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PENNY DUCKHAM: Well, hello, and welcome to this webinar, which we are putting on exclusively for NABJ. I'm Penny Duckham, and I think I know many of you. I run the Media Fellowships Program at the Kaiser Foundation. With about a month to go to sign up for coverage through the marketplaces, that's Monday, March the 31st, this seems like a good moment to take stock of where things stand.

We are joined today by several of my colleagues here in snowbound Washington, DC and I would urge you, as we go through the brief presentation, to please send in your chat questions and we will get to those as soon as we've gone through the slides. The purpose of this webinar is really to give you the chance to ask all the questions that you haven't perhaps had the chance to ask yet. We will do our very best to answer you, if not during the webinar, then subsequently by e-mail. So please send in your questions.

With that, I am going to turn over to my colleagues joining me here today, Jennifer Tolbert, Director of the State Health Reform program at Kaiser; Samantha Artiga, Director of the Disparities Policy Project; Jessica Stephens, Senior Policy Analyst; and Trina Scott, Program Officer with the Greater than AIDS Program. I'm going to move straight on to Jen Tolbert.

JENNIFER TOLBERT: Okay, thanks, Penny. Good afternoon, good morning, everyone on the webinar. Just to give you a quick roadmap of our presentation this afternoon. I'm going to start with a brief overview of the coverage provisions in the ACA and then I'll focus a little bit more on what we know about enrollment to date in the marketplaces. My colleagues, Samantha and Jessica, are then going to dig in to the ACA's Medicaid expansion and enrollment simplification requirements, as well as the status of state Medicaid expansion decisions, and the implications, especially for people of color, of state decisions not to expand the program.

To start things off, one of the main goals of the ACA is to expand coverage for those who are currently uninsured and to improve the quality of coverage for those with insurance. It does this by building on the base of employer-sponsored coverage and filling in the gaps in our current system. It expands the Medicaid program to more low income adults and creates new health insurance marketplaces where individuals and small employers will be able to go to shop for and enroll in private health coverage. Federal subsidies are available through the marketplaces to make the coverage more affordable for consumers.

Despite the goals of expanding coverage broadly, these coverage expansions are being implemented differently across states. The Supreme Court decision on the constitutionality of the ACA left the decision whether to expand the Medicaid program optional for states, and as a result, some states have chosen not to expand the program. In addition, states were given the option to run their own marketplace or partner with the federal government or default to a fully federally run marketplace. Currently, only 14 states and DC are operating as stated-based marketplace. These decisions by states, regarding the coverage expansions, affect not only who is eligible for coverage, but as I'll discuss, how many people are actually enrolling in coverage.

Through the Medicaid expansion and the subsidies in the marketplaces, the ACA provides new affordable coverage opportunities for many uninsured. When we look at the uninsured, strictly based on their

income, we find that 90-percent have incomes that would qualify them for Medicaid or the premium subsidies in the marketplaces. The remaining 10-percent have incomes above 400-percent of the poverty level or about \$94,200 for a family of four, and may be able to purchase coverage through the marketplaces, but will not be eligible for the premium subsidies.

The marketplaces opened for enrollment on October 1st. Although the rollout has been quite rocky, many of the worst problems with Healthcare.gov, as well as some of the state websites, have thankfully been resolved and improvements to the websites continue to be made. Enrollment surged in December as people rushed to sign-up for coverage that would begin on January 1st. Enrollment continued to be strong throughout January. As of February 1, 2014, over 3.3 million people had selected a qualified health plan in the marketplaces across all states. This number includes people who have paid their first month's premium, as well as those for whom the premium payment is pending. The number of people who ultimately pay the premium and actually enroll in coverage will likely be lower than the 3.3 million who've selected a plan. We anticipate that we should have a better sense of what actual enrollment looks like once the open enrollment period closes on March 31st.

Another way to gauge enrollment is to look at the number of enrollees as a share of the potential marketplace population. Or those people who are able to and are potentially likely to enroll in the marketplace. Across all states, about 11.5-percent of the population that could potentially enroll in coverage through the marketplaces, has so far signed up. In general, states running their own marketplaces have been more successful at enrolling people into coverage, although ongoing website issues in a handful of state-based marketplaces are suppressing enrollment in those states.

The reasons for the greater enrollment success in state-based marketplaces are many. These states have more fully embraced the ACA coverage expansions. They have also made greater investments in advertising and outreach efforts to raise awareness about the new coverage opportunities, and are more fully supporting community-based enrollment assistors who are working to identify eligible consumers and provide one-on-one assistance to help them enroll.

As problems with Healthcare.gov have been fixed, enrollment is increasing at a faster clip in states with a federal marketplace, especially among states in the South. In fact, eight of the ten states with the largest increases in enrollment from December to January were in the South. Still, as we saw from the previous slide, there is much work to be done, especially in these states, to reach and enroll more of the target population.

Today we have limited data on the characteristics of the marketplace enrollees. We know that 55-percent are women, 25-percent are in the coveted 18 to 34 year old age group, and 82-percent have received financial assistance with their enrollment. We anticipate that once the open enrollment period closes we should learn more about who is gaining coverage, including characteristics such as race and ethnicity, income, and how many of the folks who signed up were previously uninsured. With that, I'm going to turn it over to Samantha.

SAMANTHA ARTIGA: Great, thanks, Jen. As Jen mentioned, I really want to focus on the changes the ACA makes to Medicaid. As Jen mentioned, one primary way the ACA expands coverage is through an expansion in Medicaid eligibility. Prior to the ACA, Medicaid eligibility was limited to people who both met income requirements for the program and fell into one of several specific groups or categories,

including the elderly and people with disabilities, children, pregnant women, and parents. Before the ACA, adults without dependent children, who were sometimes referred to as childless adults, were generally excluded from the program, regardless of how low their incomes were.

Moreover, while over time states have significantly expanded Medicaid eligibility to reach most low income children, income eligibility limits for parents remain very low in many states, with a number limiting eligibility for parents to less than half the poverty level, which today is about \$10,000 for a family of three. The ACA sought to fill these gaps in coverage for low income adults in the Medicaid program by expanding Medicaid eligibility to all adults with incomes up to 138-percent of the federal poverty level, which is about \$27,000 for a family of three today or \$16,000 for a single adult, starting on January 1st of this year. As enacted in the law, this expansion was to occur in all states. However, as I'm sure you're all aware, the Supreme Court ruling on the ACA effectively made that expansion a state option.

In addition to expanding Medicaid eligibility, the ACA also included new requirements for states that were designed to make it easier for eligible people to enroll in Medicaid and to create a coordinated no wrong door enrollment system for all health coverage options, including the new marketplaces, which Jen just discussed. All states need to implement these new requirements for simplified processes, regardless of whether they choose to expand their Medicaid program. Under these requirements, states must provide individuals several options to enroll including online, by phone, in person, or mail, using a single application that will screen for eligibility for all health coverage options, including Medicaid, CHIP, and the new marketplaces. These processes are designed to rely on electronic data when possible to verify information with a goal of providing real-time eligibility determinations for individuals when possible.

Reflecting this move to a coordinated enrollment system, individuals are now connecting to the Medicaid program through multiple pathways today. In addition to the existing pathways through which people would enroll through state Medicaid and CHIP agencies, individuals are also now connecting through Medicaid when they submit applications through the new health insurance marketplaces.

Moreover, to help states as they're implementing their Medicaid expansions and these new simplified enrollment procedures, CMS has offered them several options to efficiently reach and enroll individuals using data that they may have available through other programs like their supplemental nutritional assistance program or food stamp program, as well as data they may have available through children's eligibility information. We refer to these as fast track enrollment strategies on this slide.

Lastly, some states have taken advantage of opportunities to get an early start on their Medicaid expansion prior to January of this year, and those states are now transitioning adults from these early expansion programs to the full Medicaid expansion.

Just thinking about the different ways in which the ACA will then lead to increased enrollment in Medicaid, I notice the ACA not only expands eligibility to more people, but it also makes it easier for individuals to enroll in the program and creates this no wrong door enrollment system for all health coverage options. Beyond that, there've been significant outreach and enrollment efforts occurring as a result of the broader ACA implementation. Together, these changes can be expected to lead to increased Medicaid enrollment in a number of ways.

Firstly, in all states it's likely that more people who were already eligible for Medicaid before the ACA but not enrolled, will likely now connect to coverage as they learn about new coverage options and seek to apply. Perhaps they didn't know they were eligible before or perhaps they had encountered difficulties when they tried to enroll in the past.

Secondly, in the states that are implementing the Medicaid expansion, many adults will become newly eligible for the program who previously couldn't enroll. So those adults will now be eligible and have the opportunity to apply and enroll in coverage.

Lastly, in addition to the simplified enrollment processes, there are also new simplifications that make it easier for people to renew their coverage over time. This will likely lead to greater stability and continuity of Medicaid coverage in all states and reduce the churning or gaps in coverage that might happen if someone does not successfully renew their Medicaid coverage. Then looking a bit more long term, this increased enrollment in Medicaid in the long run, will lead to increased rates of Medicaid coverage and reductions in the number of uninsured.

Where are we today in terms of success and progress in implementing these changes? We know that states are still in the progress of implementing the new eligibility and enrollment processes of the ACA and establishing the coordinated enrollment system between Medicaid and the new marketplaces. States were in different places in terms of their enrollment processes and systems prior to the ACA, so there are different extent of changes that they have to implement to meet the new ACA requirements. We know in particular that states that are coordinating with the federal marketplace are continuing to work through challenges transferring accounts between the marketplace and Medicaid and CHIP to create that coordinated coverage system, but progress is continuing to be made on that front.

In addition, CMS has recently begun reporting new timely eligibility and enrollment data for Medicaid and CHIP. These data represent a significant step forward in timely data reporting for the programs. But these data are new and states are in varying stages of readiness to report the data. As such, there remain some gaps in inconsistencies in the data, but we expect the quality and completeness of that data to improve over time. Due to some of the limitations in the early data on Medicaid eligibility and enrollment, we are somewhat limited in our ability to analyze it and draw strong conclusions about what has been happening since open enrollment for the marketplaces began in October.

What we do know is that between October and December, 2013, state Medicaid and CHIP agencies and the state based marketplaces together made over 6.3 million Medicaid and CHIP eligibility determinations. I would point out that that 6.3 million number does not include Medicaid and CHIP assessments and determinations made by the federally facilitated marketplace, which is operating in 36 states. That's because those data are currently being reported separately through the marketplace data that Jen reported. The data that Jen reported shows that 3.2 million individuals have been determined or assessed eligible for Medicaid or CHIP by the marketplaces, including 1.2 million in states relying on the federally facilitated marketplace.

Separate from that data, we know that some states have successfully enrolled large numbers of people through the facilitated enrollment options offered by CMS, in particular by using data available through their supplemental nutritional assistance programs and their children's eligibility data. We also know that

a few states have successfully transitioned large numbers of adults from their early expansion programs over to their new full Medicaid expansions, in particular California is a good example of that.

Lastly, I'll say while there has been a lot of focus right now on these enrollment data and a lot of interest in using the data to determine the impact that the ACA is having, I think really assessing the success of the law on coverage and on Medicaid is going to require some time. In the long run, what we'll really be looking for to measure success is, ultimately, the changes in the number of uninsured over time. But that will take some time for us to have available.

JESSICA STEPHENS: As Samantha just explained, one of the main aims of the Medicaid expansion was to expand coverage to low income adults in all states. What I'll spend the next couple of minutes doing is talking through the current state of affairs and the implications.

As many of you may already know, not all states are currently moving forward with the Medicaid expansion since the Supreme Court decision effectively made the expansion a state option. Looking at this map, you can see that in the dark blue, currently 26 states are implementing the Medicaid expansion, 25 are not at this time. But among those 25 states, there's open debate in six of them, as they debate in their state legislatures.

What that means is that in the 25 states that are expanding Medicaid at this time, eligibility levels will increase for adults. If you look towards the right hand side of the figures, the median Medicaid eligibility limit for both parents and childless adults in those expansion states as of 2014, is 138-percent of the federal poverty level, which amounts to about \$16,000 for an individual per year, and \$27,000 for a parent and a family of three as of 2014.

However, in states that are not expanding, Medicaid eligibility limits will remain very low. So across the 25 non-expansion states, the median eligibility limit is just 47-percent of the federal poverty level for parents, and that's about \$9,000 for a parent and a family of three. In the majority of states, childless adults, adults without dependent children, will remain ineligible for Medicaid regardless of their income. Children and pregnant women will continue to be covered at relatively high rate levels in comparison to adults in Medicaid and in CHIP.

Because Medicaid eligibility limits for adults will remain so low in states that don't expand, millions of poor adults will be left without a coverage option. The ACA envisions that nearly all low-income individuals would qualify for Medicaid, as Samantha explained in the previous umbrella slide. Therefore, tax credits are only available to individuals at or above the poverty limit. Only those individuals may qualify for these tax credit subsidies. In states that do not expand, individuals that have income above the current low limit for Medicaid and below 100-percent of the poverty level, fall into a coverage gap represented by this white portion of the umbrella in the middle. And 4.8 million poor adults fall into the coverage gap nationally.

The coverage gap and states' decisions to expand Medicaid have significant implications for people of color, although the impact of the coverage gap varies widely by race and ethnicity. Overall, three in ten uninsured adults and three in ten uninsured adults of color that could potentially qualify for the Medicaid expansion, fall into the coverage gap in states that are not expanding Medicaid. Looking more specifically at the breakdown by race/ethnicity, we see that four in ten uninsured black adults fall into this

coverage gap. This is largely because a large share of low income, uninsured blacks reside in southern states which are not expanding Medicaid. In comparison, even though larger numbers of Hispanics fall into the coverage gap, a large share of low income Hispanics live in states such as California and New York, which are expanding Medicaid. Suggesting that the individual state decisions that states make to expand or not expand have significant implications for people of color.

Just to wrap up, I'll note that as Jen explained in the beginning, the aim of the ACA coverage expansion was to reduce the number of uninsured. And millions of uninsured people of all races and ethnicity are newly eligible for health coverage in 2014. However, looking at this slide here, you can see that people of color have historically been more likely to be uninsured compared to whites. Continued coverage gaps that disproportionately affects blacks and other people of color, will likely lead to widening racial and ethnic disparities in health coverage. With that, I'll turn it back to Penny for your questions.

PENNY DUCKHAM: Thank you. Just to remind you, you have every opportunity to send in your questions for the chat. I'm just going to ask the operator, could you remind people, again, how to do that?

OPERATOR: Certainly, thank you. Ladies and gentlemen, if you would like to ask a question, please use the chat feature located in the lower left corner of your screen. One moment, please, for the first question.

PENNY DUCKHAM: I just wanted to say, we've covered a lot of numbers and factual information pretty quickly. We can go back over any of that and more. To be clear, we will be making these slides available to any of you who would like to have them and making them available to NABJ, of course, as well. The full webinar presentation will be posted later, so again, if we covered things pretty quickly, we did that deliberately so we could get through a lot. There is also a lot of other information on the Kaiser website and we can touch on that later on.

Just immediately, I'm going to take the first question from Charles Hallman at the Minnesota Spokesman-Recorder. He asks, when can we anticipate when ethnicity rates enrollment data will be available for the media to report? Jen, could you take that?

JENNIFER TOLBERT: Sure, and unfortunately, I don't have a good answer. I don't know when or even if these data will be available. The beauty of the new marketplaces and the online enrollment system is that people are applying and submitting and answering a standard set of questions that includes information on income, on race, ethnicity, household size, age, and other characteristics. We do hope that these data will be made available by the federal government, but we don't have a sense of when. So far HHS has made available fairly significant data based on age and age break outs, but again, we're waiting on some other key demographic characteristics.

PENNY DUCKHAM: DeborahBerry] asks, how do you explain the spike in enrollment in the South, particularly in states that have rejected Medicaid's expansion, such as Louisiana and Mississippi? As kind of a follow up, which goes back to that question, Jen, that you were just on, when will we know the racial breakdown of those enrollees in those southern states?

JENNIFER TOLBERT: This is Jen again. I think in part the reason we've seen such a spike in enrollment, in particular within southern states, is that enrollment in those states was stymied initially because of problems with the Healthcare.gov website. Now that those problems have been resolved and

people can more easily enroll through the marketplace in those states, I think they are doing so. In addition, there is significant demand among uninsured in these states. These states have among the highest rates of uninsured across all states, so there's a large population of people who are going to be eligible for coverage. Now, obviously many of them are low income and would otherwise be eligible for Medicaid if those states were expanding. But I think in part, also because the states aren't expanding Medicaid, the only coverage vehicle is through the marketplace, so that's likely driving more people to the marketplace to enroll than perhaps in some other states.

SAMANTHA ARTIGA: Jen, just to clarify, the data you presented on that marketplace search and enrollment, that was specifically for enrollment in the qualified health plans through the marketplace and did not include—

JENNIFER TOLBERT: Yes, did not include Medicaid, that's right. Good clarification, thank you.

PENNY DUCKHAM: Right. Cindy George] in Houston, Texas asks, could you expand on how uninsured poor, black Americans will be disproportionately affected by the lack of Medicaid expansion in the South?

JESSICA STEPHENS: Sure, a large share of low income black Americans live in the South compared to other regions. And I don't have the data in front of me, so we can follow up later, but over half—I think it's about 60-percent of uninsured black Americans that could, potentially, qualify for the Medicaid expansion, live in the southern states. The majority of southern states are not currently expanding Medicaid, including large states such as Texas, Florida, North Carolina, Georgia. And in those states, because they're not expanding, there are larger shares of black individuals who will not be able to obtain coverage. Whereas if you look at the Hispanic population, a larger share of low income Hispanics, just geographically, reside in states such as California and New York, and as a result, because those states are expanding Medicaid, they will have the option to enroll in coverage.

PENNY DUCKHAM: Marissa Evans at Kaiser Health News asks, for blacks that fall into the Medicaid eligibility gap, can you expand a little bit on what their options are going forward? Are there big changes for them awaiting in terms of how they can access care because of the ongoing effects of this set of changes?

SAMANTHA ARTIGA: Those adults who fall into the coverage gap really are left without any new health coverage options, which means that they basically are facing the same circumstances they have previously faced. What we know about the uninsured today is that even though many are working, they are often in jobs that do not offer health insurance or even when it is offered, their share of the premiums is unaffordable. Now they would be able to shop through the new marketplaces, but given the limited incomes of most of the uninsured, they likely can't afford that coverage without the tax credit subsidies which they can't access, as Jessica mentioned, if they're below 100-percent on the federal poverty level. What that means is, they'll need to continue to rely on the existing safety net of care that's available today to the uninsured, which is often community health centers and public hospitals. And while those can serve as key connections to primary care and are an important resource, there are limitations and in many cases, it can be particularly difficult for the uninsured to access the care they need on an ongoing basis for care of chronic conditions and particularly if they need any specialty care beyond what is usually accessible through a community health center.

PENNY DUCKHAM: Right. I'm going to move next to a follow up question from Charles Hallman in Minnesota, addressed to you, Jessica. Do you think there's still a fear factor among blacks and other people of color in signing up, due to sign up problems, misinformation, et cetera, and what can be done to overcome that?

JESSICA STEPHENS: Historically we've shown that lots of individuals can, regardless of race, ethnicity, face a number of barriers to enrollment. Many of those are attempted to be addressed as part of the ACA. However, recent polling data that Kaiser Family Foundation has done show that across all groups, there continues to be some misinformation about the expansions and a little bit of confusion about what options are available to individuals and when they can enroll and information about the open enrollment period. I can't speak specifically to a fear factor for black versus other groups, but I would say that is something that is more general. Though I'll also note that although the marketplace, we did mention this earlier, that although open enrollment for the marketplace ends on March 31st, there is no open enrollment for Medicaid, so there are still opportunities for many of these low income individuals to enroll in Medicaid after that. There also is no deadline for states to adopt the Medicaid expansion. So many of these states that may not be implementing the Medicaid expansion at this time, may still implement it in the future and individuals that are currently not eligible, will be able to enroll.

SAMANTHA ARTIGA: I just wanted to add, we also know from previous experience with Medicaid and CHIP, that what is really key for helping people overcome enrollment barriers and successfully enroll, is often one-on-one enrollment assistance. And particularly for people of color, often having that assistance provided by someone they can identify with and trust and feel has a similar background, is really key for helping to overcome those barriers, particularly if there's an element of fear or confusion surrounding it.

PENNY DUCKHAM: I think there's been so much focus on the March 31st deadline that making this point, for Medicaid there isn't any deadline, is going to be an important one to focus on. Actually, Charles Hallman is picking up on this a little bit. Going back to the marketplace and the exchanges, what happens to people who didn't sign up by March 31st and what are their options?

JENNIFER TOLBERT: Right, as we just said, people can sign up for Medicaid throughout the year. But if their income is above the Medicaid eligibility level, the opportunity to enroll ends on March 31st, unless there is a change in circumstance that makes them eligible for what's referred to as a special enrollment period. Those kinds of changes include someone getting married or divorced, birth or adoption of a child, someone losing a job and losing their access to employer-sponsored health insurance, so there are circumstances that would allow someone to then go to the marketplace and apply for coverage. Again, for the most part, for the general population, those who do not experience those changes in circumstances, once that open enrollment period closes, they will not be eligible to sign up for coverage until the next open enrollment period comes around, which will begin in November of 2014 and run through mid-January of 2015.

SAMANTHA ARTIGA: I don't know if it's worth pointing out, the reason for these open enrollment periods is to encourage a diverse mix of enrollment, so that people don't wait until they are sick or need healthcare to enroll in health coverage. You need these discreet open enrollment periods to ensure a healthy mix in the risk pool that enrolls in coverage.

PENNY DUCKHAM: You are speaking to people who enjoy deadlines. They are definitely deadline driven. Deborah Berry is asking, could you elaborate on the federal and local efforts, local efforts in particular, to enroll more African Americans? And what is the federal government spending on these efforts? And is anyone tracking to see how these efforts might be working?

SAMANTHA ARTIGA: I'll start. This is Samantha. I don't know how much I'm going to be able to answer the specific details and Jen can hop in when I'm done. There are a wide range of both public and private outreach and enrollment efforts going on across states. In addition to the several enrollment assistance programs that were established by the ACA, which includes Navigators, which were designed to get out there and help educate people about the coverage options and enroll in coverage, there are other private enrollment efforts that have been started up, things like Enroll America. In California there are a number of foundation enrollment initiatives that are underway. In addition, a number of community health centers received funding specifically to support outreach and enrollment efforts, which is really key because they are often a primary place where uninsured people are accessing care and can serve as the key point at which to enroll uninsured, eligible folks in care. I don't know about anything that's been specifically focused on the black community, but within each community there is a different set up of outreach and enrollment going on. I will say, there is wide variation from community to community about the extent of outreach and the availability of enrollment assistance for individuals. I think Jen can probably take on that a little more.

JENNIFER TOLBERT: Sure. Just to add to that, one of the big issues is that there's a real disparity in the availability of funding to support these enrollment assistors, these folks who can provide the one-on-one assistance and can identify and go out to specific targeted areas and help to enroll eligible consumers. The federal government had fairly limited funding that had to be spread across all the states in which it was running the marketplace. In states that were running their own marketplaces, they were able to access a larger pool of federal grant dollars and so have invested much more heavily in funding these enrollment assistors. States running their own marketplaces have tended to do a better job of being able to select enrollment assistors to target specific populations. Whether those be African American communities or people for whom English is not their first language, and other groups.

What we've seen is a real disparity in the funding, and I think that's playing out as we've seen in actual enrollments across the marketplaces. States that have had more money to invest in these types of outreach and enrollment assistance activities are, for the most part, signing up a greater share of people in the marketplaces than states that haven't invested as much in these types of activities.

PENNY DUCKHAM: I think just to expand on that question of Deborah's, too, there have been a lot of efforts by disease specific or medical specific groups and just to put in a plug here for Kaiser, we have done a lot of work on HIV and AIDS and if you haven't seen it, we have a whole website which helps people with HIV and AIDS look at the implications for the ACA. That's just one example. Other groups around cancer, the American Cancer Society have reached out to groups with cancer. I think that this is another very relevant way of looking at the implications of the Affordable Care Act on different groups.

Now we're going to switch slightly into the weeds. This is looking at the whole impact of this earnings/wage gap and where that might affect enrollment. Francesca Maxime] asks, what if someone doesn't want to enroll because they're waiting for the disparity of what they used to earn versus what they currently earn? By that she means, they're delaying doing this because they, quote, earn too much and

would have to pay too much, and now earn less than that and would be able to get subsidies, potentially. This is a difficult one because this assumes people really understand this. Assuming they've gone online, they've seen where things stand, are you seeing people hanging on there and waiting to see whether circumstances change?

JENNIFER TOLBERT: This is Jen. This is a somewhat complicated question, but I will say when it comes applying for coverage through the marketplace, the basis for determining eligibility is what someone projects to earn over the course of the coming year. It isn't based on what people earned last year, for example, even necessarily what they are currently earning. What people are asked to report, and it's different for Medicaid and CHIP, but when they're applying for coverage through the marketplace, it is based on what they expect to earn. They know that they are, for example, working seasonal employment, so maybe they're making some money now, but they expect that to drop off either over the summer or later this spring. What they need to do is to look over the course of the year and anticipate what they are likely to earn, and they can report that and be determined eligible on that basis.

There is a process of verifying the information that people are reporting, so there may be folks who are projecting their income may need to be able to provide some supporting documentation that will support the income that they are projecting over the course of the year. Another important factor to keep in mind is this process that we refer to as reconciliation, which means that as people project their income and are determined eligible for subsidies in the marketplace, there is a process when they file their taxes, because one of the requirements for obtaining the premium tax credits in the marketplace is that people file taxes for the year during which they received this subsidy. Anyone receiving a subsidy in 2014 will have to file taxes in 2015. There's a process of reconciling what people reported or projected they would earn during the year and what they actually earned. If people project that they're going to earn less than they actually did, and they received premium tax credits based on their projected income, they may owe some money back. Conversely, if they projected that they were going to earn more than they actually did, they could receive an additional tax credit on their income taxes when they file next year.

It's a complicated process and I think this speaks to the importance of these enrollment assistors, the Navigators, the in-person assistors, who can help people who have questions, who aren't quite sure of what they should report when they apply in terms of their income. They can go to those people and get assistance in having those questions answered and working through the application process.

PENNY DUCKHAM: While we're on this whole issue around taxation, could we talk a little bit about people who might face a penalty for the year? In particular, on the Medicaid side, if you would have qualified for Medicaid had you been in a state that expanded, are you still going to be subject to paying a penalty? Where does that stand? Is that difficult to know at this point?

JENNIFER TOLBERT: This is Jen. As is the case with anything tax related, it is a little bit complicated. For a simple answer, in states that don't expand Medicaid, anyone below the Medicaid eligibility threshold, so anyone with income up to 138-percent of poverty, is exempt or not subject to the penalties related to the individual mandate.

The situation is slightly different in states that do expand Medicaid. In that case, there is a group of people who won't have to pay a penalty because they are below the tax filing threshold, which means they don't make enough money to have to file taxes. Because the penalty is based on and assessed

through the tax system, those people are exempt because they're not required to file taxes. That tax filing threshold is slightly less than 100-percent of the federal poverty level. People above that tax filing threshold and up to 138-percent of the federal poverty level in states that do expand Medicaid, would be subject to the penalty if they don't sign up for coverage.

PENNY DUCKHAM: I can imagine we may need to do a webinar on all the tax stuff this time next year. This is going a little more broadly than we've discussed so far, but there's been quite a bit of buzz recently around the implications of the changes and the Affordable Care Act changes on employment. The question is the likely impact on people working less in order to get coverage and there's been some dispute about what impact it might have.

JENNIFER TOLBERT: This is a tough question to answer and I see this question as stemming, in part, from the Congressional Budget Office report that recently indicated that there would be two million fewer people working as a result of provisions in the ACA. Mainly, the availability of subsidies as well as coverage through the Medicaid program, so that people would no longer be required to work at a job that offers insurance in order to obtain health insurance coverage.

It's hard to know or anticipate what impact this will have, but I think there's value in giving people the flexibility to strike off on their own, to start their own business, or to work as an independent consultant, that many people wouldn't have as an option today because they don't have access to health insurance coverage. I think that the provisions in the ACA and the greater availability of more affordable health coverage can cut both ways and there are incentives both for people to work more and in different kinds of work settings, as much as there is incentive to work less. I think this will be something that we'll just have to investigate and see how it plays out over time.

PENNY DUCKHAM: Marissa Evans takes us back to this question around enrollment assistance programs and the degree to which we actually know how much money different states have received. Some of this may not be knowable because it's more localized, but what data is available on that?

JENNIFER TOLBERT: This is Jen again. We actually have calculated the spending on enrollment assistance per capita across all states. Unfortunately I don't have the data in front of me, but it is in a report that we issued on consumer assistance. One thing I do remember is that New Jersey, on a per capita basis, received the least amount of federal funding to support enrollment assistance. As you can imagine, other states like Texas, as well as Florida and Georgia, states with large numbers of uninsured that are relying on a federal marketplace, were among the states receiving the least amount of funding. At the opposite end of the spectrum, the District of Columbia, Hawaii, as well as other states running their own marketplaces, such as California and New York, had invested the most on a per capita basis per uninsured enrollment assistance.

PENNY DUCKHAM: Just going back over this tax stuff, can you just go back over this? If you buy coverage in the marketplace, can you go back over how the tax credits and subsidies work? Specifically, do they get paid to the individual or do they get paid to the insurance company?

JENNIFER TOLBERT: They get paid to the insurance company. They don't get paid, in any case, directly to the consumer. The way the tax credit is calculated is that what someone is required to pay is based on a percentage of their income. For example, someone at 133-percent or 138-percent of the

federal poverty level is required to pay—actually, let's make it simple. At 100-percent of the poverty level in a state that's not expanding Medicaid, that person is required to contribute 2-percent of their income towards the premium.

The amount of the tax credit that they receive is the difference between what they are required to contribute towards the premium, and the cost of the second lowest cost Silver Plan in their geographic area. That second lowest cost Silver Plan is referred to as the benchmark plan. The difference between what the consumer pays and the premium is what is received in the form of a tax credit. If the person chooses to receive that tax credit as an advance payment, that payment will be made directly to the insurance company. The individual contributes their share of the premium in order for coverage to actually begin.

PENNY DUCKHAM: I know we're not quite in April and focusing on taxes, and maybe this will kick in next year, but do you think this is something we're all going to need to have an accountant to help us figure out, or is TurboTax going to do it for us? On the screen here we've got some advice and I'm sure we'll be coming up with more from Kaiser, but what's your quick advice here?

JENNIFER TOLBERT: It's hard to say. I don't think everybody's in a position to be able to hire an accountant to help them file their taxes. I do think that there will be instructions through TurboTax and on the long forms that people have to fill out that will hopefully guide them through the process. But it is going to add more complexity to the tax filing process than currently exists. I will say that there are tax preparers like Jackson Hewitt, as well H&R Block, that are making themselves available to consumers to help them walk through and work through this process.

SAMANTHA ARTIGA: I think this points to, again, the importance of one-on-one enrollment assistance and really, at the time someone is enrolling in coverage, they hopefully would receive good education about what their health coverage options are, what choices they're making with regard to the subsidy amount they're receiving, and how that's impacted by the plan choice they make. Also the importance of reporting if they have any significant changes in income over the course of the year because, as Jen mentioned, the subsidy amounts are based on what you project to earn over the course of the year. So if that changes over the course of the year, you would want to report those changes so that the subsidy amounts you receive would be reflective of the changes in your earnings.

PENNY DUCKHAM: I think one of the other stories that we're beginning to see now that we're into almost the end of February, is the degree to which, going back to the marketplaces, the degree to which people who have enrolled have actually paid their premium. Whether they paid the first month's, whether they're going to pay the second month's, and I think that's going to be a story for all of you and for us to keep an eye on going forward. Then as the insurance companies begin to come up with the plans and the premiums for the next year, it'll be interesting to watch and see where that's going, too.

I think we've covered an awful lot of ground. Just not to lose sight of it, in the end this is about people and not about the money, but we have covered a lot of the money.

Rakesh Singh and Chris Lee, their contact information is up here on the screen. If you have follow up questions, please don't hesitate to let us know. I hope this webinar was useful and shed light on this rather complicated set of stories that you have to cover. Again, we will be making the slides and the

transcript available to NABJ and it'll be available to all of you. Please stay in touch. If there are future webinars you'd like us to do, if you think this is a helpful way forward, please let us know.

Just to put in a pitch here, on April the 10th through the 12th, we will be welcoming you back here to our Washington Conference Center for the NABJ conference on racial disparities in health. You'll have a chance to go through this and much more, thanks to a wonderful program that NABJ is putting together again.

Thank you so much for taking time today. Look forward to staying in touch with you all. Goodbye.

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