English “very well.”[7] Hawai‘i also has a unique geography, with our population spanning across seven major islands. The combination of our cultural, linguistic, and geographic diversity has posed challenges to engaging in effective outreach and education about the Marketplace. We are continuing to address this challenge and are hopeful that improvements in our strategies will facilitate greater enrollment.

October 1 Delay

The Connector experienced some well-known operational challenges last fall. First, the Connector made a decision to delay the launch of the online marketplace for two weeks. The Connector, as with all of the other Marketplaces, anticipated opening for online business on October 1, 2013. On the eve of opening, it was brought to the Connector’s attention that, despite all of the testing held to date, the portal would not perform as expected. Erring on the side of

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[5] According to the 2010 Census; Hawaii data available at: http://quickfacts.census.gov/qfd/states/15000.html.

[6] *See* Detailed Language Spoken at Home and Ability to Speak English for the Population 5 Years and Older by States: 2006-2008 (ACS), available at: http://www.census.gov/hhes/socdemo/language/.

[7] *See* U.S. Census, Language Use in the United States: 2011, available at: http://www.census.gov/prod/2013pubs/acs-22.pdf

caution, it was decided to delay the launch of the Connector's portal until October 15, 2013. Interested consumers were given the opportunity to submit a secure online initial application form between October 1 and October 15.

Since October 15, 2013, consumers have been able to fill out and submit online applications, and review, select and enroll in plans. The system is under continuous improvement in order to meet the demands of the public. As a result, the functionality and usability of the system is considerably better today than it was back in October, but much work remains to be done. The Connector is considered to be a "smart application," because of the many components that need to interoperate seamlessly behind the Connector's portal. The Connector's system must be able to interact not only with the consumer, but receive information from our state Medicaid agency, and interact with the State Data Services Hub through which information is transmitted and obtained from the Federal Data Services Hub. The coordination between all entities involved is complex.

Prior to launch on October 15, 2013, the Connector satisfied all security-related requirements imposed by the Center for Medicare and Medicaid Services (CMS) and the Internal Revenue Service (IRS) that were necessary to receive Authority to Connect to the Federal Data Services Hub via the State Data Services Hub. The Connector received written Authority to Connect from the IRS on September 27, 2013, fulfilling the last requirement to connect to the Federal Hub via the State Hub.

Expected versus Actual Enrollment

Oliver Wyman Actuarial Consulting, Inc. ("Oliver Wyman") was engaged by the Hawai'i Department of Commerce and Consumer Affairs to assist them in conducting planning tasks related to the development of the Connector (analysis enclosed). The analysis was done under the assumption that the Connector would include the Individual Marketplace and SHOP Marketplace. Oliver Wyman concluded that, based on their review, there were approximately 53,900 residents (37,900 uninsured and 16,000 direct purchasers) with incomes that would make them eligible for subsidies and would therefore be primary candidates for individual coverage through the Connector. In addition, Oliver Wyman estimates that there were approximately 151,000 individuals covered through small employers that would be eligible to enroll through the Connector. As noted below, in the context of our sustainability planning, there were several Federal and State policies implemented that have limited the Connector's ability to draw a significant number of these employers into the Marketplace.

Uninsured Rate

Prior to implementation of the Marketplace, Oliver Wyman estimated that approximately 52.6% of residents are covered by employer sponsored insurance (ESI) in either the small employer, fully insured large group or self-insured markets. Oliver Wyman also estimated that 17.1% were covered by Medicaid or other low-income assistance, and 7.6% were uninsured (of which roughly half are eligible for Medicaid). According to Oliver Wyman's report, their research showed that a large number (not quantified) of the uninsured population have incomes over 400% of the Federal poverty level (FPL), which would disqualify them for tax credits in the Connector.

Sustainability
According to the ACA, the Connector must be self-sustaining as of January 1, 2015. Under current CMS guidance, no federal funds may be used for Connector maintenance and operations after 2014. Last year, the Connector Board approved an assessment of 2% of the premiums for plans sold on the individual portal against the issuers beginning January 1, 2014, and an assessment of 2% of the premiums for plans sold on the SHOP portal against the issuers beginning July 1, 2014.

The Connector Board of Directors is engaged in a sustainability planning process to include options for reducing operating expenses and increasing revenue. As I outlined in my memorandum to the Board of Directors[8] on February 10, 2014 (enclosed), the key concept in our proposal is to supplement enrollment in the Individual Marketplace by examining the revenue opportunity provided by the Connector's SHOP while continuing to harmonize ACA implementation with the Hawai'i Prepaid Health Care Act.

The key to our sustainability has always been small employer enrollments in our SHOP. Due to the existence of Hawai'i Prepaid Health Care Act and the small number of health insurers in the state, there is little need for the average small business to use SHOP. The ACA small business tax credit is a real incentive, but few businesses may decide that the credit provides enough incentive to leave familiar insurance plans and processes they have used for many years. Also, the federal and state decisions to give SHOP employers the option to remain with their existing insurance plans through 2016 has reduced the volume of potential customers. The State has a pending request to extend this option through 2017. If granted, SHOP enrollment volume will be limited for an additional year beyond existing policy.

On the other hand, SHOP enrollment potential could increase more in 2016 and 2017 due to planned ACA enhancements to SHOP. The ACA increases the definition of small business for SHOP from 50 to 100 employees in 2016 and allows the state to permit large employers to enroll through SHOP starting in 2017. These expansions could increase the number of enrollments. Conversely, potential choices by the State, such as 1:1 age rating (i.e., community rating) or direct enrollment, could reduce the number of enrollments in SHOP. Therefore, the true revenue potential of SHOP isn't knowable yet. A sound sustainability plan should take these potential impacts on enrollment into account through alternative budget scenarios.

Innovation waivers are available under the ACA starting in 2017. Since it appears that short-term sustainability for the Connector will be challenging, and because Hawai'i's Prepaid Health Care Act already provides many benefits that are more generous than the ACA, the state innovation waiver provides a good opportunity to find a long-term solution that suits Hawai'i's unique health insurance market. This is an important factor in our board sustainability planning process.

Budget Expenditures
The Connector is currently funded by federal grants specifically set aside for the establishment of the health insurance exchanges, now known as health insurance marketplaces. All funds must be

[8] http://www.hawaiihealthconnector.com/wp-content/uploads/2013/09/Memo-to-BOD_Sustainability-Planning_021014.pdf

spent in accordance with the allocations outlined in each grant application. Funds not expended and/or not expended in accordance with the grant allocations would need to be retained by the Federal government. Hawai‘i has received four Federal grant awards: one Planning Grant, two Level One Establishment Grants, and one Level Two Establishment Grant. While Hawai‘i is a small state, we are subject to the same Federal requirements as all other states for establishing the necessary infrastructure to implement and operate a State-based Marketplace. We expect variation across these states in spending on personnel and other discretionary measures, but the underlying establishment costs will be comparable from state to state to ensure that the structural components of the Marketplace are compliant and secure. Our small size means that Hawai‘i has fewer individuals to spread these costs across.

On September 30, 2010, the Hawai‘i Department of Commerce and Consumer Affairs (DCCA) was awarded $1,000,000 for the following activities: conduct background research on the issues related to developing an Exchange; involve stakeholders in the planning process; examine integration of the Exchange with existing programs; assess resource capabilities; consider the appropriate governance mechanism; determine appropriate accounting and reporting guidelines; determine appropriate technical infrastructure; research business operations including implementation issues; examine regulatory and policy aspects; and appoint a task force to discuss the issues concerning implementation of an Exchange and receive and process comments from the public.

On November 29, 2011, the DCCA was awarded a Level One Establishment Grant in the amount of $14,440,144, which was later reassigned to the Connector; on August 23, 2012, the Connector was awarded a second Level One Establishment Grant in the amount of $61,815,492. The first Level One grant (Level One-1) in the amount of $14.4 million dollar was initially awarded to the Insurance Division of the Department of Commerce and Consumer Affairs (DCCA) on or about November 17, 2011, for a term of one year. At this time, the interim board under Act 205 had not been appointed and the Executive Director had not yet been hired. The Level One-1 grant was subsequently reassigned to the Connector on March 11, 2013, with an amount of approximately $10.2 million remaining in the grant. An extension was obtained to November 17, 2013. This grant has been completed, subject to final processing.

The funds from the Level One-1 grant were utilized to retain the IT Consultant (Public Consulting Group (PCG)) to establish the project management office, establish the Connector offices, hire staff and meet criteria as required for a mandatory design review with the Center for Consumer Information and Insurance Oversight (CCIIO), which oversees the Marketplaces and grants. As of the end of June 2013, approximately $8.5 million had been expended to establish the Connector and to begin the IT process.

The second Level One grant (Level One-2) was applied for by the Connector in June 2012. The Federal government awarded the Connector $61.8 million on August 23, 2012. This is the primary funding source for the Connector to build its IT system that would become the health insurance marketplace for Hawai‘i. A large portion of the funds were “restricted” until the Connector was able to release specific information pertaining to its vendors, to CCIIO. The primary vendors supported by this grant are: 1) CGI Technologies (IT Vendor); 2) Turning Point (Independent Verification and Validation Services contractor); 3) PCG (IT Consultant/Project

Manager); 4) Mansha Consulting (Integrated Project Management and IT Services); 5) MVNP (communications); and other vendors. This funding also provided support for the operational expenses such as establishing the Hi‘i Ola public education and outreach program and continued operation of the Connector. The funds in the Level One-2 were set to expire on August 22, 2013; however, the Connector has received an extension to August 21, 2014.

On April 8, 2013, the Connector was awarded a Level Two Establishment Grant in the amount of $128,086,634. The funds are set to expire on April 7, 2014; the Connector has requested an extension for the funds. Hawai‘i’s Level Two Establishment Grant was requested and awarded to allow the Connector to hire staff, develop and execute contracts, and continue to develop a strong infrastructure to assure performance of activities related to the creation and on-going operation of the Marketplace. In addition, the requested funding has been and will be used toward building a robust outreach and stakeholder engagement strategy, such as implementation of the in-person assister program, a comprehensive and coordinated training program to reach a wide audience, the development and implementation of the Call Center, and a variety of other outreach activities.

Budget Allocations and Current Spending Levels

As of December 31, 2013, the Connector has spent about 28% of the total amount of Federal grant monies awarded to us. The majority of Federal funds spent to date have been for our vendor contracts. Additional monies have been spent on salary and wages, benefits, and other program development activities. Additional details on the amount of money that has been spent and how can be found in our financial overview (enclosed)[9]. The Connector’s most significant contract is with CGI for the development and maintenance of the online health exchange and hosting environments.

The Connector has executed two contracts dedicated to marketing and advertising services, with MVNP and Oahu Publications Inc. Spending on these contracts is capped at roughly $3.2 million; as of the end of last year, roughly 86% of those dedicated funds had been expended. The MVNP contract expired at the end of 2013; the Oahu Publication contract is scheduled to expire at the end of 2014.

The Connector also has contracts with: a law firm for legal services; the Department of Human Services (DHS), our state Medicaid agency, for system integration and connectivity between DHS’ Medicaid system, the State Data Services Hub and the Connector; Mansha Consulting, for Integrated Project Management and IT services; Maximus, for Contact Center operations; Turning Point for independent verification and validation testing and documentation; and Public Consulting Group (PCG) for PMO services and IT and business consulting, and information system development.

Priorities going forward

In addition to finalizing a workable sustainability plan for the Connector, we see several short-term challenges that we are working to address.

Application Backlog

[9] Also available at: http://www.hawaiihealthconnector.com/wp-content/uploads/2013/09/HHC-Q2FY14-Quarter-Ended-12.31.13-Financial-Overview-2.21.14.pdf

As of March 30, 2014, there were roughly 11,000 financial assistance applications in our system that had not yet been processed and, in turn, these individuals have not yet been enrolled in coverage. Under the current process, all consumers who want to be considered for financial assistance are sent from the Connector to DHS for a Medicaid eligibility determination. Some applications that have been returned to the Connector because the individuals did not qualify for Medicaid need additional information to allow the Connector to determine eligibility for premium assistance. To address this issue, the Connector increased staff in our contact center to conduct additional outreach to applicants and get that needed information. We have also indicated that if individuals submitted an application by March 31, we will work with them to get coverage, even if they had not yet picked a plan.

Outreach

We understand that community education and outreach efforts and public awareness need to be improved for the next open enrollment period. For these reasons, the Connector issued two requests for proposals last week seeking contractors to perform marketing services and public relations. Looking forward to the rest of 2014 and beyond, the Connector hopes to partner with community based groups to extend its outreach into the communities that are underserved and help to educate these populations about the services available to them, including health insurance plans, premium assistance, the Affordable Care Act, and Medicaid (in coordination with the Department of Human Services (DHS)).

Conclusion

On behalf of the Hawai‘i Health Connector, I appreciate the opportunity to discuss these issues with you today. We have much left to accomplish, but we believe in the mission of the Connector and are fully committed to contributing our part in Hawai‘i’s long history of providing access to affordable, quality health coverage to our residents.

OLIVER WYMAN

CURRENT STATUS OF INSURANCE COVERAGE IN THE STATE OF HAWAI'I

HAWAI'I DEPARTMENT OF COMMERCE & CONSUMER AFFAIRS, INSURANCE DIVISION

Josh Sober, FSA, MAAA

Tammy Tomczyk, FSA, MAAA

MARSH & McLENNAN COMPANIES

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Executive Summary

The Affordable Care Act of 2010 (ACA) provides funding assistance for the planning and establishment of the American Health Benefit Exchanges (Exchanges). Under the ACA, each state may elect to set up an Exchange that will create a new marketplace for heath insurance. Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) was engaged by the Hawai'i Department of Commerce and Consumer Affairs to assist them in conducting planning tasks related to the development of Hawai'i's Connector (the Connector). The Connector would include the individual Exchange and Small Business Health Options Program (SHOP) Exchange. One of our primary tasks of this engagement was to prepare background research of Hawai'i's current population and health insurance marketplace. Much of what we present in this report will serve as a basis for future phases of this planning project.

For this report, we have relied on numerous data sources both as a basis for estimates as well as to validate our conclusions. We based much of the demographic analysis on data from the American Community Survey (ACS). The ACS is conducted by the United States (US) Census Bureau and participation in it is required by law for those who are selected. We felt it important to rely on a primary data source to ensure consistency of estimates, and we chose the ACS because, among other reasons, the US Census Bureau attempts to correct a well documented phenomenon of population surveys called "the Medicaid undercount." The Medicaid undercount manifests itself when Medicaid enrollment estimates from survey data are substantially lower than actual state enrollment reports. For these analyses, we have relied on estimates from calendar year 2010. In addition, we relied on publicly available financial statements from insurer participants in Hawai'i's insurance market, as well as on information from insurance carriers' websites.

Based on the ACS data and information from the Med-QUEST Division in the Department of Human Services, we estimate that Hawai'i's residents are covered by the following modes of insurance. (Please note that the estimates of persons and standard deviations are in 1,000's.)

Table 1.1
Coverage Summaries (in 1,000's)

	Hawai'i			Nation		
Coverage	**Persons**	**Distribution**	**Stand Dev +/-**	**Persons**	**Distribution**	**Stand Dev +/-**
Employer (non-Medicare)	717	52.6%	4.7	148,868	48.2%	70.9
Employer (Medicare)	95	7.0%	1.3	13,668	4.4%	16.6
Military (Active)	93	6.8%	2.3	5,236	1.7%	17.5
Military (Retired)	1	0.1%	0.2	357	0.1%	3.3
Direct Purchase	44	3.2%	1.6	16,616	5.4%	34.0
Medicare	77	5.6%	1.4	22,455	7.3%	20.0
Medicaid	193	14.2%	3.5	43,541	14.1%	49.9
Dual	39	2.9%	1.4	9,815	3.2%	19.2
No Coverage	104	7.6%	2.2	48,257	15.6%	48.1
Total	1,363	100.0%		308,813	100.0%	

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the table shows, we estimate that approximately 52.6% of residents are covered by employer sponsored insurance (ESI) in either the small group, fully insured large group or self insured markets. We also estimate that 17.1% are covered by Medicaid or other low-income assistance, and 7.6% are uninsured. Identifying characteristics that might indicate a person's tendency to change insurance modes was one of our chief goals in evaluating Hawai'i's population. In subsequent sections, we present some specific elements of the ACA that helped guide our review of those characteristics. Although we present summaries of Hawai'i's population composition, we show results of our migration models in a forthcoming research paper.

The majority of Hawai'i's residents are insured by ESI. However, Hawai'i's Prepaid Health Care Act and the State's large military presence make Hawai'i unique from other states. In particular, the Prepaid Health Care Act prescribes coverage levels for employers as well as contribution requirements. As a consequence, Hawai'i not only has a lower uninsured rate than other states, but its benefits are more generous. Because of the efficacy of the Prepaid Health Care Act, we suspect that the ACA's provisions will not induce Hawai'i's employers to drop employee coverage at the rate we anticipate for employers in other states.

Although the State has few residents covered by individual health insurance, this segment of the population will be significantly affected by provisions of the ACA. These policy owners are likely to see changes in premium rates, but more importantly, they will face a new domain of incentives as well as a new venue for purchasing coverage.

For its low-income population, Hawai'i also has a robust managed Medicaid program. In addition to people qualifying under TANF or CHIP, the State's Med-QUEST program provides coverage to low-income, childless adults through its QUEST-Ace and QUEST-Net programs.

With the Prepaid Health Care Act, the military presence, and expanded Medicaid programs, the uninsured population in Hawai'i is 7.6%, which is lower than the national average. The ACA provides incentives in the form of tax penalties and credits for these individuals to enter the insurance market. However, the data supporting this background research showed that a large number of the uninsured population have incomes over 400% of the Federal poverty level (FPL), which would disqualify them for tax credits in the Connector. There are no clear indications of why these people do not obtain coverage, so it is difficult to assess their likelihood of obtaining coverage once it becomes a requirement.

The basic health program (BHP) is expected to support provisions of the ACA and stabilize coverage for the low-income population. There is evidence that a significant portion of the population under 200% of FPL (non-Medicaid and Medicaid eligible) will gain or lose their Medicaid eligibility with some frequency. The BHP is intended to smooth the transition from Medicaid eligibility to non-Medicaid eligibility without the burden of re-enrollment or potential change in providers. If Hawai'i were to contract with a plan under the BHP, the Federal government would provide the State 95% of the premium tax credits and cost-sharing subsidies that would have been provided for those individuals had they been enrolled with individual coverage in the Connector. Although members could be required to pay a premium, there would also be some level of cost-sharing subsidization for BHP participants, based on their income.

The strength and viability of Hawai'i's Connector will depend directly on the number of people that use it. In this background research, we have only identified residents that could be affected by the ACA's incentives; we have not considered the likely enrollment in the Connector. Based on our review, there are approximately 53,900 residents (37,900 uninsured and 16,000 direct purchasers) with incomes that would make them eligible for subsidies and would therefore be primary candidates for individual coverage through the Connector. In addition, there are currently approximately 151,000 individuals covered through small groups that would be eligible to enroll through the Connector. Although we do not expect that all of these residents would enroll in the Connector, our forthcoming analysis from Oliver Wyman's micro-simulation model will produce a more precise estimate. These estimates include individuals with income between 139% of FPL and 200% of FPL; so, many of these individuals would also be eligible for a BHP if the State were to employ it.

This background research precedes additional analysis that Oliver Wyman will provide to Hawai'i as part of this planning process. In this paper, we attempt to present a historical representation of Hawai'i's population; this background presentation includes no projections of either the population or the composition of the State's insurance market. Other papers in the series include a discussion of the State's essential health benefits package design, projections of the State's insurance market as produced by Oliver Wyman's proprietary microsimulation model, and projections of potential Basic Health Plan enrollment (under a scenario in which the

State elects to participate in such a program). The conclusions in this report will provide a basis for these further analyses.

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Introduction

Under the Affordable Care Act (ACA), the Federal government provides funding assistance for the planning and establishment of the Exchanges. Each state may elect to set up Exchanges that will create a new marketplace for heath insurance. The Exchanges will offer consumers a choice of health plan options, oversee the pricing and certification of health plans offering coverage within the Exchanges, calculate premium subsidies and provide information to assist consumers in their purchasing decisions.

Oliver Wyman was engaged by the Hawai'i Department of Commerce and Consumer Affairs (DCCA) to assist them in conducting planning tasks related to the development of Hawai'i's Health Connector (the Connector), which includes the individual Exchange and Small Business Health Options Program (SHOP) Exchange. As one of our initial tasks, we conducted background research required to assess Hawai'i's current population and health insurance marketplace, as well as to prepare this report. This research serves multiple purposes. First, it will provide the DCCA and other key stakeholders and decision makers with a view of Hawai'i's market prior to the implementation of significant reforms. Second, it will serve as the basis for many of the inputs into our modeling, which will occur in a subsequent phase of our work.

In the following sections, we provide a general overview of Hawai'i's current market composition by payer type, including the uninsured. Next, we take a more detailed look at each of the key payer types in turn, examining distributions by various demographic, socioeconomic, and in some cases, geographic categories. For the commercial markets, we include information on current benefit offerings and associated premiums. We also present a summary of some of the rating factors and methodologies used by carriers currently offering coverage in Hawai'i's individual and small group markets. We also provide some initial, high-level indications of the effect that changes required under the ACA could have on rates in these markets in Hawai'i. Finally, we provide a primer on the Basic Health Program (BHP), an optional program that Hawai'i may elect to set up for individuals with incomes between 138% and 200% of the Federal Poverty Level (FPL).[1]

Oliver Wyman has prepared these projections exclusively for the DCCA, to assist the State of Hawai'i (the State) in planning and preparing for the establishment of the Connector. Consistent with Paragraph 24 of the General Conditions of the Contract for Professional Services, this report was prepared for the sole use by the State. All decisions in connection with the

[1] Although the ACA specifies an income threshold of 133% of FPL, it includes a 5% disregard, effectively making the threshold 138% of FPL

implementation or use of advice or recommendations contained in this report are the sole responsibility of the State. This report is not intended for general circulation or publication, nor is it to be used or distributed to others for any purpose other than those that may be set forth herein or in the definitive documentation pursuant to which this report has been issued. These estimates were based on regulations issued by the United States Department of Health and Human Services (HHS), several of which are still in draft form. Our work may not be used or relied upon by any other party or for any purpose other than for which they were issued by Oliver Wyman. Oliver Wyman is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available as of October 1, 2012, and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability. We have relied on a wide range of data for our analysis including but not limited to information received from commercial carriers offering coverage in the State and various State agencies. We have not independently audited these data, however we have reviewed it for reasonableness and asked clarifying questions where warranted.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. The State is responsible for all financial and design decisions regarding the ACA. Such decisions should be made only after the State's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated within this report.

Lastly, the State understands that Oliver Wyman is not engaged in the practice of law and this report, which may include commentary on legal issues and regulations, does not constitute, nor is it a substitute, for legal advice. Accordingly, Oliver Wyman recommends that the State secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

This report is intended to be read and used as a whole and not in parts. Separation or alteration of any section or page from the main body of this report is expressly forbidden and invalidates this report.

There are no third party beneficiaries with respect to this report, and Oliver Wyman does not accept any liability to any third party. In particular, Oliver Wyman shall not have any liability to any third party in respect of the contents of this report or any actions taken or decisions made as a consequence of the results, advice, or recommendations set forth herein.

The information contained in this document and in any of the attachments is not intended by Oliver Wyman to be used, nor can it be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

3

Data and Reliance

In preparing this report, we have reviewed numerous sources of information on participants in Hawai'i's health insurance marketplace. The information included reports from the Med-QUEST Division, the Department of Human Services (DHS), the Department of Labor and Industrial Relation (DLIR), Milliman (one of the consultants for the State), rating data provided to us from carriers in the State, presentations of Hawai'i's estimated uninsured population, reports from the Centers for Medicare and Medicaid Services (CMS), data from the US Census Bureau, the Medical Expenditure Panel Survey (MEPS), Dun and Bradstreet, annual statutory financial statements of insurers issuing policies in Hawai'i, and various other sources. As a simplified characterization of these data, we can best classify them as representing either Hawai'i's population or an insuring entity covering Hawai'i's residents and workers. In the sections below, we discuss our primary data sources for these two classifications of information.

Population Data

We relied on various data sources from the US Census Bureau in estimating both the overall size of the population in Hawai'i as well as in segmenting the market by characteristics such as type of insurance coverage, age, gender and income. Our primary source for these data was the American Community Survey (ACS).

As we have reviewed potential data sources for this and for similar projects, we felt it important that we have one primary data source as a starting point for our analysis. Had we instead relied on data from numerous independent sources as the basis for various aspects of our analysis, we would have faced potential inconsistencies in definitions, time periods and collection techniques among these various sources. As such, we found two primary data candidates for our analysis: the Current Population Survey (CPS) and the ACS. The CPS is conducted by the US Census Bureau and the Bureau of Labor Statistics. It includes interviews of 60,000 households and is primarily focused on reviewing employment levels. The ACS is also conducted by the US Census Bureau. It is sent to approximately 2.9 million housing units per year and gathers information that is only contained in the long form of the decennial census.

We selected the ACS data for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. ACS applies logical edits to the data to adjust for this 'Medicaid Undercount.'[2] Second, the ACS questionnaire includes the question: "Is this person CURRENTLY covered by any…health insurance or health

[2] *http://www.census.gov/hhes/www/hlthins/publications/coverage_edits_final.pdf*

coverage plans?"[3] (Emphasis is from the survey). In contrast, the CPS assesses insured status over an entire year. The first presentation of the question is more consistent with our approach to the forthcoming migration modeling, as it examines a population at a point in time. Third, enrollees are legally obligated to respond to the ACS so, the response rate is quite high (i.e., 98% in 2009).[4] The high response rate both helps to ensure precision of the survey data and hopefully eliminates any potential bias in the Census Bureau's methodology. Fourth, and finally, the ACS includes measures that permit the calculation of standard errors from the sample. We may find these capabilities helpful once we begin developing assumption ranges for the model.

Although the ACS data possess many advantages, they also pose several challenges. We identify some of those challenges here. First, the ACS data are drawn from a small subset of Hawai'i's households. The US Census Bureau then assigns weights to each respondent so that they are intended to characterize the entire population. The data present a less reliable picture of the population as questions become more specific. For example, if we wish to review broad income ranges for Hawai'i's entire population, the ACS queried 13,615 individuals from whom we can assess those levels of income in 2010. We can be fairly certain that the income reported from those 13,615 individuals will be representative of the income for all of Hawai'i's 1,363,621 residents in that year. However, if we wish to examine the income for the privately employed, uninsured population between the ages of 18 and 30, we have only 198 respondents during that same year from which to draw our conclusions. If only a few of these respondents have incomes that are very different from the population they are intended to represent, our conclusions could be skewed. As our questions become more specific the data become less reliable.

Second, because of these credibility issues and because the US Census Bureau includes an allocation methodology for those questions that a respondent might not address in the questionnaire, the estimates will often differ from other credible data sources. For example, the following table shows several estimates of Hawai'i's uninsured population as a percent of the total in 2010.[5]

Table 3.1

Study / Survey	Uninsured
ACS	7.6%
Kaiser Permanente*	8.2%
Gallup Poll**	10.6%

*Hawaii's Uninsured Population Update, Lee, 2011

**http://www.gallup.com/poll/146579/texans-likely-uninsured-mass-residents-least.aspx

[3] *http://www.census.gov/acs/www/Downloads/questionnaires/2009/Quest09.pdf*

[4] *http://www.census.gov/acs/www/methodology/response_rates_data/*

[5] *Please note that we have used 2010 ACS data in this report and in support of the model because the 2011 data will not be available until September or October 2012*

As the table above shows, determining the number of uninsured in Hawai'i could largely depend on the data source reviewed. Between Gallup and ACS, there is a difference of about 40,000 individuals. The reader must understand that the data in some cases are subject to this degree of uncertainty. There will be no perfect picture of Hawai'i's population at the end of the report. As we proceed with modeling the migration of these individuals across different modes of insurance, it will be our task to assess the range of possible responses to the ACA's incentives. It will also be our task to assess the range of possible error in the starting assumptions.

Additional Medicaid Edits

During our review of the ACS data, there were clear inconsistencies with two external sources. First, the Med-QUEST Division identified Medicaid enrollment at the beginning of 2010 totaling 254,000;[6] the ACS data only accounted for 204,000 Medicaid enrollees. Second, statutory financial statements filed by insurers in Hawai'i's market suggest that the ACS overstated those residents with Direct Purchase coverage by approximately 40,000.

We first note that Med-QUEST's reports reflect what would seem to be the upper limit of possible Medicaid enrollment. Medicaid enrollees in households with enrolled children are passively re-enrolled.[7] In addition to passive enrollment, there are other potential sources for data differences. First, in the ACS, the US Census Bureau attempts to address the Medicaid undercount phenomenon identified above. However, their edits do not account for coverage of low-income childless adults. Although the ACS may do a good job of adjusting those enrollees that would traditionally qualify for Medicaid (e.g., Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI)), they have no edits for non-traditional enrollees (e.g., those that would qualify for the QUEST-Net and QUEST-ACE programs). In addition, there may be Compact of Free Association (COFA) enrollees recognized in the Medicaid program that are not recognized in the ACS. According to DHS, they estimate that there are between 10,000 and 12,000 COFA enrollees with Medicaid coverage; ACS recognizes only 5,000. Third, with the disruption to the economy in 2008 and 2009, we would expect volatility (and thus, inconsistency) in enrollment estimates as the number of Medicaid covered persons grows.

Although we were unable to fully reconcile these Medicaid enrollment inconsistencies, we did reclassify a number of people in the ACS data into Medicaid that were not originally identified in that program. Specifically, we revised the insurance classification to "Medicaid" for individuals who indicated they had Direct Purchase coverage who also satisfied one of the following criteria:

- Household earnings below 200% FPL (or whose income was not identified)
- Under the age of 18 with household income less than 301% of FPL

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[6] *http://www.med-quest.us/ManagedCare/MQDquestenroll.html; for 2012, the enrollment is closer to 287,000*

[7] *OW teleconference call with DHS on August 1, 2012*

- Over the age of 17,[8] not the primary resident, with household income over 200% of FPL, and personal income less than $20,000

This process reclassified approximately 31,000 individuals from Direct Purchase to Medicaid. To support these modifications, we note (as indicated above) that the Direct Purchase counts in the ACS data were approximately 40,000 enrollees higher than what was shown in the publicly available financial statements for commercial carriers. We assumed that anyone eligible for coverage under QUEST-Net or QUEST-ACE would obtain that coverage rather than purchase an individual policy even if the coverage was not as comprehensive in 2010. We also assumed that any child eligible for CHIP would be enrolled in that program even if his or her parents had purchased an individual policy. Finally, we assumed that there may be persons who still reside with their parents, who do not qualify for coverage as a child under their parents' policies, and who can obtain coverage under QUEST-Net or QUEST-ACE.

In any other cases, when we have become aware of clear inconsistencies between the ACS data and an alternative, reliable source, we have presented that source and the possible consequences of these inconsistencies.

Medical Expenditure Panel Survey

We also used the Agency for Health Care Research and Quality's MEPS data from 2010 to develop characteristics of Hawai'i's small employer market. MEPS identifies key statistics for the small employer market by state, including employer offer rates, employee take-up rates and premiums by tier. All statistics in the MEPS data are available by various group sizes.

Annual Financial Statement Data

We used annual financial statements to identify total enrollment, premium, claims and other data for Hawai'i's individual, small group, and large group insurance markets. Although we also reviewed prior years' data, the primary source for this work was the 2010 and 2011 Annual Statutory Financial Statements filed on the Health or the Life, Accident and Health (LAH) Statement. To support new insurer reporting requirements, 2010 and 2011 Annual Statements include a new schedule, the Supplemental Health Care Exhibit. Insurers are required to report this schedule separately for each state in which they write comprehensive major medical business.[9] The Supplemental Health Care Exhibit reports detailed income statement data based on individual, small group employer, large group employer, government business, other business, other health and uninsured plans. Small group employers are defined as groups with up to 100 employees,[10] except in states exercising an option under the ACA to define small

[8] *The coverage expansion for dependents to age 26 was implemented in September 2010. Because we are approximating the March 2010 population, we are segmenting dependents at age 18.*

[9] *Experience for individual plans sold through an association or trust is allocated to the state issuing the certificate of coverage. Experience for employer business issued through an association or trust is allocated based on the location of the employer. Experience for group plans with employees in more than one state is allocated to state based on situs of contract.*

[10] *Sole proprietors are not considered a small group under the ACA and will not be eligible to enroll in the SHOP Exchange.*

groups as those with up to 50 employees until 2016. The large group employer category includes the Federal Employees Health Benefit (FEHB) program and state and local fully insured government programs. We obtained access to the Annual Statutory Financial Statement data through a subscription service.

Carrier Data Call

In order to review the current product offerings, premiums and rating structures used by carriers offering coverage in the individual and small group markets, we issued a carrier data request. In this request, we asked that carriers in Hawai'i provide distributions of their enrollees by line of business; we also asked that they provide information about current rating practices.

This information enhanced several aspects of our background research related to the individual and small group markets. We note that in these assessments we supplemented this information with other information such as product brochures gathered from carrier's websites. From these response data, we hope to assess the disruption that might occur in the market with the implementation of the ACA.

As none of the sources of information described above contains a complete picture of the current market, we combined the data from each source to establish the 2010 baseline profile of Hawai'i's insurance marketplace and individuals expected to be eligible for coverage through the Hawai'i Connector in 2014. To ensure data consistency, we compared various summaries of the data across independent sources. Our process of validating these data also highlighted how the various sources overlap and/or fit together and ensured the combined information on which the model estimates are based made sense. Where necessary, we smoothed results so that the final baseline profile presents a coherent, internally consistent picture of the current environment.

Throughout this report, distributions based on FPL are built from the ACS's definition of income and FPL. Starting in 2014, the IRS will use a new definition of family size based on the number of personal exemptions that an individual claims on his or her tax return for determining eligibility for premium credits. However, we do not believe this change to the definition of household income will have a material impact on our findings.

While we have reviewed each of these data sources for reasonableness, and where discrepancies arose we performed further investigation to reconcile any differences, we have not independently audited any of these data.

Finally, please note that some exhibits show population distributions where the figures are rounded. In several cases, the sum of the rounded values from those distributions may not equal 100%. We have tried to provide total estimates for these distributions, but the reader should be aware that the total estimates will not agree with the sum of each weight.

4

Overview of Hawai'i's Current Health Insurance Market

Hawai'i's geography, significant military presence, employer regulations, and existing public programs make it unique among the states and how it will be affected by the ACA. In this section, we will discuss in more detail some of those qualities that make Hawai'i unique. We provide an estimate of how prevalent modes of coverage are employed among Hawai'i's residents, and we introduce those components of the ACA that we expect will most influence the viability of the Hawai'i Connector.

The Hawai'i Connector is intended to provide a robust marketplace where individuals and small employers will be able to shop for health coverage. Additionally, it is expected to provide greater transparency for these purchasers by grouping plans with similar actuarial values and clearly indentified premiums. The viability of the Hawai'i Connector will depend both on the number of participants and the willingness of carriers to offer coverage through them.

There are numerous distinguishing features that make Hawai'i unique among the states. Although we will use later sections to explore some of these features in more depth, there are three features of Hawai'i's health insurance market that we introduce here. First, Hawai'i has a much larger military presence as a percentage of the population than the rest of the country. As of 2010, the ACS data show that nearly 7% of Hawai'i's population received health coverage through the military; less than 2% of the nationwide population is insured through military coverage.

Second, Hawai'i's Prepaid Health Care Act (PHCA) ensures that employers in the State provide coverage to their workers at a much higher rate than do employers in the rest of the country. According to the ACS, nearly 60% of Hawai'i's residents (both active and retired) receive some level of coverage through an employer (e.g., their employer, their spouse's employer, etc.). For the country as a whole, 53% of individuals obtain coverage from an employer. We anticipate that the presence of the PHCA will strongly affect how the ACA influences Hawai'i's health insurance marketplace.

Third, Hawai'i already has experience with an expanded Medicaid program. Hawai'i's QUEST program began as a demonstration waiver (1115a) in August 1994. And through the QUEST-Net and QUEST-ACE programs, Hawai'i has provided some level of coverage to low-income, childless adults. Although the total percentage of the State's population in Medicaid is comparable to the rest of the country, there are far more adults in Hawai'i's Medicaid program.

As a consequence of these three dynamics, Hawai'i also has a much lower rate of uninsured persons than the rest of the country. The following table shows our estimates of enrollment in

2010 both for Hawai'i's residents and the country as a whole. (Please note that the estimates of persons and standard deviations are in 1,000's).

Table 4.1
Coverage Summaries (in 1,000's)

	Hawai'i			Nation		
Coverage	**Persons**	**Distribution**	**Stand Dev +/-**	**Persons**	**Distribution**	**Stand Dev +/-**
Employer (non-Medicare)	717	52.6%	4.7	148,868	48.2%	70.9
Employer (Medicare)	95	7.0%	1.3	13,668	4.4%	16.6
Military (Active)	93	6.8%	2.3	5,236	1.7%	17.5
Military (Retired)	1	0.1%	0.2	357	0.1%	3.3
Direct Purchase	44	3.2%	1.6	16,616	5.4%	34.0
Medicare	77	5.6%	1.4	22,455	7.3%	20.0
Medicaid	193	14.2%	3.5	43,541	14.1%	49.9
Dual	39	2.9%	1.4	9,815	3.2%	19.2
No Coverage	104	7.6%	2.2	48,257	15.6%	48.1
Total	1,363	100.0%		308,813	100.0%	

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Based on the hierarchy that we applied to the ACS data, the table shows that approximately 104,000 residents of Hawai'i are uninsured. As a percentage of the population, the 7.6% estimate of the uninsured also compares favorably with an estimate prepared by the Kaiser in 2010.[11] Next, the table shows that approximately 211,000 residents are covered by Medicare (i.e., retirees with employer administered benefits, those with Medicare alone and those residents dually eligible for Medicare and Medicaid). We do not expect the presence of the Hawai'i Connector to substantially affect the coverage for those residents under Medicare or TriCare. Also, the estimate is consistent with estimates of the Medicare eligible population as identified by CMS (i.e., 204,000).[12] The table shows that the number of residents covered by Direct Purchase insurance is approximately 44,000. This is somewhat higher than the membership (i.e., 31,000) reported in 2010 statutory financial statements by insurance companies with products in Hawai'i. There are multiple reasons why these enrollment figures may be higher than expected. For example, the ACS data may include persons who have

[11] *Lee, Dr. Sang Hyop. 2011. Hawai'i's Uninsured Population Update. Kaiser Permanente.*

[12] *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/MA-State-County-Penetration-Items/CMS1234724.html*

coverage through COBRA (who should be classified as ESI). Finally, the table shows that Hawai'i's Medicaid enrollment was approximately 232,000 in 2010 (Medicaid eligible and dually eligible residents). As discussed in the Data section, this estimate is lower than what is directly reported by the Med-QUEST Division, but higher than what is reported in other survey data.

Because residents can reflect multiple modes of insurance through the ACS, we must classify these individuals into a single category to ensure that we do not double count them. Our hierarchy is very aggressive in assigning enrollees to Medicaid.[13] That is, the hierarchy automatically assigns enrollees to Medicaid if they show any indication of Medicaid coverage. We have not removed anyone from these estimates; so, they may be somewhat different than what is shown on the US Census Bureau's website. Finally, in addition to best estimates, we have included estimates of standard deviation; the ACS provides the tools to prepare these measures. As we model migration, we can employ ranges implied by these statistics to reflect potential statistical error in our starting assumptions.

Key Provisions

There are several key elements of the ACA that we expect will affect how individuals move between their current coverage (or non-coverage) and other coverage modes. As we reviewed Hawai'i's population, we tried to identify those characteristics that would most likely interact with the provisions of ACA. In the following paragraphs, we describe the provisions on which we put particular weight.

The ACA introduces a number of new rating requirements for insurers offering coverage in the individual and small group markets beginning in 2014. Specifically, insurers will no longer be allowed to deny coverage for pre-existing conditions, they will no longer be allowed to rate based on morbidity, gender, industry or group size, and they will be limited in how they are allowed to vary rates based on age.

In general, the ACA's restrictions will have the effect of increasing rates for the young, for males in younger age ranges and for the healthy. They will likely also lower rates for the elderly, for females in younger age ranges, for the unhealthy and for those in very small groups or industries that tend to exhibit higher than average morbidity. These restrictions will limit the extent to which carriers can reflect differences in risk when setting premium rates. (Over time, and in the absence of other requirements, these new restrictions may drive the young and the healthy out of the market or to alternative sources of coverage. The Department of Health and Human Services (HHS) is attempting to mitigate these dynamics in the individual and small group markets by implementing a risk sharing mechanism that will require insurers with healthy enrollees to subsidize insurers with less healthy enrollees. From 2014 to 2016, a transitional reinsurance program is also being implemented in the individual market to help reduce rate

[13] *Appendix C*

shock that might otherwise occur due to high risk individuals entering that market. These programs will be available for plans in the individual and small group markets.)

In addition, the government will now levy annual fees on health insurers of $8 billion starting in 2014 and increasing to $14.3 billion by 2018.[14] The fees will be apportioned based on the insurer's market share, with tax exempt insurers considering only 50% of premium in calculating market share and self funded plans excluded. State managed Medicaid programs and Medicare Advantage plans will also be subject to these fees. Much of the ultimate cost of these fees will likely either be passed on to the insurers' members or put additional pressure on state Medicaid budgets. Some parties have estimated the effect of these fees on premiums to be in the range of 2% to 3%.[15]

Under the ACA, insurers must offer qualified health plans, which satisfy requirements related to marketing, networks, covered benefits, etc. In addition, insurers must offer coverage for these qualified health plans with cost sharing at specific actuarial values. The law identifies these values as Platinum, Gold, Silver, and Bronze (with corresponding actuarial values of 0.9, 0.8, 0.7, and 0.6, respectively). Insurers must offer both Silver and Gold plans if they participate in the Exchange.

Central to the ACA is an individual mandate that imposes a penalty or tax for those individuals who do not maintain minimum essential coverage. The mandate is not universal and provides an exemption for certain low-income individuals who cannot afford coverage (those where the cost of coverage is more than 8% of their income).[16] The penalty is a flat payment of $95 in 2014, $325 in 2015 and $695 in 2016 (on an individual basis), or alternatively, it is a percentage of the household income (1.0% in 2014, 2.0% in 2015, and 2.5% in 2016) with the tax reflecting the larger amount. For a single individual earning $25,000 per year (or approximately 220% FPL in 2010), the penalty would be the following:

Table 4.2
ACA Individual Mandate Example

	2014	2015	2016
Income*	$25,000	$25,000	$25,000
Flat Tax Amount	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amount	$250	$500	$625
Resulting Tax	$250	$500	$695

*Assumes no wage inflation

[14] *The Health Care and Education Reconciliation Act, Subtitle E, Section 1406*

[15] *http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf*

[16] *Exemptions include those below with income below the filing threshold, those belonging to Native American tribes, those in prison, undocumented individuals, those with hardship exemptions, and those with religious exemptions.*

Please note that our micro-simulation model reflects individual preference regarding the value of coverage and its cost relative to fees for being uninsured.

The ACA will provide tax credits to eligible individuals and families with incomes up to 400% of FPL toward the purchase of a qualified health insurance plan through the Hawai'i Connector. Credits will be determined based on the Silver plan in the Connector with the second lowest premium. The credits will be set so that the premium will be limited to a certain percentage of income (on a sliding scale). The following table shows sample income and tax credit levels for an individual related to a theoretical plan level with a monthly premium of $430:

Table 4.3
Sample Income and Tax Credit Levels

Sample FPLs	Income	Plan Cap %	Plan Cap $	Plan Cost*	Tax Credit
133%	14,815	2.0%	296	5,160	4,864
175%	19,493	5.2%	1,004	5,160	4,156
225%	25,063	7.2%	1,798	5,160	3,362
275%	30,632	8.8%	2,688	5,160	2,472
325%	36,202	9.5%	3,439	5,160	1,721

*Assuming this represents the cost for the second lowest cost Silver plan sold through the Connector

Ultimately, the individuals are not obligated to participate in a certain plan level. They may participate in a plan with additional benefits or lower cost sharing, but the tax credit will be calculated relative to the plan index cost (i.e., the Silver plan in the Hawai'i Connector with the second lowest premium).

The ACA requires an annual assessment from large employers (those with 50 or more full-time equivalent employees) that do not offer minimum essential health coverage to their employees. This assessment is equal to $2,000 per employee with a disregard for the first 30 employees. For example, an employer that did not provide coverage to its 250 full-time employees would face a penalty of $440,000 = (250 – 30) x $2,000. Similarly, large employers that do offer coverage and whose employees enroll through the Connector (as a result of eligibility for tax credits) will face an assessment of $250 per month for each month the employee receives coverage through the Connector. In a following section, we discuss the provisions of Hawai'i's PHCA and the incentives that it provides employers. We expect that the PHCA provisions will mitigate the effect of any employer penalty for non-coverage in the ACA.

Beginning in 2014, the ACA extends Federal funding to states that provide Medicaid coverage to individuals who are not Medicare eligible and have incomes below 138% of FPL (133% of FPL with a 5% disregard), regardless of their assets. Hawai'i already has expanded coverage for these childless, low-income adults, and the Federal government will pay a larger share of the cost for covering these individuals starting in 2014 (with funds increasing to 90% by 2020). Effective July 2012, Hawai'i introduced changes to the Medicaid program and how it provides

coverage to childless adults. In particular, the State decreased eligibility income thresholds for childless adults from 200% of FPL to 133% of FPL.

There are a number of other changes to the Medicaid program under the ACA. In particular, it requires that Hawai'i be able to enroll Medicaid eligible residents in Medicaid through the Hawai'i Connector (if that person is found to be eligible as a result of application for coverage through the Connector).

The ACA also provides states the option of establishing a Basic Health Program (BHP) under which a state may enter into contracts for offering one or more health plans providing at least the essential health benefits to eligible individuals.[17] The BHP is intended to smooth the transition between Medicaid and commercial coverage for those enrollees between 138% and 200% FPL (and below 133% FPL for lawfully present immigrants). There is evidence that this population transitions in and out of Medicaid eligibility with some frequency — the BHP is designed to ensure that there is limited disruption in coverage or access.

[17] *Eligible individuals are those with incomes between 133% and 200% of FPL (below 133% of FPL for lawfully present immigrants), are not eligible for Medicare, and do not have access to affordable ESI that provides minimum essential coverage.*

5

Hawai'i's Private Employer Market

In this section, we examine Hawai'i's private employer market. We first present specific provisions of the PHCA. An understanding of the PHCA and how it interacts with the ACA will be critical in anticipating employers' responses to the new health reform law. We also examine new incentives facing Hawai'i's employers under the ACA. Next, we present characteristics of Hawai'i's employers and their employees without regard to insurance coverage status. We then examine the subset of workers that have employer sponsored insurance (ESI) coverage. Finally, we present new small group rating requirements under the ACA.

Prepaid Health Care Act

The PHCA was enacted in 1974, and although it does not apply to government workers and certain other industries (e.g., seasonal agricultural workers); it has a substantial effect on Hawai'i's ESI market. The PHCA requires that applicable employers in Hawai'i provide health care coverage to employees who work twenty hours per week and earn 86.67 times Hawai'i's minimum wage over the course of a month. These coverage requirements begin after an employee has worked for his or her employer for four consecutive weeks.

The PHCA also prescribes certain other requirements. For example, all benefit designs must meet certain minimum standards as determined by the DLIR. The DLIR makes this determination with the assistance of a PHC Advisory Council, which is made up of representatives of various groups. The minimum standards for benefit designs apply to both self-funded employers and those purchasing coverage from insurers. Employers can offer a 7a plan (the prevalent plan), which includes benefits equal to or better than those offered by the plan with the most subscribers in the State. Currently, the prevalent PPO plan has a $100 deductible and 90% in-network coinsurance (with some services at 80%), and under it, the employer is not obligated to pay for any part of dependent coverage.[18] Alternatively, employers can offer a 7b plan, which has a more limited benefit design than the prevalent plan. However, employers that offer the 7b plan are then obligated to pay 50% of the dependent premium. Currently, the 7b plans have a $300 deductible and 80% coinsurance.

Under certain circumstances, employees can waive the mandated coverage. If, for example, an employee is covered through Medicaid, Medicare, or an approved plan, they can complete a notification form for their employer, effectively exempting the employer from its health care coverage responsibilities under the PHCA. However, if the employer does provide coverage, not

[18] http://hawaii.gov/labor/dcd/PDF/PHC/HMSA%20HC-7-a-1-%20-Rev%2009-11.pdf

only must the coverage satisfy minimum benefit requirements, it must satisfy certain contribution requirements as well. Under the PHCA, employees can be required to contribute up to the lesser of 50% of plan cost or 1.5% of income; for most employees, contributions will almost always be capped at 1.5% of income. This contribution requirement is critical in understanding how the ACA will affect employee behavior. Employees will only be eligible for tax credits in the individual exchanges if they can demonstrate that their contributions for employer sponsored coverage are more than 9.5% of their income. Consequently, anyone whose employer complies with the PHCA is unlikely to qualify for tax credits in the Connector.

The PHCA imposes certain penalties for employers that do not comply.[19] For example, an employer that does not provide coverage to eligible employees will be penalized $1 per day per employee for the time during which they were non-compliant. Also, an employer that willfully fails to comply with any provision of the PHCA can be fined $200 for each violation. Perhaps the most compelling provision is the following: any employer who fails to provide coverage to eligible employees will be liable to pay for health care costs incurred by these employees during the period in which the employer was non-compliant. An employer that does not provide coverage to an eligible employee faces significant risk if the employee becomes ill. In addition to the financial incentives for providing coverage, there is also likely additional difficulty in attracting employees that might have other job opportunities with employers that do offer coverage.

Based on discussions with the DLIR, we suspect that neither the 7a plan (i.e., the Prevalent Plan) nor the 7b plan will have an actuarial value near 70%, which is the actuarial value of plans at the silver metallic level. The ACA requires that carriers offer plans that provide the essential health benefits package. Based on discussions with the DLIR, some carriers currently offer parts of this package (e.g., prescription drug coverage) as a rider; they will no longer be able to market any parts of the EHB package as an add-on.

Because of the presence of the PHCA, employers in Hawai'i may be less likely than those in other states to terminate their coverage. Because many more residents of Hawai'i obtain their coverage through their employer, the Connector (i.e., the individual Exchange) may have lower participation (as a percentage of the total population) than will the Exchanges in other states. If this high coverage rate among employers persists, fewer Federal funds in the form of tax credits would come into the State. In addition, the cost per enrollee to run an Exchange will be higher with fewer enrollees.

Employer Incentives

The ACA introduces several new rating requirements for insurers. Although we have discussed some of these requirements in a previous section, we continue our discussion of specific requirements in this section. In general, the new regulations are expected to increase premiums for some groups and decrease them for others. The premium disruption will depend on the

[19] *http://www.capitol.hawaii.gov/hrscurrent/Vol07_Ch0346-0398/HRS0393*

demographic composition of the group, the group's current morbidity load, and the efficacy of a new risk sharing mechanism. This new risk sharing mechanism will require small group insurers with healthy enrollees to subsidize insurers with less healthy enrollees.

The ACA includes other provisions that will affect premiums in the group market. First, the government will assess new fees against insurers; as previously identified, some estimate that these will be in the range of 2% to 3% of premium.[20] In addition, there are several other new taxes and fees (such as fees assessed on pharmaceutical manufacturers and a 2.3% excise tax on medical devices) that will affect premium.

In the short-term, some small employers will receive incentives in the form of tax credits to offer coverage to their employees.[21] Employers with fewer than 25 full-time employees who have an average annual salary of less than $50,000 and pay at least 50% of the single premium for health insurance can receive a tax credit up to as much as 35% of the employer's contribution (25% if the employer is a non-profit) in 2010 through 2013. The maximum credit is available to employers with less than ten full-time employees and an average annual salary of less than $25,000. The credit is phased out as the number of full-time employees increase to 25 and the average annual salary increases to $50,000. In 2014 and later, employers can take the tax credits for two consecutive years, after which no additional credits are available. In these years the maximum credit is increased to 50% of the employers' contribution, with a similar phase-out schedule based on employer size and average payroll as occurs between 2010 and 2013.

Although the presence of the PHCA will likely minimize coverage attrition (among those employers to which it applies), the ACA introduces some incentives for employers to drop coverage. For example, most low-income individuals will be eligible for tax credits if they purchase coverage directly through the Connector. An employer with many low-income employees may find that it is less costly to pay the penalty and simply provide their employees with additional compensation to cover the cost of the unsubsidized portion of the premium. In this case, these subsidy-eligible employees that purchase individual coverage in the Connector might also qualify for cost-sharing subsidies. As specified though, the presence of the PHCA will likely eliminate this option for many employers.

Hawai'i's Private Employer Market

As we review Hawai'i's ESI market, it will be important that we understand the composition of those employers participating in it. When looking at distributions of private workers in each industry across the island groups, there is a clear difference in the geographic concentration of those workers. The following table shows that distribution.

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[20] *http://www.ahipcoverage.com/wp-content/uploads/2011/11/Insurer-Fees-report-final.pdf*

[21] *http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers*

Table 5.1
Employee Distribution by Industry

Industry	Island			Industry Distrubtion
	Oahu	Hawai'i	Kauai, Maui, Molokai	
Agr, Mining, Util	37.4%	33.7%	28.9%	2.8%
Const & Manu	60.6%	19.3%	20.1%	13.8%
Trade	70.7%	14.0%	15.3%	16.8%
Transp, Info, Finan	75.0%	8.6%	16.4%	11.5%
Real Estate	61.3%	11.2%	27.5%	3.8%
Prof, Sci, Tech	71.4%	10.2%	18.4%	5.3%
Mang, Admin Srv	57.4%	17.2%	25.5%	6.1%
Education	79.7%	14.7%	5.6%	3.6%
Health & Soc Srv	77.1%	11.8%	11.1%	12.1%
Arts, Ent, Food, Other	64.0%	13.5%	22.5%	24.1%
Total	67.2%	14.2%	18.6%	100.0%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows the distribution of persons employed in each industry group for all islands (rightmost column); it also shows the distribution for a specific industry across each island group. For example, the column at the right shows that 2.8% of the total privately employed population is in agriculture, mining or utilities. While the preceding columns show that approximately the same number of people across each island group are employed in agriculture, mining, and utilities (at 37.4%, 33.7%, and 28.9% in Oahu, Hawai'i, and the remaining islands, respectively).

There are several notable observations from the preceding table. First, Oahu has a higher concentration of persons employed in transportation, information, and finance, as well as education and health and social services (75.0%, 79.7%, and 77.1% respectively versus 67.2% for all industries in total). Second, the other islands have a higher concentration of persons employed in construction, manufacturing and real estate as well as in agriculture, mining and utilities. For many in this second group, the PHCA does not apply. Businesses employing seasonal agricultural workers or real estate salespersons paid by commission are exempt from the law (as it applies to those workers). As such, a higher proportion of workers outside Oahu may decide to take advantage of subsidies available through the Exchanges.

As part of Oliver Wyman's micro-simulation model, we create theoretical (or synthetic groups) for estimating the possible effects of various elements of the ACA. In creating these groups, we pool persons with the same industry type; as a consequence, we are able to tailor other assumptions, like group size or participation, to specific industries. The distributions in the preceding table are critical in creating these synthetic groups.

The ACS also permits us to examine coverage status by industry for employed persons.

Table 5.2
Coverage Status by Industry

Industry	with ESI	FT Uninsured	PT Uninsured	Other Cov	Total
Agr, Mining, Util	70.2%	5.8%	5.7%	18.3%	2.8%
Const & Manu	64.9%	7.2%	8.2%	19.7%	13.8%
Trade	69.8%	3.9%	5.9%	20.4%	16.8%
Transp, Info, Finan	75.1%	4.3%	4.7%	15.8%	11.5%
Real Estate	69.8%	2.4%	4.4%	23.4%	3.8%
Prof, Sci, Tech	69.6%	4.9%	4.6%	20.8%	5.3%
Mang, Admin Srv	65.0%	7.3%	10.0%	17.7%	6.1%
Education	72.1%	1.3%	4.2%	22.4%	3.6%
Health & Soc Srv	78.0%	2.9%	3.4%	15.7%	12.1%
Arts, Ent, Food, Other	66.7%	4.7%	8.4%	20.2%	24.1%
Total	69.8%	4.6%	6.4%	19.1%	100.0%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As with the preceding table, the distribution in the rightmost column shows private employment by industry. Each column on the rows preceding those entries show how the employed population is distributed for each specified status. For example, the table indicates that 12.1% of privately employed persons work in health and social services. Among those employed persons, 78% have health insurance through an employer.

Please note that we identify full-time workers as those who have worked 35 hours or more in the week preceding the response to the ACS questionnaire. The ACS does not provide information with the detail that would be necessary to assess coverage eligibility under the PHCA. Also, the ACS does not specify whether coverage is obtained through the respondent's employer or someone else's employer. For example, a real estate agent might have coverage through his wife who works as a health care worker. This theoretical person would contribute weight to the 'real estate employee with ESI' cell even though the coverage in that case is not truly associated with the industry. (We do not think this introduces error unless there is reason to suspect a systematic bias in coverage. For example, if we thought most real estate agents were married to health care workers, such a dynamic could produce a bias in our estimates.)

On average, about 69.8% of private employees have coverage through an employer. The table identifies some industries in which workers are more likely to be covered by an employer (e.g., health and social services at 78.0% and transportation, information, and finance at 75.1%). We have already noted geographic differences in distributions of employment by industry. It is not clear that persons are more or less likely to have coverage because of the industry in which they work (e.g., health and social services) or because of the place in which they work (e.g., Oahu).

Data sources beyond the ACS allow us to examine other characteristics of Hawai'i's private employer market. The following table is from the 2010 MEPS data summaries, and it shows distributions of private employees by group size.

Table 5.3
Group and Employee Distributions (Private)

Organization	Hawai'i		Nationwide	
Employees	Groups	Employees	Groups	Employees
2 to 9	55%	12%	58%	12%
10 to 24	13%	9%	12%	9%
25 to 99	10%	18%	8%	14%
100 to 999	8%	19%	7%	18%
1,000 or more	15%	42%	15%	47%

2010 Medical Expenditure Panel Survey – http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

Please note the group size classifications are determined at the organization level. For example, the employees at a large chain, fast food restaurant might be classified in the largest group size even though the particular establishment responding to the MEPS questionnaire might only employ a few dozen people.

Although employers in the mid group market (i.e., 25 to 99) are proportionally larger in Hawai'i than in the country as whole, the table shows that the composition of groups by organization size in Hawai'i is very similar with the nationwide composition. The MEPS data yield some other interesting observations about Hawai'i's private employers. For example, MEPS reports the average nationwide single premium as $4,940 for employees at establishments that offer coverage. In Hawai'i, the corresponding single premium estimate is $4,294; this estimate is also reported with an average deductible estimate that is lower in Hawai'i than in the country as a whole.

The following table, also from the 2010 MEPS data, highlights how unique coverage rates are in Hawai'i's employer market relative to the country as a whole. Coverage is offered at a much higher rate in all group sizes. In total, 84.7% of employers in Hawai'i offer coverage, while only 53.8% of employers nationwide do. This difference is particularly striking among groups with fewer than 25 employees. In Hawai'i, 77.2% employers in this segment offer coverage; for the whole country, 36.7% of employers in this segment offer coverage. As a consequence, a larger percentage of small group employees will likely be eligible to enroll in the Hawai'i SHOP Exchange than will employees of groups this size in other states. However, the ultimate decision to enroll in the SHOP lies with the employer; even if the potential market for the SHOP is relatively large, potential enrollment is no guarantee of participation. The enrollment will ultimately depend on the SHOP's appeal to employers.

Table 5.4
Employee Contribution Rates

Hawai'i

Employer Size	% of Establishments Offering Coverage	Employee Contribution	Employee % of Total	Family Contribution	Family % of Total
2 to 9	73%	$223	5%	$1,330	11%
10 to 24	94%	$108	2%	$2,327	20%
25 to 99	100%	$266	6%	$3,112	26%
100 to 999	100%	$597	14%	$4,945	41%
1,000 or more	100%	$633	15%	$3,060	25%

Nationwide

Employer Size	% of Establishments Offering Coverage	Employee Contribution	Employee % of Total	Family Contribution	Family % of Total
2 to 9	32%	$857	16%	$3,208	24%
10 to 24	61%	$889	18%	$4,427	33%
25 to 99	81%	$1,009	21%	$4,574	35%
100 to 999	95%	$1,081	21%	$4,050	29%
1,000 or more	100%	$1,044	21%	$3,443	24%

2010 Medical Expenditure Panel Survey – http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

In addition to showing offer rates, the table also shows annual employee contribution rates for single and family coverage. In particular, the average contribution rates for single employees are lower for all group sizes in Hawai'i than they are nationwide. The table also shows that average family contribution rates for groups with 100 or more employees are higher in Hawai'i than they are nationwide. We suspect that these higher contribution rates are present because the PHCA does not require employers to contribute to dependent coverage under the prevalent plan.

According to the MEPS data, 98% of all employees working for a private employer in Hawai'i work for an employer that also offers coverage. Of those employees, only 80% are eligible for coverage, and of those that are eligible, only 84% enroll in the plan. This means that 67% (= 80% x 84%) of employees working for a private employer offering coverage are actually enrolled in the plan. The corresponding estimate for employees nationwide is 60%. For the whole country, 78% of employees that work for employers offering coverage are eligible; of these nationwide employees, only 77% of them actually enroll. Not only do more employees in Hawai'i work for employers offering coverage, but those that are eligible, enroll at a higher rate (84% versus 77%).

There are several possible reasons why only 84% of the employees in Hawai'i who are eligible for coverage are enrolled. First, some may find that coverage offered through their spouse's employer is more affordable (e.g., $0 premium). Further, some employees, particularly those in

good health, may perceive the value of coverage to be less than the cost. Finally, some employees may have coverage through other means (e.g., through Medicaid).

The table below shows the distribution of the previously mentioned 67% enrollment rate in Hawai'i and the 60% enrollment rate nationwide by group size. The table shows that, for both large and small groups, the enrollment rate for private sector employees who are offered ESI coverage is higher in Hawai'i than it is for the nation as a whole. This higher rate of enrollment is principally due to higher take-up of coverage among employees that are eligible for it.

Table 5.5
ESI Coverage by Group Size Among Private Sector Employees

	Hawai'i		Nationwide	
	Distribution of Employees	% Covered by Employer	Distribution of Employees	% Covered by Employer
Group Size				
2 to 9	12%	72%	12%	64%
10 to 24	9%	70%	9%	57%
25 to 99	18%	71%	14%	56%
100 to 999	19%	69%	18%	58%
1,000 or more	42%	62%	47%	61%
SG & LG				
0 to 49	29%	70%	28%	59%
50 or more	72%	65%	73%	60%
Total	100%	67%	100%	60%

2010 Medical Expenditure Panel Survey – http://meps.ahrq.gov/mepsweb/data_stats/state_tables.jsp

It is also worth noting that a larger proportion of Hawai'i's private employees work in groups with 25 to 99 employees (relative to the nation as a whole), while there is a lower representation of private employees in groups with 1,000 or more employees.

In addition to examining employers and their coverage tendencies, it is also important to examine the characteristics of the Hawai'i's employees that are covered by ESI. The following table shows the distribution of active employees of groups by age and gender:

Table 5.6
ESI Enrollment Rates (Active Private Employees)

	Hawai'i		Nationwide	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	11.7%	10.7%	12.6%	12.0%
18 to 24	4.8%	3.9%	4.7%	4.7%
25 to 29	3.5%	3.7%	3.2%	3.6%
30 to 34	3.9%	3.7%	3.6%	3.9%
35 to 39	4.7%	4.1%	3.9%	4.2%
40 to 44	4.1%	4.7%	4.3%	4.5%
45 to 49	4.8%	4.7%	4.6%	5.0%
50 to 54	4.4%	5.0%	4.6%	5.0%
55 to 59	4.3%	4.6%	4.0%	4.4%
60 to 64	3.9%	4.1%	3.3%	3.5%
65+	0.4%	0.5%	0.3%	0.3%
Total	50.5%	49.5%	49.1%	50.9%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the table shows, there are not substantial differences between Hawai'i's age and gender composition and the composition for individuals from the rest of the country. Other than enrollment of child dependents, the number of persons covered by ESI appears to peak around the 45 to 54 age ranges. We also note that, with some minor exceptions, enrollment for men and women tracks very closely between Hawai'i and the nation as a whole.
In addition to demographic estimates, we can also examine coverage through ESI by income level. The following table shows the distribution of active employees of private groups by their relationship to FPL:

Table 5.7
ESI Coverage (in 1,000's)

	Hawai'i		Nationwide	
FPL	**Persons**	**Percentage**	**Persons**	**Percentage**
0 to 100%	36	5.0%	7,704	5.2%
101% to 138%	17	2.4%	4,214	2.8%
139% to 200%	37	5.2%	11,173	7.5%
201% to 300%	113	15.8%	24,231	16.3%
301% to 400%	137	19.0%	25,214	16.9%
401% +	377	52.5%	76,332	51.3%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Consistent with the country as a whole, Hawai'i's residents with ESI are weighted toward the higher income ranges specified here. Given the contribution requirements of the PHCA, it is somewhat surprising that there are not more ESI enrollees at the lower income levels. In fact,

the table shows that there are a higher proportion of individuals with ESI at the higher income ranges (i.e., above 300% of FPL) in Hawai'i than in the rest of the country.

Fully Insured Group Coverage Offered in Hawai'i

Beginning in 2011, the ACA implemented rules that require carriers to meet new minimum loss ratio requirements separately for the small group and large group markets. Carriers that do not meet the loss ratio requirements must refund premiums to policyholders. In order to support enforcement of these new rules, Statutory Financial Statements now include a Supplemental Health Care Exhibit that permits review of each carrier's experience by line of business.

The following table provides a summary of the 2011 large group experience (51 employees or more) for each carrier in the Hawai'i market.

Table 5.8
Large Group Carriers

Carrier	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Hawai'i Medical Services Assn	3,928,805	$275.45	$247.95	90%
Kaiser Foundation Health Plan Inc	1,625,121	305.09	295.66	97%
University Health Alliance	223,800	129.42	118.77	92%
Hawai'i Management Alliance Assn	228,897	227.04	204.12	90%
Kaiser Permanente Ins Co*	80,186	66.71	58.66	88%
Total	6,086,809	$273.42	$251.79	92%
Average	507,234			

*Kaiser Permanente is part of Kaiser Foundation Health Plan, but files separately for their OON POS benefits

2011 Annual Statutory Financial Statements, Supplemental Health Care Exhibit

The table shows that approximately 507,000 individuals were covered under a fully insured large group policy in 2011. These individuals are covered by five carriers (under four organizations) that filed statutory financials for group business in Hawai'i. Of those five, over 90% of individuals covered in large groups are covered by the top two carriers, Hawai'i Medical Services Association and Kaiser Foundation Health Plan, Inc. Although there is some variation of loss ratio by carrier, the aggregate loss ratio is consistent with our expectations for large group blocks of business. (Please note member months reflect covered individuals, not employees)

Although reported premiums vary by insurer, it is important to note that the premiums in the table above reflect the underlying differences in demographics and benefits.

For several reasons, we anticipate that a majority of the individuals covered by large groups are unlikely to participate in the Connector or the SHOP (at least until 2017). First, states may expand the SHOP to include large employers starting 2017, but until then, large groups are not eligible to enroll in them. Second, the PHCA provides large employers significant financial incentives to maintain coverage for their employees. It is unlikely that these groups would drop coverage and move the enrollees into the individual Connector.

As noted, the Supplemental Health Care Exhibits also provide carriers' experience for small group (50 employees or less). The following table provides a summary of that experience in 2011.

Table 5.9
Small Group Carriers

Carrier	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Hawai'i Medical Services Assn	917,694	$373.32	$329.75	88%
Kaiser Foundation Health Plan Inc	316,553	298.39	261.77	88%
University Health Alliance	275,599	123.21	97.71	79%
Hawai'i Management Alliance Assn	268,564	250.32	200.72	80%
Kaiser Permanente Ins Co	30,021	72.27	49.40	68%
Total	1,808,431	$298.82	$258.67	87%
Average	150,703			

*Kaiser Permanente is part of Kaiser Foundation Health Plan, but files separately for their OON POS benefits

2011 Annual Statutory Financial Statements, Supplemental Health Care Exhibit

The table identifies approximately 151,000 individuals that were covered under a small group policy in 2011. Of the carriers offering small group coverage, Hawai'i Medical Services Association is still the largest based on enrollment. However relative to large group carriers, we see a larger proportion of enrollment (i.e., about 30%) covered by the two smallest carriers (i.e., University Health Alliance and Hawai'i Management Alliance Association, but excluding Kaiser Permanente). The small group market shows less concentration than the large group market.

We note that the small group premiums are almost 10% higher than the large group premiums. Although there are no clear indications of what may cause these premium differences, there are a number of possible reasons. These reasons include but are not limited to differences in demographics and benefit offerings, differences in mix by industry, greater anti-selection in the small group market, and lower administrative expenses on a per member basis in the large group market.

The loss ratios for small group lines of business are also slightly more volatile across carriers than are the loss ratios across carriers for large group lines of business. For the entire small group market, the observed loss ratio (i.e., incurred claims divided by premium) in 2011 was 87%.

In order to demonstrate compliance with the minimum loss ratio requirements, carriers are allowed to make several adjustments to the raw loss ratio. For example, carriers may increase claims in the numerator for expenses related to quality improvement activities; similarly, carriers may lower the premium in the denominator to recognize certain taxes and fees. These adjustments are carrier specific and increase the "adjusted" loss ratio. In addition, the minimum loss ratio regulations prescribe a credibility adjustment based on each carrier's enrollment; this

adjustment also serves to increase the "adjusted" loss ratio. Although a carrier may show a loss ratio below the required minimum (e.g., University Health Alliance in the table above), they may not owe policyholders a premium refund once the loss ratio calculation includes these additional adjustments.

Rate Development in the Small Group Market

Hawai'i's small group market is currently defined as employers with two to 50 employees. We note that the ACA defines small group as at least one but no more than 100 employees on business days during the preceding calendar year. The ACA allows states to substitute "50 employees" for "100 employees" in the definition until 2016. Therefore, Hawai'i can continue to use its current definition of small group until 2016. We also note that, while the ACA definition of small group includes groups of one, recently released regulations related to establishment of Exchanges indicate that coverage for only a sole proprietor would not constitute a group health plan under the Employee Retirement Income Security Act (ERISA). These sole proprietors would not be entitled to purchase coverage in the small group market under Federal law, and therefore, it appears that these groups of one would not be eligible to participate in the Hawai'i SHOP Exchange.

There are a number of provisions within the ACA that can change either the average premium or the premium charged to a specific small group, or both. In order to better understand these changes in Hawai'i's small group market, Oliver Wyman submitted a data request to carriers asking that they provide information about their current blocks of business. Because of the number of responses, we are unable to provide information about the carriers' rating methods without potentially revealing information about specific carriers. However, we can discuss what changes in the ACA will mean in general terms for the small group market. For example, we can specify that some carriers do not use all rating tools available to them (e.g., rating by industry). Rate shock for groups with these carriers will be mitigated because their carrier does not employ all of the soon-to-be prohibited tools. And, there are some carriers that employ rating elements (morbidity, group size) that will no longer be permitted after 2013. We discuss these changes in the following paragraphs with some additional detail.

First, health plans will no longer be allowed to rate small groups based on their health status.[22] This provision will tend to lower premiums for those groups with employees in poor health, while increasing premiums for those employees in good health. From the carrier responses, we do see that some groups will be affected by the elimination of health status as a rating characteristic.

Second, health plans will be limited in their ability to rate groups based on the age of their employees, and will no longer be able to rate based on gender, group size or industry.[23] These

[22] Section 2701(a) of the ACA

[23] Section 1201 of the ACA

provisions will tend to lower premiums for older employees and smaller groups, while increasing premiums for younger employees — especially younger males — and larger small groups. Based on the carrier responses, we are assessing the expected effect the new rating rules will have on small group premiums.

Third, new minimum benefit and coverage requirements will tend to put upward pressure on small group premiums.[24] The CBO estimates that premiums in the nationwide small group market will increase by as much as 3% in 2016 as a result of required increases in benefits. Finally, new fees prescribed in the ACA will place upward pressure on premiums if passed along to policyholders. These fees, which we briefly identified at the start of the section, have several forms, but they include the following:

- Annual fees levied on health insurers[25]
- Temporary fees on all health insurance issuers and third-party administrators of group health plans for reinsurance in the individual market[26]
- Fees assessed against pharmaceutical manufacturers[27]
- An excise tax on medical devices [28]

Starting in 2014, the ACA requires that insurers must adopt an adjusted community rating approach as described above. This requirement will limit how carriers can reflect risk differences when setting premium rates. The effect that this new restriction has on premiums will depend upon the degree to which Hawai'i's small group carriers currently employ these measures. Hawai'i has historically afforded its carriers flexibility in how they rate groups and vary premiums based on age, gender, geography, industry, group size and morbidity.

In the forthcoming analysis supported by Oliver Wyman's micro-simulation model, we will recognize the effect of these new rating restrictions in our aggregate summaries.

[24] Section 1302(a) of the ACA

[25] Section 9010 of the ACA

[26] Section 1341(b)(3)(B) of the ACA

[27] Section 9008 of the ACA

[28] Section 9009 of the ACA

6

Hawai'i's Individual Direct Purchase Market

In Section 6, we take a closer look at Hawai'i's Direct Purchase (or individual) market, examining various characteristics of its carriers and members. In particular, we segment the population based on the prevalence of insurance coverage by age, income, average insurance premiums and certain benefit characteristics. Finally, as in the section on ESI, we present a summary of carriers currently offering coverage in the Direct Purchase market; we show their current market share and premium levels. We also present a summary of benefit plans and some rating practices currently used to develop rates in the individual market, along with an initial, high level impression of the potential effect that rate compression required under the ACA may have on premiums.

Individual Incentives

Of the provisions introduced by the ACA, the Direct Purchase market may see more changes than any other market. The ACA establishes new rating requirements for insurers, new fees for insurers and ancillary providers, tax credits to purchase coverage in the Connector for certain low-income individuals, expanded funding of Medicaid, and various other characteristics. In this section, we will provide a discussion of the market's demographics and new rating requirements for insurers; however, many of these other topics are either covered in more depth in other sections or they are less likely to affect enrollee behavior in this market than in other markets.

Demographics

We are principally concerned with four populations in this background research report: the ESI, Direct Purchase, Medicaid and uninsured. The Direct Purchase population is the smallest of these four. As we present exhibits from the 2010 ACS data, it is important that the reader be aware that, although the market size estimate is credible in total, some estimates of the segmented population may lack credibility due to the small size of this particular market.

The Direct Purchase market has the following age and gender distribution.

Table 6.1
Direct Purchase Enrollment Rates

	Hawai'i		Nationwide	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	11.5%	9.8%	11.6%	10.9%
18 to 24	0.5%	0.8%	7.9%	7.7%
25 to 29	2.2%	2.7%	4.0%	3.6%
30 to 34	4.2%	4.4%	2.9%	2.8%
35 to 39	3.9%	2.5%	3.0%	2.9%
40 to 44	3.1%	3.6%	3.3%	3.4%
45 to 49	3.7%	5.8%	4.0%	4.1%
50 to 54	5.4%	5.6%	4.3%	4.4%
55 to 59	6.8%	7.2%	4.1%	4.8%
60 to 64	7.3%	8.1%	4.1%	5.5%
65+	0.0%	0.9%	0.3%	0.4%
Total	48.6%	51.4%	49.5%	50.5%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The ACS data show that Hawai'i's Direct Purchase market is generally consistent with the Direct Purchase market for the rest of the country. We note a distinctly lower percentage of Direct Purchase members in the 18 to 24 range in Hawai'i than in the rest of the country. We also note a higher percentage of Direct Purchase members in the 50 to 64 range in Hawai'i than in the rest of the country. We often see that early retirees will either go without insurance or purchase coverage directly. Based on the distribution above, it appears that early retirees in Hawai'i may seek out individual policies at a higher rate than we see for that population in the rest of the country.

The ACS data show that participants in the Direct Purchase market have the following income levels.

Table 6.2
Direct Purchase (in 1,000's)

	Hawai'i	
FPL	**Persons**	**Percentage**
201% to 300%	7	15.6%
301% to 400%	9	20.7%
401% +	28	63.7%

2010 American Community Survey – Person Level Data,
http://www2.census.gov/acs2010_1yr/pums/

(As mentioned in the Data section, we have assumed that anyone in the ACS data identified as a direct purchaser and with income below 200% FPL is better classified as a Medicaid enrollee.) The table shows that the majority of Direct Purchase enrollees have incomes above 400% FPL. These higher income members will not have access to tax credits through the Connector, and they could see their premiums increase as a result of required benefit increases, participation of new policyholders in the individual market and a new insurer tax beginning in 2014. In addition, rate compression from both the elimination of gender rating as well as new age rating restrictions (i.e., no more than a 3:1 difference in rates by age) could lead to additional increases in rates for certain demographic cells, essentially amplifying the increase. Some of these members may question the value of their health coverage relative to its cost, and simply choose to go without coverage and pay the individual penalty. Please note that the individual penalty for these higher earners will increase with their income; so, forgoing coverage may be less desirable as the penalties increase. Also, the new rating restrictions may make premiums more attractive for certain members, drawing in new participants to the Direct Purchase market.

Rate Development in the Individual Direct Purchase Market

Beginning in 2011, carriers were required to meet new minimum loss ratio requirements. To support examination of these requirements, the Statutory Financial Statements include a new Supplemental Health Care Exhibit. As such, we are now able to provide certain summary measures by line of business. The following table summarizes the Direct Purchase market in 2011, using information from these publicly available financial statements.

Table 6.3
Hawai'i - 2011 Direct Purchase Experience

Carrier	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Hawai'i Medical Services Assn	199,000	260.71	226.96	87%
Kaiser Foundation Health Plan Inc	176,000	221.75	208.74	94%
Total	375,000	$242.43	$218.41	90%
Average	31,250			

2011 Annual Statutory Financial Statements, Supplemental Health Care Exhibit

The table above shows that roughly 31,250 residents were covered under an individual policy at any point in time in 2011. Over the course of the year, individuals will obtain or drop coverage; so, these were not necessarily the same 31,250 people each month.

From the ACS data, we estimated that roughly 44,000 individuals reported having Direct Purchase coverage. There are several potential reasons for the inconsistency. For example, the underlying level or type of coverage may be a source of the difference. The figures in the table above are from the Supplemental Health Care Exhibit, and they represent comprehensive health coverage. The ACS asks respondents if they have "insurance purchased directly from an insurance company by this person or another family member." Therefore, someone with a hospital indemnity or other limited benefit policy may appear in the ACS data as having Direct

Purchase coverage depending upon how they interpret the question. In addition, a person with COBRA coverage might respond that they have purchased coverage directly from an insurance company; in such a case, the carrier would report that person under a group line of business.

The entire market for individual policies is occupied by two carriers, Hawai'i Medical Services Association (HMSA) and Kaiser Foundation Health Plan, Inc. (Kaiser). And between these two carriers, the market is split relatively evenly. The combined loss ratio for the two carriers is 90%, which is higher than we would expect in the individual market. To provide the reader a basis for comparison, the new minimum loss ratio requirements under the ACA prescribe a loss ratio of no more than 80% for individual lines of business. This prescribed minimum includes a number of offsets for taxes, quality improvement initiatives, etc; it also includes a credibility adjustment. Given the size of the market, these adjustments would likely enable traditional loss ratios that are closer to 75%. Furthermore, the 2011 loss ratio for these two carriers appears to be characteristic of their experience rather than an anomaly for the one year. In 2010, the aggregate loss ratio for individual lines of business was 92%.

The table also shows that in 2011 the average monthly premium for the two carriers was $242 per member per month (PMPM). The average premium in the table above is lower than the average premium of $299 PMPM that we observed in the small group market (Table 5.9 in the previous section). There are a number of reasons why we would expect this difference. For example, the PHCA requires a minimum level of coverage for group employees, while there is no such restriction in the individual market. Also, coverage in the small group market is sold on a guarantee issue basis, as required by Federal law. Carriers in the individual market are allowed to medically underwrite and reject individuals for coverage entirely on the basis of medical conditions. This capability to decline coverage to high risk individuals will lead to a healthier population in the individual lines of business and consequently to lower premiums.

In 2014, the ACA will prohibit insurers from denying individual coverage on the basis of pre-existing conditions.[29] The ACA will prohibit rating based on gender while also imposing new age rating restrictions. The new requirements will generally lead to increased rates for the young, for males in some age ranges, and for the healthy; they will also likely lower rates for the elderly, for females in some age ranges, and for the unhealthy. Carriers will see new limitations on their ability to reflect risk differences when setting premium rates.

As mentioned in the Data section, Oliver Wyman issued a carrier data request in which we asked each carrier to provide distributions of their enrollees by line of business. We also asked that they provide information about current rating practices. Because there are only two carriers in the market, we cannot discuss specific rating practices or enrollment characteristics from the Oliver Wyman data request without openly presenting the response data for each carrier.

[29] Section 1201 of the ACA

On the previous page, we presented average premiums offered in Hawai'i for the 2011 plan year. In addition, we have looked at each carrier's public website, and we can briefly discuss information provided there. Please note that the descriptions below are based on information **currently** available on each carrier's website. The information may not correspond with what was in place for 2010 or 2011 or what will be in place in future years.

Benefit Offerings in the Direct Purchase Market

As discussed in a previous section, the ACA requires that individuals obtain minimum essential coverage for themselves and their dependents beginning in 2014. We also discussed that the purchase of a QHP in the individual market would satisfy this requirement, thus avoiding a tax penalty.

Although HMSA offers various products that they classify as providing individual coverage (e.g., student, conversion, etc.), our review focuses on those plans identified as Individual Care Plans or the Catastrophic Care Plan. Under these plan types, HMSA offers a total of three benefit designs. Under Individual Care Plan type, HMSA offers the high option design and basic option design, and both plans are HMOs. Under the Catastrophic Care Plan, HMSA offers one design, a PPO.

Similarly, Kaiser's website presented three primary plan types. Two of the plans are more comprehensive, provide network coverage only, and have copays for most of their cost sharing provisions. The third plan provides limited coverage, only focusing on facility-based services.

The following table summarizes the single deductible, out-of-pocket (OOP) maximum, office visit cost sharing and inpatient cost sharing of these plans:

Table 6.4

	Single Deductible	Office Visit	Inpatient Visit	OOP Maximum
HMSA				
ICP High Option	$300	$20	10%	$5,000
ICP Basic Option	$500	$20	30%	$7,500
Catastrophic	$2,500	$20	20%	$3,500
Kaiser				
KP 20/Rx	$0	$20	$150 per Day	$2,500
KP 30/RX	$0	$30	$450 per Day	$4,000
KP Basic	$0	NC	$500 per Day	$5,000

http://www.hmsa.com/healthplans/individual/icp/default.aspx

http://www.hmsa.com/healthplans/individual/ccp/default.aspx

https://kaiser.healthinsurance-asp.com/expressweb/plan/AvailablePlans.action?groupId=0&quoteId=0#

The Kaiser KP Basic plan provides almost no coverage for outpatient services, while the remaining plans are generally consistent in what they cover. However, the cost sharing can vary substantially between each plan. It is also worth noting that the HMSA catastrophic plan is a PPO while the other two HMSA and Kaiser plans are HMOs.

Coverage Tier, Age/Gender, and Health Status

Based on information from each carrier's website, we were able to glean some information about current rating practices. For the three HMSA plans, rates are offered for three tiers: individual, two party, and family, and these tiers are rated over three age ranges: 0 to 24, 25 to 49, and 50+. Based on information from HMSA's website, the tier and plan relativities for the individual plans have the following form:

	Tier		
Age	**Individual**	**Two Party**	**Family**
0-24	0.68	1.36	2.04
25-49	1.00	2.00	3.00
50+	1.36	2.72	4.08

The 2012 rates presented on HMSA's website for the three plans in question do not show variations in age rating above the 3 to 1 differential prescribed by the ACA. As a consequence, we do not expect HMSA enrollees to see rate shock from the new rating requirements.

In rating its individual plans, Kaiser employs member-level rating. That is, each member in a household is assigned a unique rate rather than rates being reflective of the average family composition for Kaiser's individual line of business. Kaiser does vary their rates for these products by gender. At the time of this review, they also varied their age rates for males over the 3 to 1 differential prescribed by the ACA (3.12 between ages 64 to 18). Kaiser's individual rate differential for females was 2.7 to 1 for the same ages (i.e., 64 to 18).

Neither carrier explicitly specified that they do not rate by health status on their websites. However, both do provide explicit quotes and indicate that eligibility is subject to medical underwriting. These quotes would seem to imply that, rather than being used for rate setting, underwriting is only used to determine whether or not the carriers will make an offer of coverage.

7

Hawai'i's Low-income Market

Hawai'i's Med-QUEST Division (through the DHS) and the Federal government spent $1.7 billion in fiscal year (FY) 2011 on providing a robust health care safety net for its low-income residents.[30] Along with the presence of the PHCA, these efforts have helped to keep Hawai'i's uninsured population below the national average. Provisions within the ACA will help ease some of the budgetary pressure on the State (on a per member basis).

Hawai'i provides public coverage to low-income individuals through several managed care programs. Although some low-income enrollees are in fee-for-service (FFS), most are in managed care. The majority of Medicaid enrollees are children, new or expecting mothers, and qualifying families with children. In addition to these enrollees, the medically needy, non-citizens and aged, blind and disabled (ABD) individuals that receive SSI may qualify. Hawai'i's criteria for eligibility include Hawai'i residency status and income and asset tests. However, the asset tests will no longer apply under the ACA.

The primary Med-QUEST programs are the following:

QUEST – This program provides coverage to individuals under age 65 who are not blind or disabled with an emphasis on children and their parents. The program is administered through participating managed care organizations, with income eligibility requirements at various ages (e.g., pregnant mothers qualify for coverage with an income up to 185% of FPL). The emphasis of the program is on primary and acute care.

QUEST Expanded Access – This program covers those that qualify for Medicaid because they are 65 or older, blind, or disabled. As with QUEST, the program is administered through participating managed care organizations, with coverage provided for primary and acute care as well as long-term care services. The program emphasizes home and community based care, and many of these enrollees were covered under FFS until 2009.

QUEST Adult Coverage Expansion (or QUEST-ACE) – Through June 2012, this program provided limited health care benefits to adult beneficiaries; to be eligible, an individual must have been 19 years or older and have had household income less than 200% of FPL. In July 2012, the program was revised to cover a more comprehensive set of benefits, but eligibility was restricted so that the program only covers those with household income less than or equal to 133% of FPL. Under QUEST-ACE, an individual is eligible without having been enrolled in

[30] *http://hawaii.gov/dhs/main/reports/AnnualReports*

another Med-QUEST program (e.g., QUEST or QUEST Expanded Access), and the individual must not have additional coverage from an independent source.

QUEST-Net – As with QUEST-ACE, the QUEST-Net program offers childless adult beneficiaries limited health care benefits, and through June 2012, it restricted eligibility to those with household income below 200% of FPL. In July 2012, the program was expanded to cover a more comprehensive set of benefits, but eligibility was restricted to those with household income less than or equal to 133% of FPL. Unlike QUEST-ACE, beneficiaries in QUEST-Net must have been enrolled in the QUEST, QUEST Expanded Access or FFS programs and subsequently lost coverage due to increased income, assets, or other disqualifying reasons.

S-CHIP – This program was implemented as a Medicaid expansion program in Hawai'i, and although we identify it as a unique program here, it is a sub-program of the QUEST Expanded Access (for blind and disabled children) and QUEST programs. To qualify for coverage, children must be uninsured, under age 19, and have family incomes not exceeding 300% of the FPL. Please note that Hawai'i does not maintain a separate program for Compact of Free Association (COFA) children. The Federal CHIP Reauthorization Act of 2009 permitted COFA children to become eligible under S-CHIP. COFA and immigrant children are now covered under Hawai'i's Medicaid expansion CHIP program, and Hawai'i receives Federal matching funds for medical assistance provided to them.

Transitional Medical Assistance – Aid to Families with Dependent Children (AFDC) is the predecessor to the TANF program; anyone eligible for AFDC was automatically eligible for Medicaid. Although there are a number of eligibility requirements, an AFDC recipient who has lost eligibility due to increased earnings or work hours, is entitled to Transitional Medicaid for up to 12 months (subject to the other eligibility requirements).

In addition, Hawai'i has some low-income residents that are dually eligible for Medicare and Medicaid whose services are reimbursed on a FFS basis.

The following table shows the distribution of enrollees by program.

Table 7.1

Program	Enrollment
Quest	64.1%
S-CHIP	9.7%
Quest Expanded Access	15.6%
Quest-ACE	5.0%
Quest-Net	0.3%
Transitional Medical Assistance	2.3%
Other	3.0%
Total	100.0%

http://www.med-quest.us/PDFs/queststatistics/2012%20QUEST%20ENROLLMENT.PDF

As the table shows, most of Hawai'i's Medicaid enrollees are in some form of managed care. Hawai'i currently contracts with five of these managed care plans. Three plans support QUEST enrollment, and they are the following:

- Hawai'i Medical Services Association (HMSA) is the Blue Cross Blue Shield plan of Hawai'i
- AlohaCare is a local non-profit plan that was founded by Hawai'i's Community Health Centers
- Kaiser Foundation Health Plan is a not-for profit health plan and part of the Kaiser Permanente managed care consortium

Two additional plans support enrollment in QUEST Expanded Access, and they are the following:

- Ohana Health Plan is offered by WellCare Health Insurance of Arizona, Inc.
- Evercare is offered by UnitedHealthcare Insurance Company

In 2012, enrollees in these five plans were distributed in the following fashion.

Table 7.2

Plan	Distribution
Quest	
HMSA	45.0%
AlohaCare	29.1%
Kaiser	10.0%
Quest ExA	
Ohana	8.5%
EverCare	7.4%

http://www.med-quest.us/PDFs/queststatistics/2012%20QUEST%20ENROLLMENT.PDF

Please note that in July 2012, United and Ohana were awarded Quest contracts, bringing the total number of carriers to five. In the Data section, we speculated that the Med-QUEST Division's reports may reflect the upper limit of Medicaid enrollment. Medicaid enrollees in households with enrolled children are passively re-enrolled. This dynamic makes it more difficult to assess how many individuals are covered by Hawai'i's Medicaid program at any one point in time.

As we review the population estimates that result from the ACS survey data, we note that the total Medicaid enrollees identified from the survey are fewer than the enrollment identified by the Med-QUEST. There are several possible sources for the inconsistency. First, as noted in previous sections, the US Census Bureau attempts to correct for a systematic bias of underreported Medicaid participation in the ACS data (e.g., because members believe they have private coverage). Despite these efforts, the US Census Bureau may not have fully accounted

for all publicly financed health coverage, especially those with coverage through QUEST-Net or QUEST-ACE. Second, there are enrollees in the Medicaid program who are not United States citizens; it is not clear that the ACS have adequately accounted for these individuals in their methods.[31]

The ACS data are from surveys conducted in Hawai'i during 2010.[32] Since then, we know that the overall enrollment in Hawai'i's public programs has increased by at least 13%.[33] The following table shows the demographic composition of those enrolled in Hawai'i's Medicaid program in 2010 as identified by the ACS data.

Table 7.3
Medicaid Enrollment Rates

	Hawai'i		Nationwide	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	19.9%	19.5%	25.2%	24.1%
18 to 24	5.4%	8.1%	3.1%	4.8%
25 to 29	2.4%	3.4%	1.6%	3.1%
30 to 34	1.7%	2.6%	1.6%	2.6%
35 to 39	1.3%	1.9%	1.5%	2.4%
40 to 44	2.2%	2.5%	1.7%	2.1%
45 to 49	2.3%	2.0%	1.8%	2.1%
50 to 54	2.3%	2.8%	1.7%	2.0%
55 to 59	1.7%	2.3%	1.5%	1.8%
60 to 64	1.5%	2.0%	1.3%	1.7%
65+	4.8%	7.6%	4.3%	7.8%
Total	45.4%	54.6%	45.4%	54.6%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the table shows, the demographic composition of Hawai'i's Medicaid enrollees is, in total, consistent with the rest of the country. The primary difference is that Hawai'i's Medicaid enrollment is older, on average, than the nation's Medicaid enrollment. Because of Hawai'i's initiatives to cover low-income childless adults through QUEST-ACE and QUEST-Net, we would expect a distribution weighted towards older ages. It is worth noting that the ACS data are slightly skewed toward older age groups relative to some DHS reports.[34]

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[31] *DHS informed OW in an August 1, 2012 phone call that Medicaid covered between 10,000 and 12,000 COFA individuals, while the ACS reflects only 5,000.*

[32] *We do not expect results from 2011 ACS to be available until September 2012 or October 2012.*

[33] *http://www.med-quest.us/ManagedCare/MQDquestenroll.html*

[34] *http://hawaii.gov/dhs/quicklinks/MQD%20presentation%2004_03_2012.pdf*

Beginning in January 1, 2014, the ACA will increase Medicaid funding for states providing coverage to childless adults. For expansion states (i.e., states already providing coverage for childless adults), the new Federal Medical Assistance Percentage (FMAP) will have the following form for the expansion individuals' costs.

Table 7.4

Year	New FMAPs	Transition Percentage	Regular FMAP	Expansion FMAP*
2014	100%	50%	52%	76%
2015	100%	60%	52%	81%
2016	100%	70%	52%	86%
2017	95%	80%	52%	86%
2018	94%	90%	52%	90%
2019	93%	100%	52%	93%
2020	90%	100%	52%	90%

*Regular FMAP + (Newly eligible FMAP – Regular FMAP) x Transition Percentage

http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4

(We present this example assuming that the Federal government will recognize Hawai'i as an expansion state; if the government does not recognize Hawai'i as an expansion state, the example would not hold.) Funding from the Federal government will supplement Hawai'i's costs for the childless adults (under 138% FPL) who are covered under the QUEST-Net and QUEST-ACE programs. These additional funds will take some budgetary pressure off of Hawai'i (on a per member basis).

The following table shows the distribution of Medicaid covered enrollees by household income as identified by the ACS data.

Table 7.5
Medicaid (in 1,000's)

	Hawai'i		Nationwide	
FPL	Persons	Percentage	Persons	Percentage
0 to 100%	84	36.2%	24,930	46.7%
101% to 138%	31	13.2%	7,963	14.9%
139% to 200%	38	16.2%	8,177	15.3%
201% to 300%	31	13.4%	6,205	11.6%
301% to 400%	24	10.5%	2,718	5.1%
401% +	24	10.5%	3,364	6.3%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

According to the table, about 50% of Hawai'i's Medicaid enrollees in 2010 had household incomes above 138% of FPL, while approximately 38% of the rest of the country's Medicaid enrollees are above 138% of FPL.

As the State bears much of the coverage cost for Medicaid enrollees, it is worth examining individuals that are employed and obtain coverage through the Med-QUEST Division. This is particularly important because employees have the option to waive coverage mandated under the PHCA if they are covered by a federally established health insurance program such as Medicare or Medicaid.[35] The following table shows the distribution of employees with or without Medicaid by industry.

Table 7.6
Employee Distribution - Private Industry in Hawai'i

Industry	Medicaid	All Others
Agr, Mining, Util	2%	3%
Const & Manu	5%	14%
Trade	26%	17%
Transp, Info, Finan	12%	11%
Real Estate	5%	4%
Prof, Sci, Tech	4%	5%
Mang, Admin Srv	5%	6%
Education	7%	4%
Health & Soc Srv	5%	12%
Arts, Ent, Food, Other	29%	24%
Public Admin	0%	0%

2010 American Community Survey – Person Level Data,
http://www2.census.gov/acs2010_1yr/pums/

The table shows that employees in trade (retail and wholesale) and the arts, entertainment, and food services make-up over half of the privately employed individuals on Medicaid. The table also shows the there is a lower proportion of Medicaid-covered individuals in construction and manufacturing as well as in health and social services. We suspect that construction and manufacturing jobs are more likely to be occupied by men than women, and men are less likely to be eligible for Medicaid. We also suspect that employees and employers in health and social services will better understand their health insurance options and requirements than those in other services.

[35] *http://hawaii.gov/labor/dcd/aboutphc.shtml*

8

Hawai'i's Uninsured Population

Because one of the central goals of the ACA is to lower the number of uninsured, we devote this section of the report to examining characteristics of uninsured individuals residing in Hawai'i.

The ACA includes financial incentives designed to encourage individuals who can afford health insurance to obtain at least some minimally comprehensive level of coverage.[36] These incentives exist both as additional taxes for those that do not obtain coverage as well as tax credits for certain qualified individuals that do. The ACA also provides funding to states to ease the eligibility requirements for Medicaid. Because Hawai'i already funds expanded Medicaid programs to cover low-income adults, these initiatives may not change the number of uninsured as much as they are expected to change them in other states without expanded Medicaid coverage. For states that implement the expansion for newly eligible persons, the Federal government will provide payment at 100% of program costs for these new enrollees between 2014 and 2016. After the first two years, this FMAP percentage will decrease to 90% by 2020. As we understand it, Hawai'i already provides coverage for these people and will not receive the 100% reimbursement for them in 2014. Rather, as an expansion state, Hawai'i will receive approximately 75% of funding in 2014, with the FMAP increasing to 90% by 2020.

Uninsured Purchase Decision

The ACA's individual mandate imposes a tax on those individuals who do not maintain coverage. The mandate is not universal and provides a tax exemption for certain low-income individuals who cannot afford coverage. The tax is a flat payment of $95 in 2014, $325 in 2015 and $695 in 2016 (on an individual basis), or alternatively, it is a percentage of the household income (1.0% in 2014, 2.0% in 2015 and 2.5% in 2016). Ultimately, the tax reflects the larger of these two possible payments; however, it is capped at the national average premium for Bronze coverage.[37] Returning to our example from an earlier section, a single uninsured individual earning $25,000 per year (or approximately 220% of FPL in 2010) would incur a tax equal to that listed in the following table.

[36] *Certain exemptions apply to individuals who either cannot afford insurance or are not permitted due to religious beliefs. The ACA defines individuals who cannot "afford health insurance" as those for whom the minimum policy will cost more than 8% of their monthly income, and whose income is greater than 100% FPL.*

[37] *Children are only assessed at one half the flat amount, and there is cap for families.*

Table 8.1
ACA Individual Mandate Example

	2014	2015	2016
Income*	$25,000	$25,000	$25,000
Flat Tax Amount	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amount	$250	$500	$625
Resulting Tax	$250	$500	$695

*Assumes no wage inflation and that the national average bronze premium is less than the resulting penalty

The Health Care and Education Reconciliation Act, Subtitle A, Section 1002

Also as discussed in an earlier section, the ACA provides tax credits to eligible individuals and families with incomes up to 400% FPL for the purchase of a QHP through the Hawai'i Connector. The government will ultimately determine the credits based on both the premium for the second lowest cost Silver plan in the Connector as well as how that premium cost relates to an individual's household income. Or put differently, two individuals with the same income will get the same credit based on that income level and second lowest cost Silver plan in the Connector; the actual plan they elect has no effect on their subsidy. The premium for any taxpayer whose household income is within a given income tier will be restricted to the percent of income as identified in the following table. Within each income range, those percentages will increase (on a sliding scale in a linear manner) from the initial premium percentage to the final premium percentage.

Table 8.2

Household Income	Initial Premium Percentage	Final Premium Percentage
Up to 133%	2.00%	2.00%
133% to 150%	3.00%	4.00%
150% to 200%	4.00%	6.30%
200% to 250%	6.30%	8.05%
250% to 300%	8.05%	9.50%
300% to 400%	9.50%	9.50%

The Health Care and Education Reconciliation Act, Subtitle A, Section 1001

Subsidy-eligible individuals are not obligated to participate in the second lowest cost Silver plan. They may participate in a plan with additional benefits or lower cost sharing, but the premium tax credit will be calculated relative to that Silver plan's premium. Likewise, they may elect to purchase a plan with higher cost sharing (i.e., a Bronze plan) and receive the same premium tax credit. For the lowest income individuals, tax credits would likely cover the entire premium for coverage under a Bronze plan.

Individuals with incomes below 250% of FPL may also be eligible for cost-sharing subsidies; however, these individuals must enroll in a Silver plan to receive the subsidies. As a consequence, there is rarely an incentive for individuals with incomes below 250% of FPL to pay the additional premium for a Gold or Platinum plan. (Under such a scenario, the individual would effectively be left with a higher cost sharing burden than if they enrolled in a Silver plan and received the cost sharing subsidy.) However, the effect for these qualified individuals that use their premium subsidies to purchase a Bronze plan instead is significant; they would likely eliminate any up-front premiums. We suspect that they are less affected by the possibility of incurring bad debt and will place more importance on elimination of the premium. This dynamic may be particularly true for low-income individuals in good health who expect to incur little to no medical expenses.

If we extend the example given above, our theoretical person with an income equal to $25,000 in 2014 would face the following incentives in assessing whether or not to purchase coverage. First, they would face a penalty of $250 for not obtaining coverage. Second, they would be eligible for a tax credit. Assuming this person is a single individual, the premium for the second lowest cost Silver plan in Hawai'i is equal to $430 PMPM, and the FPL is calculated from the 2010 basis, the person would be eligible for the following credit.

Sample FPL	Income	Plan Cap %	Plan Cap $	Plan Cost	Tax Credit
220%	$25,000	7.0%	$1,750	$5,160	$3,410

The incentives for the person would be the following:

Purchase Coverage	Do Not Purchase Coverage
Plan Cost — $5,160	Tax — $250
Tax Credit — $3,410	
Realized Cost — $1,750	

** Subject to the theoretical assumptions identified above*

In this theoretical example, the marginal gross cost of purchasing insurance is $1,500 (= $1,750 - $250) (assuming the FPL from 2010). A key question becomes "what is the likelihood that this person values health insurance coverage at more than $1,500?"

However, this information alone is not enough to model the individual purchasing decision, because individuals also place value on having health insurance. In the report outlining our model approach, we will introduce the concept of utility. As we model the universe of purchasing decisions available to each individual, we will examine the marginal cost of purchasing insurance (as identified above); we also model the health status and expected benefit costs for each person. In our example, a healthy person with low expected claim costs and $1,500 in marginal insurance costs will be less likely to purchase coverage than an unhealthy person with the same expected marginal insurance costs. Or put differently, coverage is worth more to an unhealthy person, and they will be more likely to purchase it.

Population Characteristics

As with many other states, Hawai'i currently covers low-income individuals that qualify for coverage through traditional Medicaid or CHIP eligibility requirements. As discussed in the previous section, Hawai'i also has the QUEST-Net and QUEST-ACE programs in place. These programs cover certain low-income adults that would not meet Medicaid's traditional eligibility requirements in other states.

With a much larger part of the population residing in Oahu, we would expect the distribution of uninsured residents to be higher there as well. The following table shows that distribution by island grouping.

Table 8.5
Uninsured (in 1,000's)

	Uninsured		Total Population	
Island Group	**Persons**	**Percentage**	**Persons**	**Percentage**
Oahu	58	56.0%	956	70.1%
Hawaii	20	19.0%	185	13.6%
Kauai, Maui, Molokai	26	25.1%	222	16.3%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Although the majority of uninsured residents do live in Oahu, the proportion of uninsureds in Hawai'i's most populous island is substantially different than the general population. Over 70% of residents make their home in Oahu, but Oahu has only 56% of the uninsured. Please note that the ACS does not group Hawai'i's population by island, rather it groups them to achieve population clusters of a certain size. As such, we have not provided island-by-island detail beyond what you see here. However, the resulting distribution is consistent with estimates prepared from the Behavioral Risk Factor Surveillance System Survey.

There are several possible causes for this difference in uninsured rates by island grouping. As we presented it in the Private Employer Market section, a larger portion of real estate and agricultural workers work outside of Oahu. Because the PHCA does not enforce the same level of coverage requirements on employers in agriculture or commission based real estate ventures, the higher uninsured rate in the surrounding islands is directionally consistent with the predominant industries. As the State works to allocate resources in support of the Connector (and potentially the BHP), these geographic dynamics will be an important part of its planning process.

The following table shows the distribution of the uninsured by age and gender, based on data from the ACS.

Table 8.6

Uninsured Rates

	Hawai'i		Nationwide	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	5.6%	5.1%	6.2%	5.9%
18 to 24	9.1%	7.2%	10.8%	7.9%
25 to 29	8.5%	5.1%	7.9%	5.4%
30 to 34	4.2%	3.1%	6.3%	4.4%
35 to 39	4.6%	3.8%	5.5%	4.1%
40 to 44	5.8%	3.1%	5.0%	4.0%
45 to 49	4.5%	3.7%	4.8%	4.0%
50 to 54	6.6%	3.6%	4.0%	3.6%
55 to 59	3.3%	2.3%	2.8%	2.7%
60 to 64	4.1%	3.0%	1.8%	2.2%
65+	1.8%	1.8%	0.4%	0.5%
Total	58.2%	41.8%	55.3%	44.7%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

Hawai'i appears to have a lower percentage of uninsured females than the rest of the country. This gender disparity may result if Hawai'i is more effective in enrolling Medicaid eligible individuals into its program than are most states.[38] Variation in Medicaid programs across states may serve to obscure the cause of any underlying differences. The distribution in the preceding table also permits the reader to observe additional volatility in the Hawai'i sample. The nationwide distribution decreases uniformly from the 18 to 24 age band, while the Hawai'i distribution shows increases at some older age bands. This volatility likely results from the smaller sample size for Hawai'i.

Because of the potential for tax credits for low-income residents, we also consider the income of those without coverage. The following table identifies the 2010 income levels for those who are uninsured.

[38] *http://www.shadac.org/files/shadac-access-profile-jan11.pdf*

Table 8.7
Uninsured (in 1,000's)

	Hawai'i		Nationwide	
FPL	Persons	Percentage	Persons	Percentage
0 to 100%	26	25.4%	14,870	30.8%
101% to 138%	9	8.5%	6,160	12.8%
139% to 200%	12	11.4%	8,326	17.3%
201% to 300%	20	19.0%	8,735	18.1%
301% to 400%	11	10.2%	4,582	9.5%
401% +	26	25.5%	5,583	11.6%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

As the data in the table show, Hawai'i has a far larger percentage of uninsured that are above 400% of FPL than the rest of the nation. Correspondingly, there is a lower percentage of uninsured below 200% FPL. There are several questions that arise from these distributions. First, what are the characteristics of these residents earning more than 400% of FPL and what drives their decision not to purchase insurance? And second, why are there individuals who would seem to be eligible for coverage under Hawai'i's expanded Medicaid programs, but remain uninsured? We suspect that the percentage of uninsureds above 400% of FPL seem higher only because Hawai'i is better at providing coverage to its low-income population through its expanded Medicaid than is the rest of the country. (We have seen these dynamics in other states with expanded Medicaid programs.)

Often, we see a demographic group referred to as 'young invincibles' in this uninsured cohort where income is above 400% of FPL. These young invincibles are typically between the ages of 18 and 34. They also choose not to purchase coverage (though they may have the financial means) because they are relatively healthy and weigh the coverage cost as worth more than the coverage. If we first examine the uninsured by income and age for the nation, the ACS data show the following:

Table 8.8
Nationwide Uninsured

	FPL		
Age Band	0% to 200%	201% to 400%	400%+
0 to 17	8.0%	3.2%	0.9%
18 to 34	26.1%	11.6%	5.1%
35 to 64	26.3%	12.6%	5.5%
65+	0.5%	0.2%	0.1%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows the distribution of the uninsured across the various age and income categories (i.e., the sum of the cells should equal 1.00; it differs by 0.001 because of rounding). From the table, we see that generally the uninsured at all income levels are evenly split between 18 to 34

year-olds and 35 to 64 year-olds. Please note that 35 to 64 year-olds have about 71% more people in the total population; so for those above 400% of FPL, the uninsured rate is higher among the 18 to 34 year-olds than it is among the 35 to 64 year-olds. If we now examine the uninsured by income and age for Hawai'i, the ACS data show the following:

Table 8.9
Hawai'i Uninsured

	FPL		
Age Band	**0% to 200%**	**201% to 400%**	**400%+**
0 to 17	5.7%	3.4%	1.6%
18 to 34	17.5%	10.4%	9.3%
35 to 64	21.1%	14.1%	13.3%
65+	1.0%	1.4%	1.2%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows that young invincibles with income above 400% of FPL may be a larger percentage of the uninsured in Hawai'i than what we see in the rest of the country (9.3% versus 5.1%). However, the percentage of uninsured at each income level is weighted more towards those between the ages of 35 and 64 than it is towards those between the ages of 18 and 34. It appears that Hawai'i's large percentage of uninsureds above 400% of FPL is not the result of a large young invincibles population.

The ACS data also show that there are a number of uninsured adults with incomes below 200% of FPL. It seems that some of these individuals would have qualified for coverage under Hawai'i's QUEST-Net or QUEST-ACE programs in 2010. Returning to the table on a previous page, approximately 45% of those without coverage are below 200% of FPL. It is unclear why persons who would seem to be eligible for one of Hawai'i's Medicaid expansion programs would remain without coverage. These individuals may have met the State's income requirements for eligibility but not the asset requirements. Perhaps these individuals feel there is a stigma attached to publicly sponsored coverage. Perhaps they are healthy and unaware of the program, or perhaps there is some other unknown dynamic. In 2003, the Robert Wood Johnson Foundation funded a public survey of the uninsured in Hawai'i.[39] According to that analysis, only 37% of the uninsured respondents had investigated ways to obtain health insurance. Modeling the behavior of these individuals and how they might respond to the incentives in ACA will be a challenge.

Effective September 2010, insurers were required to offer coverage for dependents under the age of 26.This requirement differs for grandfathered and non-grandfathered plans. [40] Based on

[39] *http://www.healthcoveragehawaii.org/research/generalpublicsurvey.html*

[40] *For grandfathered policies until 2014, coverage is only required to be extended to dependent children to age 26 if the dependent child does not have another offer of employer-sponsored health coverage.*

estimates published in the Congressional Research Service,[41] we estimate that this provision of the ACA could affect between 1% and 3% of the uninsured population. We will recognize the effect of these changes when we project the population in the future modeling portion of the project.

[41] *Chaikind and Fernandez, "Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA)," Congressional Research Service (2011).*

9

Basic Health Program

With the State's expanded Medicaid program and the introduction of tax credits for some low-income participants in the Connector, provisions of the ACA are expected to stabilize coverage for the low-income population. In this section, we discuss the BHP option and how it will support these provisions, we introduce some of its requirements, and we address how it might affect Hawai'i's low-income residents.

Tax credits (through the purchase of insurance in the Connector) are the ACA's primary approach to compel non-Medicaid eligible individuals to maintain coverage when their income is less than 200% of FPL. However, there is evidence that a significant portion of the population under 200% of FPL will gain or lose Medicaid eligibility with some frequency. The BHP is intended to smooth the transition from Medicaid eligibility to non-Medicaid eligibility without the burden of re-enrollment or potential change in providers. If implemented, states will be permitted to offer a BHP to non-Medicaid individuals that meet the following criteria:

- They are not eligible for Medicaid or CHIP
- They are under 65 years old at the beginning of the plan year and not eligible for Medicare, or TRICARE, or Veteran's Health Care
- Their income falls between 133%[42] and 200% FPL for US citizens and between 0% and 200% FPL for lawfully present immigrants.
- If they have access to ESI coverage, it does not provide coverage for essential benefits or is deemed unaffordable based on their income

Within the BHP, states contract with health plans to provide essential health benefits for these non-Medicaid eligible low-income individuals. However, there are numerous requirements for participating plans, including the following:

- The health plans must maintain a minimum medical loss ratio of 85%
- Contracts must be awarded through a competitive bidding process (as much as such an approach is possible)
- Coverage must be coordinated with Medicaid and CHIP
- The plan must provide essential health benefits

If Hawai'i were to contract with a plan under the BHP, the Federal government would provide the State 95% of the premium tax credits and cost-sharing subsidies that would have been provided

[42] *A 5% disregard applies when determining Medicaid eligibility; therefore the effective value is 138%.*

for those individuals had they been enrolled with individual coverage in the Connector. The Federal Government would base Hawai'i's reimbursement not on the cost of the covered enrollees, but rather on the average cost of those covered in the individual market (both inside and outside the Connector). If costs are lower than the Federal Government's tax credit, the BHP would have to offer reduced premiums, reduced cost sharing, higher provider reimbursement, or additional benefits. Also, if no excess funds are available from the Federal Government, the State would have to cover the cost of any additional benefits that are not included in the essential benefits package.

Individuals enrolled in the BHP can only be required to pay premium that is no more than what they would have had to pay for the second lowest cost Silver plan in the Connector (i.e., net of any tax credits). There will be some level of cost-sharing subsidization for BHP participants. For those individuals between 100% and 150% FPL, the State will receive cost-sharing subsidies (funded by the Federal government) so that the member can be required to pay cost sharing that is no more than what they would pay under the equivalent Platinum level benefits. For those individuals with income between 150% and 200% FPL, the State would receive cost-sharing subsidies so that the member can be required to pay cost sharing that is no more than what they would pay under the equivalent Gold level benefits.

If we again look at the ACS data and estimate who might be eligible for the BHP, we find that they have the following distribution:

Table 9.1

Current Coverage Status	Potential BHP Enrollment
ESI	24.2
Medicaid	16.4
Uninsured	9.7

2010 American Community Survey – Person Level Data,

http://www2.census.gov/acs2010_1yr/pums/

Please note that we have not included dual eligible enrollees or those that are currently covered under Medicare, as they are not eligible to participate in the BHP. We have also removed anyone that is employed by the government in the ESI estimates; we have also excluded anyone identified as having ESI in the same household where the principal person or their spouse is employed by the government. Finally, the table above does not recognize lawfully present immigrants below 133% of FPL with fewer than five years of residency. These individuals do not qualify for Federal funding under Medicaid, but would qualify for the BHP.

10

Exchange Eligibility Estimates

The strength and viability of Hawai'i's Connector will depend directly on the number of people that use it. In this background research, we have only identified residents that could be affected by the ACA's incentives; we have not considered the likely enrollment in the Connector.

In the following table, we show individuals that could be eligible for subsidies through the Connector; we show these individuals by coverage mode. Some segments of the population will not qualify for credits in the Exchange, however, some of these non-qualifying persons (especially younger individuals) may be more comfortable purchasing coverage online than they would through an agent; we have not explicitly considered this population in the discussion below.

Table 10.1

Current Coverage Status	Persons per Category (1,000's)
Uninsured	
139% to 400%	37.9
401% +	26.5
Direct Purchase	
139% to 400%	16.0
401% +	28.0
ESI	
139% to 400%	189.7
401% +	232.7

2010 American Community Survey – Person Level Data,

http://www2.census.gov/acs2010_1yr/pums/

From the table, there are approximately 53,900 residents (37,900 uninsured and 16,000 direct purchasers) that would be eligible for subsidies through the Connector. (Please note that these estimates do not include the COFA population; they are currently classified as Medicaid and total approximately 5,000 members based on our estimates.). In presenting these estimates, we are including those with income between 139% and 200% from the above categories, assuming that there is no BHP. If a BHP is implemented, the number of eligible persons we have estimated in the table above would come down. We have also identified workers that might be eligible for coverage through the Exchange. Given the strength of the PHCA, we suspect that there are fewer employers that would drop coverage in Hawai'i than what we anticipate in other states. In addition, the provision of the PHCA that requires employee contributions of no more

than 1.5% of income (for most workers) will disqualify many of the employees for subsidies in the Connector. However, some that are uninsured or that have Direct Purchase coverage and household income above 400% FPL, might purchase insurance through the Connector. If the Connector provides an accessible and transparent view of available products, those individuals may decide that the Connector is the best venue for their purchase.

The segment of the population that creates the greatest uncertainty is the small group employers that could receive coverage through the SHOP Exchange. We have identified approximately 151,000 Hawai'ians enrolled in fully insured small group coverage in 2011.

Participating Carriers

There are numerous considerations that carriers will have to make when deciding whether or not to participate in the Connector. The health insurance market in Hawai'i is dominated by two carriers, and any carrier wishing to participate in the State's Connector is going to explicitly recognize the effect of a potential presence from these two large carriers. Plans considering participation in the Connector will also consider the size of the potential market. As the number of subsidy-eligible people participating in the market increases so will the attractiveness of offering plans in the Connector. Conversely, the presence of a BHP will lower the size of the subsidy-eligible market, and consequently, it may make the market less attractive.

Smaller carriers may be attracted to the Connector because it could lower some of their administrative costs. A cost reduction of this kind would allow them to offer products that are more competitive with the larger plans in the market. Also, the Connector will presumably present smaller carriers' products alongside those products of larger carriers. In addition to showing products from different carriers on an equal footing, the Connector will also allow consumers to compare premiums for plans with like benefits or similar actuarial values. Any marketing advantage the larger carriers have would likely be mitigated on the Connector. Finally, the risk adjustment mechanism will help moderate gains and losses for these smaller carriers, which should help address concerns regarding anti-selection within the Connector.

Lastly, carriers may decide not to participate in the Connector if the market's potential does justify administrative cost and compliance requirements. For example, if Hawai'i were to require that benefit designs in the Connector be at specific actuarial values (e.g., 0.70, 0.80, etc.) rather than ranges, or even small tolerances around these values, carriers may decide that compliance with the requirements is too costly. Also, carriers may decide not to participate in the SHOP because employees are provided flexibility in multi-benefit choice situations (i.e., employees can choose similar metals from different carriers). In the period immediately following implementation, carriers would find it difficult to accurately recognize such anti-selection in pricing. Finally, if the State funds the Connector in part through carrier fees, it would raise carriers' costs and act as another barrier to participation in the Exchange.

APPENDIX A

Estimate of Individuals Covered by Public Coverage

In the following table, we identify the public coverage enrollment implied by the Med-QUEST's program enrollment report. The table shows the raw estimate of enrollment in different insurance modes under ACS. It shows the estimates of enrollment after we have revised the status of many Direct Purchase enrollees. We implemented this revision to more closely match the Direct Purchase enrollment identified by Hawai'i's insurance carriers.

Table A.1
Coverage Summaries (in 1,000's)

	Without Medicaid Edits		With Medicaid Edits	
Coverage	**Persons**	**Distribution**	**Persons**	**Distribution**
Employer (non-Medicare)	717	52.6%	717	52.6%
Employer (Medicare)	95	7.0%	95	7.0%
Military (Active)	93	6.8%	93	6.8%
Military (Retired)	1	0.1%	1	0.1%
Direct Purchase	72	5.3%	44	3.2%
Medicare	77	5.6%	77	5.6%
Medicaid	165	12.1%	193	14.2%
Dual	39	2.9%	39	2.9%
No Coverage	104	7.6%	104	7.6%
Total	1,363	100.0%	1,363	100.0%

2010 American Community Survey – Person Level Data, http://www2.census.gov/acs2010_1yr/pums/

The table shows the magnitude of the adjustments that Oliver Wyman applied to both the Direct Purchase and Medicaid categories.

APPENDIX B

Hierarchy for Assigning ACS Respondents to a Payer Mode

The following table shows the hierarchy that we used to classify enrollees in the ACS data.

Hawai'i — ACS Category map

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
1	1	1	1	1	1	1	DUAL
1	1	1	1	1	1	2	DUAL
1	1	1	1	1	2	1	DUAL
1	1	1	1	1	2	2	DUAL
1	1	1	1	2	1	1	DUAL
1	1	1	1	2	1	2	DUAL
1	1	1	1	2	2	1	DUAL
1	1	1	1	2	2	2	DUAL
1	1	1	2	1	1	1	ESI_R
1	1	1	2	1	1	2	ESI_R
1	1	1	2	1	2	1	ESI_R
1	1	1	2	1	2	2	ESI_R
1	1	1	2	2	1	1	ESI_R
1	1	1	2	2	1	2	ESI_R
1	1	1	2	2	2	1	ESI_R
1	1	1	2	2	2	2	ESI_R
1	1	2	1	1	1	1	MCAID
1	1	2	1	1	1	2	MCAID
1	1	2	1	1	2	2	MCAID
1	1	2	1	2	1	1	MCAID
1	1	2	1	2	1	2	MCAID
1	1	2	1	2	2	1	MCAID
1	1	2	1	2	2	2	MCAID
1	1	2	2	1	1	1	ESI_A
1	1	2	2	1	1	2	ESI_A
1	1	2	2	1	2	1	ESI_A
1	1	2	2	1	2	2	ESI_A
1	1	2	2	2	1	1	ESI_A
1	1	2	2	2	1	2	ESI_A
1	1	2	2	2	2	1	ESI_A

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
1	1	2	2	2	2	2	ESI_A
1	2	1	1	1	1	1	DUAL
1	2	1	1	1	1	2	DUAL
1	2	1	1	1	2	1	DUAL
1	2	1	1	1	2	2	DUAL
1	2	1	1	2	1	1	DUAL
1	2	1	1	2	1	2	DUAL
1	2	1	1	2	2	1	DUAL
1	2	1	1	2	2	2	DUAL
1	2	1	2	1	1	1	ESI_R
1	2	1	2	1	1	2	ESI_R
1	2	1	2	1	2	1	ESI_R
1	2	1	2	1	2	2	ESI_R
1	2	1	2	2	1	1	ESI_R
1	2	1	2	2	1	2	ESI_R
1	2	1	2	2	2	1	ESI_R
1	2	1	2	2	2	2	ESI_R
1	2	2	1	1	1	1	MCAID
1	2	2	1	1	1	2	MCAID
1	2	2	1	1	2	1	MCAID
1	2	2	1	1	2	2	MCAID
1	2	2	1	2	1	1	MCAID
1	2	2	1	2	1	2	MCAID
1	2	2	1	2	2	1	MCAID
1	2	2	1	2	2	2	MCAID
1	2	2	2	1	1	1	ESI_A
1	2	2	2	1	1	2	ESI_A
1	2	2	2	1	2	1	ESI_A
1	2	2	2	1	2	2	ESI_A
1	2	2	2	2	1	1	ESI_A
1	2	2	2	2	1	2	ESI_A
1	2	2	2	2	2	1	ESI_A
1	2	2	2	2	2	2	ESI_A
2	1	1	1	1	1	1	DUAL
2	1	1	1	1	1	2	DUAL
2	1	1	1	1	2	1	DUAL
2	1	1	1	1	2	2	DUAL
2	1	1	1	2	1	1	DUAL
2	1	1	1	2	1	2	DUAL

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
2	1	1	1	2	2	1	DUAL
2	1	1	1	2	2	2	DUAL
2	1	1	2	1	1	1	MIL_R
2	1	1	2	1	1	2	MIL_R
2	1	1	2	1	2	1	MCARE
2	1	1	2	1	2	2	MCARE
2	1	1	2	2	1	1	MCARE
2	1	1	2	2	1	2	MCARE
2	1	1	2	2	2	1	MCARE
2	1	1	2	2	2	2	MCARE
2	1	2	1	1	1	1	MCAID
2	1	2	1	1	1	2	MCAID
2	1	2	1	1	2	1	MCAID
2	1	2	1	1	2	2	MCAID
2	1	2	1	2	1	1	MCAID
2	1	2	1	2	1	2	MCAID
2	1	2	1	2	2	1	MCAID
2	1	2	1	2	2	2	MCAID
2	1	2	2	1	1	1	DP
2	1	2	2	1	1	2	DP
2	1	2	2	1	2	1	DP
2	1	2	2	1	2	2	DP
2	1	2	2	2	1	1	DP
2	1	2	2	2	1	2	DP
2	1	2	2	2	2	1	DP
2	1	2	2	2	2	2	DP
2	2	1	1	1	1	1	DUAL
2	2	1	1	1	1	2	DUAL
2	2	1	1	1	2	1	DUAL
2	2	1	1	1	2	2	DUAL
2	2	1	1	2	1	1	DUAL
2	2	1	1	2	1	2	DUAL
2	2	1	1	2	2	1	DUAL
2	2	1	1	2	2	2	DUAL
2	2	1	2	1	1	1	MIL_R
2	2	1	2	1	1	2	MIL_R
2	2	1	2	1	2	1	MCARE
2	2	1	2	1	2	2	MCARE
2	2	1	2	2	1	1	MCARE

Employer	Direct Purchase	Medicare	Medicaid	TriCare	VA	Indian Health	Category
2	2	1	2	2	1	2	MCARE
2	2	1	2	2	2	1	MCARE
2	2	1	2	2	2	2	MCARE
2	2	2	1	1	1	1	MCAID
2	2	2	1	1	1	2	MCAID
2	2	2	1	1	2	1	MCAID
2	2	2	1	1	2	2	MCAID
2	2	2	1	2	1	1	MCAID
2	2	2	1	2	1	2	MCAID
2	2	2	1	2	2	1	MCAID
2	2	2	1	2	2	2	MCAID
2	2	2	2	1	1	1	MIL_A
2	2	2	2	1	1	2	MIL_A
2	2	2	2	1	2	1	MIL_A
2	2	2	2	1	2	2	MIL_A
2	2	2	2	2	1	1	MIL_A
2	2	2	2	2	1	2	MIL_A
2	2	2	2	2	2	1	NATIVE
2	2	2	2	2	2	2	NOCOV

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Services provided by Mercer Health & Benefits LLC.

HAWAI'I HEALTH
CONNECTOR

Memorandum

TO: Board of Directors
FROM: Tom Matsuda, Interim Executive Director TM
DATE: February 10, 2014
RE: Sustainability Planning

This memo documents the guidance provided by the Board of Directors to Connector staff regarding a proposed framework for developing a sustainability plan for the Hawai'i Health Connector.

Key Affordable Care Act (ACA) and state law factors impacting sustainability

1. Extension of deadline to spend Section 1311 federal grants
    a. Current ACA rule:
        i. IT design and development funds: Must be obligated by 12/31/14
        ii. Operations and Maintenance funds: Must be spent by 12/31/14
    b. As of 11/30/13, the Connector had about $110 million unobligated
    c. The Connector is asking its federal funding agency (CCIIO) for an extension of both deadlines to 12/31/15. It is unclear when the decision will be made.

2. Definition of small business, for access to SHOP[1] and small employer tax credits:
    a. Current state law: 50 employees or less
    b. State option: Increase to 100 employees before 2016
    c. 2016 ACA mandate: Increases definition to 100 employees nationwide

3. Options regarding large employers (over 100 employees):
    a. Current ACA rule:
        i. SHOP is only for small employers until 2017

[1] Small Business Health Options Program (SHOP) refers to the portion of the exchange system that allows small businesses to select health insurance plans for their employees, and allows their employees to enroll in a plan.

ii. Small business tax credit expires end of 2016

b. State option: Allow large employers to use SHOP starting in 2017

4. ACA Innovation Waiver (ACA Section 1332)[2]:
   a. Innovation waivers can take effect no sooner than January 1, 2017
   b. Federal administration has up to 180 days to make a decision on a state's waiver application

5. Other possible State options:
   a. Extend "grandmothered" health plans into 2016
   b. Set age band rating between 1:1 and 3:1 (currently at 3:1)
   c. Allow for direct enrollment

Proposal framework

This is an outline of a sustainability plan presented as a chronology between now and 2017. It provides 2 basic options, depending on whether the extension of time to spend federal grant funds in 2015 is approved or not during the current legislative session.

The Connector currently is focused on increasing enrollment in the Individual Marketplace to reduce the number of uninsured/underinsured Hawai'i residents and provide more affordable insurance options through the ACA individual tax credit ("Advance Premium Tax Credit" (APTC)) and Cost-sharing Reductions (CSR). That effort must continue in any sustainability plan as a core goal of the ACA. The key concept in this proposal is to supplement enrollment in the Individual Marketplace by examining the revenue opportunity provided by the Connector's Small Business Health Options Program (SHOP).

A sustainability plan built solely on individual enrollments is not sufficient because Hawaii's uninsured population is so low. There are about 100,000 uninsured in Hawaii (8% of the population), and about half of those people probably eligible for Medicaid. Enrolling as many of the uninsured as possible this year would certainly help support sustainability in 2015.

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[2] ACA Section 1332 allows states to apply for an innovation waiver to excuse individual states from certain requirements of the ACA. The rules for the waiver process have not yet been issued. The intent is to provide states with unique circumstances to take different paths to achieve the goals of the ACA.

Section 1332 includes the following:
"Before a state may submit a waiver, its legislature must pass legislation authorizing the state to apply for a waiver, and the state must receive public comments on its proposal. In addition, the state's proposal must include a list of the sections of the ACA the state desires to waive, its specific plans to offer coverage as comprehensive and affordable as under the ACA, and a detailed ten-year budget that is deficit neutral to the federal government. The applicable Secretary or Secretaries will have 180 days to make a determination on a state's submitted waiver application."

The following example illustrates the basic revenue equation:

- Connector fee applied to all plans sold: 2% of plan premiums
- Approximate operating cost of the Connector in 2015: $15 million
- Average premium of all plans on the Connector = X per month

Example 1: X = $500 per month

$500 per month x 2% = $10 per enrollment per month
$10 per month x 12 months = $120 per enrollment per year
$15 million annual operating cost ÷ $120 per enrollment = 125,000 enrollments needed

Example 2: X = $400 per month

$400 per month x 2% = $8 per enrollment per month
$8 per month x 12 months = $96 per enrollment per year
$15 million annual operating cost ÷ $96 per enrollment = 156,250 enrollments needed

The calculation of actual premiums applied to the 2% fee will be more complicated. Because of age band rating, the premium amount is different for each year of age. Thus an older average age demographic of enrollees will mean higher revenue per plan sold. Enrolling many "young invincibles" will mean lower revenue per plan sold. Also, for calculating revenue in 2014, the 2% fee for individual plans started January 1, 2014, while the 2% fee for SHOP plans will start on July 1, 2014.

SHOP has a large enrollment potential now[3] that could increase more in 2016 and 2017 due to planned ACA enhancements to SHOP. The ACA increases the definition of small business for SHOP from 50 to 100 employees in 2016 and allows large employers to enroll through SHOP starting in 2017. These expansions could increase the number of enrollments. On the other hand, potential choices by the State, such as 1:1 age rating, extension of "grandmothered" plans, or direct enrollment, could reduce the number of enrollments in SHOP. Therefore, the true revenue potential of SHOP isn't knowable yet. A sound sustainability plan should take these potential impacts on enrollment into account through alternative budget scenarios.

The ACA small business tax credit expires at the end of 2016. After that, there is no ACA mandate to

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[3] For example, the Oliver Wyman actuarial analysis of the Basic Health Plan Option for Hawaii (dated February 7, 2013), prepared for the Insurance Division, DCCA, estimated of the number of people enrolling through SHOP in 2014 as follows:

- Low estimate: 52,000
- High estimate: 104,000
- Total lives covered in the small group market: 207,000

Unfortunately, we have not found estimates of the number of potential small businesses using SHOP who would be eligible for the small business tax credit.

motivate employers to go through SHOP. This means that SHOP functionality and user experience by that time must provide so much value and convenience to employers that they want to enroll their employees through SHOP and are willing to bear the additional cost (either through the existing 2% fee or through a replacement revenue mechanism adopted by the Legislature) as an acceptable trade-off for that service.

If we build a plan that takes these unpredictable ACA changes to SHOP into account over the next 3 years and we also acknowledge the current reality of our situation by having a plan for system improvements and cost cutting, then we start to have a credible context for a sustainability plan. If we are successful in realizing the potential to increase online SHOP enrollments, the vast majority of those enrollments will be by employers who are subject to Prepaid. This means that Hawaii will have successfully leveraged the Connector's federal funding to substantially modernize and upgrade the State's Prepaid enrollment system.

Option 1 (Assumes extension of grant funds through 2015)

A grant extension gives us breathing room to improve the system, increase enrollment in both Individual and SHOP marketplaces, and work out a long term sustainability plan with State partners. The duration of the grant extension would be a critical factor. At this time, we have requested an extension but there is no indication from our federal partners when a decision will be made.

1. Present to October 2014

    a. Continue system improvement (performance/usability) to increase enrollment. Focus on Individual Marketplace enrollment to March 31. Then focus on improvements to SHOP to make it more attractive and useful to small businesses. Finish improvements before May 1 to accommodate the push to enrollment for small businesses with plan years starting July 1, 2014.
    b. Continue to enhance and improve education and outreach functions of the Hi'i Ola program, to build public understanding about the ACA and the Connector. Prepare to support and expand the Navigator program after federal funding expires.
    c. Establish metrics/enrollment goals to evaluate progress towards sustainability in 2015 and 2016. Tie metrics to 2015 and 2016 budget forecasts and potential changes to the small group market.
    d. Work with the Legislature and the State Administration to support the planning study by the Governor's Office, including greater coordination with the Healthcare Transformation initiative.
    e. Find ways to reduce ongoing operating and maintenance costs.

2. November 2014 to December 2015

   a. 2nd Open Enrollment period begins November 15, 2014. Aim to have a fully functioning and first-class user experience in the Individual Marketplace by then. Work to increase enrollments.
   b. Continue SHOP improvements to functionality and usability. Provide training to the small business community about the ACA and SHOP. Use marketing to attract businesses that have a January 1, 2015 plan year start. Support and expand the Navigator program.
   c. Finalize all system development including approved interfaces with State partners.
   d. Consider proposing legislation in the 2015 session to increase the SHOP definition of small business to 100 employees. Even if this doesn't happen, prepare later in the year to handle larger enrollment volume when the federal mandatory increase to 100 employees takes effect in 2016.
   e. Work with the Legislature and the State Administration planning process to propose a policy framework for evaluating an ACA innovation waiver as an optional action. Due to the complexities and procedural requirements for an innovation waiver, consider legislation to set the groundwork in the 2015 session.
   f. Regularly evaluate the marketplace system, enrollment and sustainability progress against previously established performance metrics. At regular intervals, assess the current and projected impact of ACA small business market changes on SHOP enrollment and revenue, and project the possible revenue impact of having large employers enroll through SHOP in 2017.

3. 2016 and beyond

   a. Decide whether an application for an Innovation Waiver is necessary for Hawaii.
   b. If necessary, work with the Legislature and the State Administration on legislation for an Innovation Waiver in the 2016 legislature. Legislative action is a prerequisite to filing a waiver application. The federal government has up to 180 days to make a waiver decision, so the application must be filed no later than July 1, 2016 if it is to take effect on January 1, 2017, the earliest possible date under the ACA.
   c. If a waiver is unnecessary or is denied, consider legislation to expand SHOP to include large group market enrollments starting in 2017.

Option 2 (Assumes extension of grant funds is denied)

Assuming the breathing room provided by the grant extension does not happen, Option 1 is accelerated:

1. The current board planning process focuses on completing the details of this plan, establishing realistic budgeted revenue and expense targets, and providing metrics/milestones/scenarios to gauge progress towards sustainability against those targets. This validates the plan for the Legislature and State Administration and provides an objective basis for legislative decisions.
2. The planning study proposed by the State administration also will have to happen concurrently during this session instead of afterwards, supported by our board planning work.
3. If the results of (1) and (2) above indicate that the Connector likely is not sustainable in 2015 without the federal funding extension, then that finding becomes an objective basis for a revenue decision by the Legislature in this 2014 session, <u>but only for calendar year 2015</u>. In other words, the temporary infusion of state funding would serve the same function that the federal grant extension would have had: gives us breathing room in 2015 to take the actions outlined in Option 1. Revenue for 2016 can be considered, if necessary, in the 2015 session.

Under both options, a major goal is to be able to make an informed final decision about applying for the Innovation Waiver before the 2016 legislative session begins. If the objective conclusion is that the Connector is sustainable long term, then the scope of the waiver application could be reduced or eliminated.

If, on the other hand, the conclusion is that the Connector is not sustainable long term even with SHOP enhancements, then major changes will have to be requested in the waiver application. The process outlined in Option 1 will have provided objective criteria and measurements to substantiate the application. Options could include, for example, a waiver of the SHOP requirement for Hawaii.

Obviously, this plan outline will have to be supplemented with more details, including enrollment/revenue and cost reduction scenarios, in the next step of our planning process. The challenge for our planning process, as explained above, is that there are many changes impacting our enrollment in the next three years, and many of those changes will be unpredictable external decisions beyond our control.

HAWAI'I HEALTH
CONNECTOR

Financial Overview

FY2014 through December 31, 2013

Operating Budget vs. Actual

Six Months Ended December 31, 2013

	Six Months Ended December 31, 2013					
	Operating Budget	Actual	Budget Over (Under) Actual	% variance	FY14 Total Budget	% Operating Budget Remaining
Support & Revenue						
Federal Grants	93,378,788	21,502,866	71,875,922	77%	138,853,510	85%
Subrecipient Grants	(22,238,718)	(1,761,273)	(20,477,445)	92%	(28,105,400)	94%
Issuer Fees	-	-	-	-	1,068,501	100%
Other Grant Revenue	-	38,000	(38,000)	-	-	-
Non-Grant Revenue	-	763	(763)	-	-	-
Total Support & Revenue	71,140,070	19,780,356	51,359,714	72%	111,816,611	82%
Expenditures						-
Personnel Costs	3,062,069	2,384,928	677,141	22%	6,124,138	61%
IT Contracts - Build	45,488,842	8,410,338	37,078,504	82%	64,752,714	87%
IT Contracts-Maintenance & Operations	1,671,138	1,051,597	619,541	37%	5,013,411	79%
Non-IT Contractual Services	13,763,250	5,019,379	8,743,871	64%	19,824,174	75%
Other Non-IT Contracts	5,734,173	413,622	5,320,551	93%	11,390,173	96%
Equipment	142,001	3,682	138,319	97%	1,142,000	100%
Travel	582,001	68,289	513,712	88%	1,188,000	94%
Supplies	208,000	152,146	55,854	27%	350,500	57%
Other	488,596	498,211	(9,615)	-2%	963,000	48%
Total Expenditures	71,140,070	18,002,192	53,137,878	75%	110,748,110	84%
Net Revenues over Expenditures	-	1,778,164	(1,778,164)		1,068,501	

Operating Budget vs. Actual

Quarter Ended December 31, 2013

	Three Months Ended December 31, 2013			
	Operating Budget	Actual	Budget Over (Under) Actual	% variance
Support & Revenue				
Federal Grants	35,576,700	11,615,068	23,961,633	67%
Subrecipient Grants	(12,441,741)	(1,599,687)	(10,842,054)	87%
Issuer Fees	-	-	-	-
Other Grant Revenue	-	38,000	(38,000)	-
Non-Grant Revenue	-	325	(325)	-
Total Support & Revenue	23,134,960	10,053,705	13,081,254	57%
Expenditures				
Personnel Costs	1,648,807	1,167,294	481,513	29%
IT Contracts - Build	10,618,143	4,588,826	6,029,317	57%
IT Contracts-Maintenance & Operations	1,671,138	527,693	1,143,445	68%
Non-IT Contractual Services	5,459,271	2,138,264	3,321,007	61%
Other Non-IT Contracts	3,114,000	173,507	2,940,493	94%
Equipment	-	1,176	(1,176)	0%
Travel	303,003	28,304	274,699	91%
Supplies	104,500	136,847	(32,347)	-31%
Other	216,098	218,751	(2,653)	-1%
Total Expenditures	23,134,960	8,980,661	14,154,298	61%
Net Revenues over Expenditures	-	1,073,044	(1,073,044)	

Variance Analysis- Revenue

Six Months Ended December 31, 2013

- YTD Grant revenue $50 million lower than budget
  - Delay in completion of Exchange
  - IT build, Contact Center, & Outreach
  - Operating budget of $71 million for Q1&2 FY2014.

Variance Analysis- Subrecipient grants

Six Months Ended December 31, 2013

Subrecipient grants:

- Q1 & Q2 budget of $22 million
- < $2.0 million expended.
  - Delays in expending $:
    - Marketplace Assister Grants- $2.7M
    - State cost allocation- $4.5 million
    - State Partners - $11.8 million

Variance Analysis- Expenditures

Three and Six Months Ended December 31, 2013

IT Contracts- Build:

- Six Months Ended 12/31/13:
  - Actual 81% lower than budget
  - Significant "budgeted" deliverables of $37M pending at 12/31/13.
- Quarter Ended 12/31/13:
  - Actual 57% lower than budget
  - $6 million of "budgeted" deliverables pending at 12/31/13

Variance Analysis- Expenditures (continued)
Six Months Ended December 31, 2013

Personnel Costs:

- Actual 22% lower than budget
- Actual FTEs of 43 versus 53 budgeted

IT Contracts- Maintenance & Operations:

- Actual 37% lower than budget
- Actual M&O date was delayed

Variance Analysis- Expenditures (continued)
Six Months Ended December 31, 2013

NON-IT Contracts:

Description	Budget	Actual	$ Budget Over (Under)	% Variance	Total FY2014 Budget
Contact Center	$ 4,887,000	$ 1,786,000	$ 3,101,000	63%	$ 6,023,000
Outreach/ Public Relations	8,171,000	2,156,000	6,015,000	74%	12,736,000
Legal	705,000	1,077,000	(372,000)	(53%)	1,065,000
total	$13,763,000	$ 5,019,000	$ 8,744,000		$19,824,000

Variance Analysis- Expenditures (continued)
Six Months Ended December 31, 2013

Non-IT Contract Expenditures:

- **Contact Center**
  - Actual lower than budget due to delay in delivery of CRM deliverable.
  - Still pending delivery.
- **Outreach and Public Relations**
  - Media and PR increased at a pace slower than budgeted.
  - Media curbed slightly due to technology delays
- **Legal**
  - Actual is 53% or $372,000 greater than budget.
  - Additional expenses due to accelerated timing of contracts
  - Legal issues associated with problems with launch of Exchange.
  - Inside Counsel performed de facto CIO role during most of Q2.
  - Expectation that legal costs will exceed total FY 14 budget by $400,000.

Variance Analysis- Expenditures (continued)
Six Months Ended December 31, 2013

Other NON-IT Contracts:

Description	Budget	Actual	$ Budget Over (Under)	% Variance	Total FY2014 Budget
Mailing	$ 2,167,000	$ 0	$ 2,167,000	100%	$ 4,333,000
Evaluation/ Monitoring	1,233,000	31,000	1,202,000	98%	2,467,000
Consultants/ Temporary Services	1,074,000	383,000	1,321,000	78%	2,700,000
Bank/ Lockbox Charges	630,000	0	630,000	100%	1,890,000
Total	$ 5,734,000	$ 414,000	$5,320,000		$ 11,390,000

Grant Timeline

Year Ended June 30, 2012	Year Ended June 30, 2013	Year Ended June 30, 2014	Year Ended June 30, 2015

Nov. 29 '11 — Apr. '13 — Nov. 28 '13

1st Level One $14,440,144 (Re-Assigned-previously awarded to DCAA)

Aug. 23 '12 — Aug. 22 '13 — Aug. 22 '14

2nd Level One $61,815,492 (Extension 2nd Level One)

Apr. 8 '13 — Apr. 7 '14 — Dec. 31 '14

Level Two $128,086,634 (Extension Level Two)

Grant Budget vs. Actual
2nd Level One
Grant Inception to December 31, 2013

	2nd Level One Grant Budget	Actual $ Incurred	Remaining 2nd Level One Grant $	% Remaining
Revenue	$ 61,815,492	$ 30,742,564	$ 31,072,928	50%
Expenditures				
Salaries & Wages	$ 3,650,000	$ 3,195,026	$ 454,974	12%
Fringe Benefits	1,460,000	359,447	1,100,553	75%
Equipment	142,000	93,629	48,371	34%
Supplies	24,600	27,070	(2,470)	-10%
Travel	209,300	147,195	62,105	30%
Other	704,604	741,400	(36,796)	-5%
IT Contracts	50,984,000	22,412,674	28,571,326	56%
Non-IT Contracts	4,640,988	3,812,495	828,493	18%
Total Expenditures	$ 61,815,492	$ 30,788,937	$ 31,026,555	50%

Grant Budget vs. Actual
Level Two
Grant Inception to December 31, 2013

	Level Two Grant Budget	Actual $ Incurred	Remaining Level Two Grant $	% Remaining
Revenue	$128,086,634	$ 11,887,475	$ 116,199,159	91%
Expenditures				
Salaries & Wages	$ 6,144,500	$ -	$ 6,144,500	100%
Fringe Benefits	2,590,300	304	2,589,996	100%
Equipment	3,946,350	373	3,945,977	100%
Supplies	650,500	119,986	530,514	82%
Travel	3,712,275	40,526	3,671,749	99%
Other	1,353,800	80,433	1,273,367	94%
In Person Assisters	21,000,000	477,021	20,522,979	98%
IT Contracts	41,626,802	5,038,659	36,588,143	88%
Non-IT Contracts	47,062,107	6,079,247	40,982,860	87%
Total Expenditures	$128,086,634	$ 11,836,550	$ 116,250,084	91%

Grant Funding Obligated

Contract Inception to December 31, 2013

Contractor Name	Contract Amount	Less: M&O Subsequent to 12/31/14	Expended to Date (12/31/13)	Remaining Obligated Balance
Allen Communication Learning Services	$ 292,961		$ 283,173	$ 9,788
CGI Technologies and Solutions, DDI	49,424,338		18,750,228	30,674,110
CGI Technologies and Solutions, O&M	14,441,126	(8,327,280)	1,044,263	5,069,583
CGI Technologies and Solutions, Inc. Total	63,865,464	(8,327,280)	19,794,491	35,743,693
Mansha Consulting, LLC Total	13,166,949		7,818,065	5,348,884
Maximus DDI Total	3,878,574		1,073,217	2,805,357
Maximus O&M Total	4,967,095	(1,687,290)	712,900	2,566,905
Maximus Total	8,845,669	(1,687,290)	1,786,117	5,372,262
Milici Valenti Ng Pack Inc. Total	1,992,815		1,830,305	162,510
Oahu Publications, Inc. Total	1,200,000		917,799	282,201
Public Consulting Group Inc. Total	4,150,330		3,377,059	773,271
Turning Point Global Solutions LLC Total	1,476,821		1,099,671	377,150
	$ 94,991,009	$ (10,014,570)	$ 36,906,680	$ 48,069,759

Note: An obligation to the State of Hawaii Department of Health and Human Services is included in the FY2014 operating budget and will be included as obligated once negotiations conclude with a signed agreement between the Connector and DHS.