

# THE SHARE PLAN

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## WYOMING'S STRATEGY FOR **H**EALTH, **A**CCESS, **R**ESPONSIBILITY, AND **E**MPLOYMENT



WYOMING DEPARTMENT OF HEALTH  
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## SECTION 1: THE SHARE PLAN, AN INTRODUCTION

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Over the course of the past three and a half years, the State of Wyoming has considered and analyzed many options for a Medicaid expansion in Wyoming. The Wyoming Department of Health (WDH) has written multiple reports for Wyoming decision-makers to understand the costs associated with an expansion, the benefits and detriments to the State of an expansion, and the options available to the State for an expansion.

In addition to reports, the WDH has researched, written, and evaluated different plans for expanding Medicaid. In search of the plan that best meets the needs of the State, the WDH has pieced together components of other states' plans for expansion, as well as created components specific to a Wyoming expansion. The result of this work is the recommended plan: the SHARE Plan. The SHARE Plan best meets the differing and ranging needs of the State, and is the best deal for Wyoming.

Guided by legislative discussion and gubernatorial direction, the WDH designed the SHARE Plan as a **S**trategy to:

1. Support the **H**ealthcare system
2. Improve **A**ccess to healthcare coverage and providers
3. Encourage **R**esponsibility of participants and of the State
4. Provide access to **E**mployment services

### *Support the **H**ealthcare system*

The SHARE Plan will utilize Wyoming Medicaid's current provider network in which between 94-99% of Wyoming providers participate (depending on type; only dental providers fall below this).<sup>1</sup> Using this network will allow Wyoming's healthcare system to accommodate an influx of newly covered SHARE participants with a wide array of providers. Additionally, expanding healthcare coverage will provide support to Wyoming providers who serve patients with low incomes. A Medicaid expansion plan will provide additional financial support to Wyoming's healthcare providers who currently serve the low-income uninsured without compensation. Providing a source of funding for this service will likely create new healthcare jobs that will benefit all Wyoming citizens.

### *Improve **A**ccess to healthcare coverage and providers*

The SHARE Plan will provide thousands of uninsured Wyomingites access to healthcare coverage. This coverage will include access to the ten Essential Health Benefits required by the ACA, as well as certain services required by Medicaid regulation. This package will be more

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<sup>1</sup> Kaiser Health News. 6 August 2012. Retrieved from: <http://kaiserhealthnews.org/news/third-of-medicaid-doctors-say-no-new-patients/>

limited than the benefits package provided by traditional Medicaid. Because the SHARE Plan will be administered by the State's Medicaid program, participants will have access to Medicaid's large provider network. Under the SHARE Plan, the State will tailor benefits packages based on certain demographics of participants in order to provide targeted healthcare that will best serve participants and better manage costs.

*Encourage **R**esponsibility of participants and of the State*

**Personal Responsibility:** The SHARE Plan will require participants to take an active role in their healthcare coverage. All participants will complete health assessments and pay appropriate co-payments. Participants with higher incomes will also pay a monthly premium. Additionally, for participants who complete health challenges throughout the year, premium reductions will be applied. This allows the SHARE Plan to reward participants who take an active role in their health.

**State Responsibility:** The SHARE Plan provides the best value to the State. It provides the necessary benefits package at the lowest cost of any plan examined by the WDH. Choosing this plan allows the State to expand Medicaid without increasing the amount of general funds it spends on the healthcare of its citizens. The expansion through the SHARE Plan will be budget neutral to the WDH. At the time this report was written, Wyoming has forgone approximately \$100-120 million per year due to its inaction with regard to the possible Medicaid expansion.<sup>2</sup> This is federal taxpayers' money. The expansion of Medicaid allows a significant amount of money to come back to the State.

Finally, while the WDH did analyze many potential expansion plan designs, it recommends the SHARE Plan be administered by the State's Medicaid program. Keeping the administration of the SHARE Plan within the State allows the State to take responsibility for the quality, cost, and consistency of the plan.

*Provide access to **E**mployment services*

The SHARE Plan connects its participants with work assistance benefits. While the WDH understands not all participants in the SHARE Plan will need these benefits, it would allow those that do to easily access appropriate services. The SHARE Plan also strengthens the relationship between the WDH and the Department of Workforce Services (DWS), which enables better service to mutual clients.

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<sup>2</sup> See <http://health.wyo.gov/director/reports.html> for the Medicaid Cost Study (2012), by Milliman, Inc., for details on figures used to create these estimates.

## SECTION 2: MAKING THE CASE FOR EXPANSION

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Currently, Wyoming Medicaid is limited to Wyoming residents that meet not only financial but also categorical eligibility criteria (i.e., a person must be low income and pregnant/disabled/etc.). Wyoming now has the opportunity to provide healthcare coverage to all Wyoming residents under 138% FPL.

Medicaid expansion is the right course of action for Wyoming. While there are many reasons to support an expansion of healthcare coverage for a low-income population, this report will focus on the three most significant reasons.

1. Expansion will increase access to healthcare for an estimated 17,600 low-income individuals. An estimated two-thirds of these individuals are currently in the ‘coverage gap,’ which means they are not eligible for federal tax credits (subsidies) on the health benefits marketplace, and have no access to affordable healthcare coverage if the State does not expand.
2. Expansion will strengthen Wyoming’s healthcare sector and overall economy, adding an estimated 800 jobs.<sup>3</sup> Providing healthcare to this relatively healthy population is an investment in future economic productivity.
3. Expansion will save the State money. Expansion will allow for a reduction in current General Fund safety net programs. From a State perspective, the WDH expects that the expansion will be funded internally.

### *Increased Access to Healthcare means a Healthier Wyoming*

As originally written, the ACA expanded Medicaid eligibility to all individuals under the age of 65 (who are not Medicare eligible) with incomes up to 133% (with a 5% set-aside) of the federal poverty level (FPL), thus providing baseline health coverage for most low-income adults. However, in 2012, the Supreme Court ruling on the constitutionality of the Affordable Care Act (ACA) limited the ability of the United States Department of Health and Human Services (HHS) to enforce the provision to require all states to expand their Medicaid programs. Medicaid expansion thus became optional for states.

Because the ACA was written to rely on a Medicaid expansion in all states, the Supreme Court decision created a “coverage gap” for those under 100% of the FPL. Individuals with incomes below poverty are not eligible for federal subsidies to purchase private healthcare coverage; if the state in which they live does not expand Medicaid, they will have no access to affordable healthcare coverage. For individuals not eligible for Medicaid and who have incomes above 100% FPL, the ACA made available “advanced premium tax credits,” or subsidies, to purchase private health insurance coverage on the newly created health benefits marketplaces/exchanges.

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<sup>3</sup> See Appendix B for details on economic growth related to expansion.

Lack of access to healthcare coverage is associated with early death and decreased quality of life.<sup>4</sup> Each year, an estimated 30% of the uninsured forgo needed care due to cost, and they are less likely to receive preventive care services, such as annual physicals and recommended cancer screenings. For instance, in 2013, only 33% of the nation's uninsured saw a primary care physician, compared to the 74% of individuals with employee-sponsored insurance (ESI) and 67% of Medicaid recipients who received primary care that year. Lack of insurance also contributes to increased debt and uncompensated care, with 40% of the uninsured having unpaid medical bills.<sup>5</sup>

Recent studies have estimated a 6.1% reduction in mortality rates among the newly eligible population in states that have expanded Medicaid.<sup>6,7</sup> One recent study estimates the annual impact of optional Medicaid expansion on health outcomes in Wyoming to include:

- between 22 and 69 lives saved;
- 638 fewer individuals with catastrophic medical expenditures;
- 1,245 additional women aged 21-64 with pap smears in the last 12 months;
- 743 additional women aged 50-64 with a mammogram in the past 12 months;
- 1,281 additional diabetics using diabetes medication, and
- 2,158 individuals with depression now in treatment.<sup>8</sup>

#### *Expansion will help Wyoming Providers and Businesses*

The opportunity to expand Medicaid comes at a time when hospitals and medical providers are coming under increased pressure nationwide to lower costs and provide higher quality of service. As an example of this impact, the ACA contains a provision that will cut reimbursements to what are known as Disproportionate Share Hospitals (DSH). These are hospitals that, by population, treat a larger amount of the poor and uninsured than their peers in the industry. The Centers for Medicare and Medicaid Services (CMS) has historically made payments to these hospitals to compensate them for serving more of this typically-uninsured population, but the ACA reduces these payments. The reductions were scheduled to take place in 2014, but Congress recently passed legislation to delay them until 2016.

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<sup>4</sup> Wilper, A.P., Wollhandler, S., Lasser, K.E., McCormick, D., Bor, D.H., and Himmelstein, D.U. 2009. "Health Insurance and Mortality in US Adults." *American Journal of Public Health*. 99 (12). Retrieved from: <http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2008.157685>

<sup>5</sup> Kaiser Family Foundation. October 2014. "Key Facts About the Uninsured Population." Retrieved from: <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

<sup>6</sup> While these statistics are significant, mortality is not the only measure of health. It does not account for changes in quality of life or the impact of improved health on work productivity and the greater economy.

<sup>7</sup> Sommers, B.D., Baicker, K., & Epstein, A.M. 2012. "Mortality and Access to Care Among Adults after State Medicaid Expansions." *New England Journal of Medicine*. 367, 11. p. 1025-1034. Retrieved from: <http://www.nejm.org/doi/full/10.1056/NEJMsa1202099>

<sup>8</sup> Dickman, S., Himmelstein, D., McCormick, D., & Woolhandler, S. 30 January 2014. "Opting Out of Medicaid Expansion: The Health and Financial Impacts." *Health Affairs*. Retrieved from: <http://healthaffairs.org/blog/2014/01/30/opting-out-of-medicaid-expansion-the-health-and-financial-impacts/>

Nevertheless, DSH payments will be reduced in the near future. Small and rural hospitals in Wyoming who treat a large share of the poor and uninsured will likely face federal funding cuts under the new law. Many of these hospitals already face high costs because they deliver care that goes uncompensated, treating uninsured individuals who have no means of accessing care other than hospital emergency departments. In 2011, the Wyoming Hospital Association estimated that hospitals in Wyoming provided approximately \$200 million in uncompensated care to individuals with no healthcare coverage.<sup>9</sup>

If Wyoming chooses not to expand its Medicaid program, many adults with incomes below 100% FPL will continue to use hospitals' emergency departments as their primary source of health care. Emergency room use for non-emergent care drives up costs for all healthcare consumers in Wyoming. Impact on all healthcare consumers is further exacerbated when hospital care is uncompensated.

The expansion of Medicaid in Wyoming would not only decrease the amount of uncompensated care for Wyoming providers, it could also drive down prices in the private market (i.e., could reduce cost-shifting). While hospital market concentration and competition are important factors determining a hospital's ability to cost-shift, more uncompensated care in Wyoming hospitals has been associated with higher prices paid by insurers.<sup>10</sup>

In addition to the benefits provided to healthcare providers, Wyoming businesses could also benefit from an expansion of Medicaid. An analysis conducted jointly between the WDH and the Economic Analysis Division (Wyoming Department of Administration and Information)<sup>11</sup> suggests that the injection of \$100 - \$120 million in federal funds each year as a result of an optional expansion of Medicaid would create approximately 800 jobs and increase State Gross Domestic Product (GDP) by approximately \$50 million, representing 0.13% of a \$38.4 billion economy.<sup>12</sup> Five hundred of the total new jobs are projected to be created in Wyoming's healthcare industry, representing an increase of approximately 1.7% in that sector. The results of this collaborative study (see Table 1, next page) represent the estimated changes to Wyoming's economy due to the expansion of Medicaid.

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<sup>9</sup> Perdue, D. President, Wyoming Hospital Association. Guest Opinion: "Legislature Should Support Full Medicaid Expansion." Retrieved from: [http://www.wyohospitals.com/\\_pdf/2014/Medicaid%20Expansion%20OpEd.pdf](http://www.wyohospitals.com/_pdf/2014/Medicaid%20Expansion%20OpEd.pdf)

<sup>10</sup> Wyoming Department of Health. September 2014. "Cost Shifting and the Impact of New Hospitals." September, 2014. Retrieved from: [www.health.wyo.gov/Media.aspx?mediaId=16057](http://www.health.wyo.gov/Media.aspx?mediaId=16057)

<sup>11</sup> Please contact Mindy Chai, Ph.D., with DUPRE for information about this analysis.

<sup>12</sup> State GDP is an economic measure of added value, taking total new output produced and subtracting out the value of inputs.

**Table 1: Economic changes due to potential expansion (WDH/EAD Analysis)**

Category	2014	2015	2016	2017	2018	2019	2020
<b>Total Employment (Jobs Created)</b>	409	826	861	852	822	806	783
<b>GDP (millions)</b>	\$26.31	\$53.70	\$56.43	\$56.19	\$54.51	\$53.75	\$52.42
<b>Output (millions)</b>	\$44.29	\$90.53	\$95.30	\$94.88	\$91.98	\$90.47	\$87.96
<b>Personal Income (millions)</b>	\$19.60	\$42.08	\$47.69	\$50.67	\$51.92	\$53.18	\$53.66

*Expansion will save Wyoming money*

Each year that the State does not expand Medicaid, Wyoming forgoes approximately \$100-120 million (see Milliman, Inc., 2012) in federal funds that could finance needed services for vulnerable, low-income individuals. Many of these services are currently provided with state general funds.

Federal tax dollars from residents in all 50 states are currently being used to fund the enhanced federal medical assistance percentage (FMAP) for Medicaid expansion populations, in states that choose to expand. Over 70% of Wyoming residents who file a federal tax return end up owing federal income tax.<sup>13</sup> Wyoming tax-paying citizens, like those in other states choosing not to expand Medicaid, are effectively paying for Medicaid expansion in other states without any benefit or return.

In addition to the general benefit afforded by returning taxpayer dollars to Wyoming, the expansion of Medicaid would result in a variety of administrative savings to Wyoming state agencies. Specifically, a number of programs operated by the WDH provide healthcare services to individuals who have no other pay source could be reduced or eliminated. Many of these programs are funded primarily by the State General Fund (SGF). If the state expands its healthcare coverage through the SHARE Plan, many of these programs will no longer be needed because those currently served will have access to healthcare coverage. Examples of state-funded programs that could be offset through Medicaid expansion include, but are not limited to:

- Prescription Drug Assistance Program;
- Breast and Cervical Cancer Program;
- Colorectal Cancer Screening Program;
- Employed Individuals with Disabilities Program;
- Mental Health and Substance Abuse Outpatient Program, and
- HIV/AIDS Medication Program.

<sup>13</sup> Tax Foundation. 24 September 2012. "Non-Payers By State." Retrieved from: <http://taxfoundation.org/blog/monday-map-nonpayers-state>

Offsetting specific programs will maximize available federal funding for Wyoming's healthcare system by shifting financing from programs that use primarily state general funds to Medicaid, which is funded by both state and federal funds. The federal government will fund approximately 90% of the Medicaid expansion program through the enhanced FMAP for services delivered to the expansion population.

By offsetting state-funded health care programs and utilizing enhanced federal funding created by the ACA to expand healthcare coverage, the Wyoming Department of Health would be able to fund the expansion in a cost-neutral capacity.

## SECTION 3: THE ACA AND WYOMING HISTORICAL RESPONSE

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The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were passed by Congress and signed by the President in March of 2010. Together, these Acts are referred to as the Affordable Care Act or the ACA. The passage and implementation of the ACA created a new healthcare landscape nationwide, and forced states to make key decisions on how to react to many of the law's provisions.

Upon the passing of the ACA, several states joined a lawsuit challenging the constitutionality of several provisions of the ACA. This lawsuit was resolved in the summer of 2012, when the US Supreme Court issued its ruling in *National Federation of Independent Businesses et al. v. Sebelius, Secretary of Health and Human Services et. al.* The court upheld the individual mandate to purchase insurance but struck down the requirement for states to expand Medicaid, effectively making that decision optional to states.

Table 2 (next page) presents Wyoming's responses to the ACA, arranged by year (2010-2013), and is organized by actions made by the Wyoming Legislature as well as Wyoming's Executive Branch. After the table, a more detailed history of actions in 2014 is presented. Please see Appendix A for a complete narrative description of Wyoming's actions related to the ACA from 2010 to 2013.

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**Table 2: Wyoming’s Responses to the ACA, 2010-2013**

Year	Executive Branch	Legislative Branch
<b>2010</b>	<ul style="list-style-type: none"> <li>• Gov. Freudenthal chose not to join a lawsuit with several states questioning the constitutionality of the ACA.</li> <li>• Gov. Freudenthal’s administration created the State Agency Leadership Team for Wyoming’s Health (SALT) to study the impacts of the ACA to Wyoming state agencies.</li> <li>• Gov. Freudenthal’s administration created the Health Benefit Exchange Task Force to study the options available to the State for the operation of the required health benefit exchanges.</li> </ul>	
<b>2011</b>	<ul style="list-style-type: none"> <li>• Gov. Mead was inaugurated in January.</li> <li>• Gov. Mead instructed Wyoming’s Attorney General to join multi-state challenge of the ACA.</li> </ul>	<ul style="list-style-type: none"> <li>• Several bills were brought forth in Wyoming’s 2011 Legislative Session in response to the ACA. The following bills were passed:               <ul style="list-style-type: none"> <li>○ SEA93, <i>Medicaid Cost Study</i>; Milliman, Inc. was chosen to conduct the study;</li> <li>○ HEA102, <i>Health Insurance Exchanges</i>; created Wyoming’s Health Insurance Exchange Steering Committee;</li> <li>○ Senate Enrolled Joint Resolution No. 2, <i>Health Care Freedom</i>; constitutional amendment.</li> </ul> </li> </ul>
<b>2012</b>	<ul style="list-style-type: none"> <li>• WDH issued two significant reports in 2012:               <ul style="list-style-type: none"> <li>○ Results from the Milliman, Inc. study created by SEA93 in 2011, and</li> <li>○ <i>The Optional Expansion of Medicaid in Wyoming: Costs, Offsets, and Considerations for Decision-Makers</i>.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• During the 2012 Budget Session of the Wyoming Legislature, only one bill was passed related to the ACA:               <ul style="list-style-type: none"> <li>○ SEA42; amended Health Insurance Exchange Steering Committee.</li> </ul> </li> <li>• The state took no action to create or implement a state-run or regional Health Insurance Exchange or Marketplace.</li> </ul>
<b>2013</b>	<ul style="list-style-type: none"> <li>• In Gov. Mead’s 2013 State of the State Address, he challenged the Legislature to create a Wyoming-specific response to the ACA.</li> <li>• Upon the direction of the Governor, the WDH released a report entitled <i>The Wyoming Approach for Medicaid Expansion, Alternate Benefit Plan Options</i>. The report presented five options for a Wyoming-specific approach to expansion.</li> </ul>	<ul style="list-style-type: none"> <li>• The Wyoming Legislature continued to act in response to the ACA in the 2013 Legislative Session, passing:               <ul style="list-style-type: none"> <li>○ HEA119, which authorized a Select Committee to study the impacts of a health insurance exchange on the state. HEA119 also included a provision prohibiting the state from expanding Medicaid without legislative approval.</li> <li>○ SF0122 was introduced to allow the state to expand Medicaid; the bill was not passed.</li> </ul> </li> </ul>

## Wyoming's Responses to the ACA in 2014

### *Legislative Branch*

In the 2014 Budget Session of the Wyoming Legislature, several bills related to Medicaid expansion were brought forward at the committee level, but failed introduction or died in committee. These bills are detailed in the following list.

- SF 0118, *Medicaid-staged expansion*: authorized a Medicaid expansion demonstration waiver utilizing a premium assistance model similar to the Iowa model. This bill was not passed.
- SF 0108, *Obamacare Relief*: failed introduction in the Senate.
- SF 008, *Medicaid expansion-insurance pool*, sponsored by the Joint Labor, Health and Social Services Interim Committee: failed introduction in the Senate.
- HB 0084, *Medicaid expansion-limited benefits*, sponsored by the Joint Labor, Health, and Social Services Interim Committee: failed introduction in the House.
- HB 0080, *Medicaid waiver-tribal health programs-2*, sponsored by the Select Committee on Tribal Relations, authorized the WDH to investigate a demonstration waiver providing expanded Medicaid coverage to persons of American Indian descent. It failed introduction in the House.
- HB 0161, *Medicaid expansion-2*: failed introduction in the House.

While the legislature did not pass a bill to expand Medicaid, it did amend the 2014 Budget Bill to include Section 338 which authorized the Governor, the WDH, and Wyoming Department of Insurance to begin negotiations with the federal Medicaid agency with regard to a Wyoming expansion. Section 338 of HEA0041 (the Budget Bill) stated, “The director of the department of health, the insurance commissioner and the governor may negotiate with the center [sic] for Medicare and Medicaid services for a demonstration waiver to provide Medicaid coverage for all persons [eligible under the ACA].”<sup>14</sup> Section 338(a)(i) precluded a Medicaid expansion, however, “until approved by the legislature.”

If the Governor, Director of the Department of Health, or insurance commissioner engaged in negotiations with CMS as permitted by Section 338, then the WDH was required to submit the terms of the proposed waiver application to the joint appropriations interim committee and the joint, labor, health and social services interim committee in the fall of 2014.

### *The Executive Branch*

After the 2014 Budget Session, the governor directed the Department of Health to begin exploring options for a Medicaid waiver program as authorized by Section 338 of the Budget

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<sup>14</sup> HEA0041, Section 338(a).

Bill. Additionally, the governor directed the Department of Health to pursue negotiations with CMS upon completion of a plan for a draft waiver demonstration program.

### *The Work of the WDH*

Within the confines of Section 338, the WDH began work to design a plan for a Medicaid expansion that would provide the most benefit the State of Wyoming. The WDH conducted research on other states' Medicaid programs, interviewed other states' Medicaid staff, analyzed benefits and costs of several options for programs, and drafted several options for a Medicaid expansion plan for discussion with the Department of Insurance and the Governor.

The WDH initially focused its work on creating a plan that included premium assistance to expand healthcare coverage. Premium assistance waiver programs had been approved by CMS in multiple states. Under a premium assistance waiver program, the participants are given financial assistance to purchase private insurance plans that meet Medicaid and ACA requirements. In addition to those plans, the state must provide “wrap-around” coverage for services and benefits not covered by the insurance plan, but which CMS requires for Medicaid beneficiaries. These “wrap-around” benefits could include non-emergency transportation, family planning services, and cost-sharing reduction payments.

Using premium assistance programs from Utah, Iowa, and Arkansas as guides, the WDH created multiple expansion plan options that included a demonstration waiver program (or programs) for premium assistance. As part of its analysis of these plans, the WDH estimated costs using existing premium prices for private insurance plans sold on the Federally Facilitated Marketplace (FFM, or Marketplace) in Wyoming. The cost estimates for a premium assistance expansion plan were approximately 132% more expensive to the State than a full Medicaid expansion with traditional Medicaid.

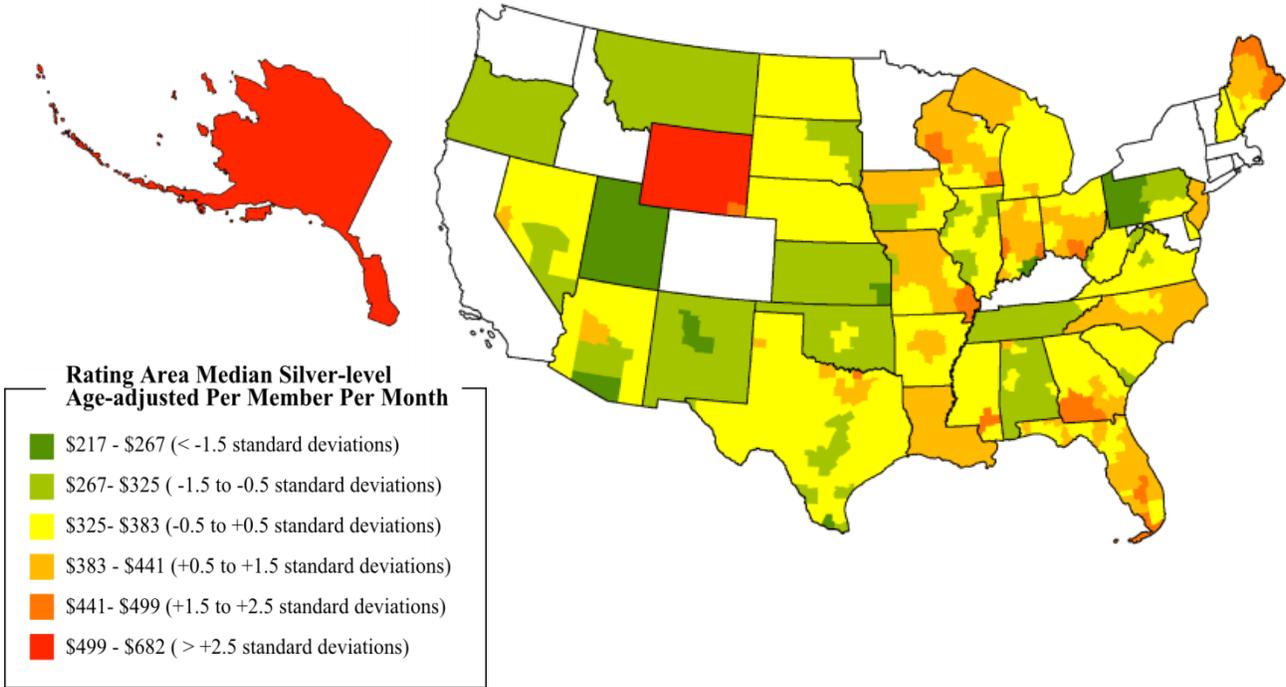
This high cost is due to the fact that Wyoming's Marketplace health insurance premiums are among the highest in the nation. The map in Figure 1 (on the next page) compares age-adjusted insurance prices among states in the U.S., using recently-released data<sup>15</sup> from the federally-facilitated marketplace.

Ultimately, it was determined that the WDH would not recommend a plan that involved premium assistance, due to the significantly higher costs. Wyoming's Marketplace health insurance premiums are among the highest in the nation. Calculations by the WDH, presented in Table 3 (on the next page), compare state and federal costs for three different Medicaid expansion plans that were considered throughout this process.

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<sup>15</sup> Center for Consumer Information and Insurance Oversight. Retrieved from: <http://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html>

**Figure 1. 2015 Federally-facilitated Marketplace Cost Comparison**



**Table 3. Medicaid Expansion: Plans & Cost Comparisons (in millions)**

Table 3. Medicaid Expansion: Plans & Cost Comparisons (in millions)								Total Cost as % of Traditional Medicaid
Year		2016	2017	2018	2019	2020	Total	
<b>Wyoming SHARE Plan (4% Admin Cost)</b>	State	\$1.5	\$6.0	\$9.8	\$11.4	\$14.5	\$43.2	<b>95%</b>
	Federal	\$53.7	\$110.6	\$112.5	\$116.6	\$119.5	\$512.9	
	<b>Total</b>	<b>\$55.2</b>	<b>\$116.7</b>	<b>\$122.2</b>	<b>\$127.9</b>	<b>\$134.1</b>	<b>\$556.1</b>	
<b>Traditional Medicaid (4% Admin Cost)</b>	State	\$1.6	\$6.4	\$10.3	\$12.0	\$15.3	\$45.5	<b>100%</b>
	Federal	\$56.5	\$116.5	\$118.4	\$122.7	\$125.8	\$539.9	
	<b>Total</b>	<b>\$58.1</b>	<b>\$122.8</b>	<b>\$128.6</b>	<b>\$134.7</b>	<b>\$141.1</b>	<b>\$585.4</b>	
<b>Full Premium Assistance<sup>16</sup> (2% Admin Cost)</b>	State	\$1.4	\$7.0	\$12.2	\$14.4	\$18.8	\$53.8	<b>132%</b>
	Federal	\$75.5	\$155.6	\$158.1	\$163.9	\$168.0	\$721.2	
	<b>Total</b>	<b>\$76.9</b>	<b>\$162.6</b>	<b>\$170.3</b>	<b>\$178.3</b>	<b>\$186.9</b>	<b>\$775.0</b>	

<sup>16</sup> Under a potential premium assistance plan, the entire Medicaid expansion population (0-138% FPL) would receive premium assistance to purchase health insurance plans on the private Marketplace. Wyoming has two issuers currently offering plans on the Marketplace: WINhealth and Blue Cross Blue Shield. Monthly premiums are among the highest in the nation. When tobacco ratings and cost-sharing reduction subsidies are factored in for Silver-level premiums, both issuers have higher “per member per month” (PMPM) costs than traditional Medicaid. Even with the lower cost of administration to the State, this option would have an approximate 32% higher cost than traditional Medicaid (132% of traditional Medicaid).

### *2014 CMS Negotiations*

Throughout the summer of 2014, the WDH, along with the Governor's Office, had several meetings with federal officials from CMS to discuss possible designs for a Medicaid expansion plan that would meet and address Wyoming's unique healthcare challenges. Wyoming sought to include policy priorities within its Medicaid expansion plan that would require a waiver from certain federal Medicaid rules, such as employment, personal responsibility, and support for Wyoming's healthcare industry.

In the end, the WDH was able to tailor a Medicaid expansion plan that meets the specific needs of Wyoming citizens, and supports the healthcare policy priorities outlined by Governor Mead and the Legislature. Details of this plan, the SHARE Plan, are presented in the next section.

## SECTION 4: THE SHARE PLAN

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Wyoming’s Strategy for **H**ealth, **A**ccess, **R**esponsibility, and **E**mployment, or “SHARE Plan,” is designed with Wyoming’s values in mind.

The SHARE Plan for Medicaid expansion includes two programs based on the income of the participant. Participants with higher incomes (101-138% of federal poverty level) would take part in a demonstration project wherein they would pay a monthly premium in order to receive the alternative benefits package. Participants with lower incomes (less than 100% of the federal poverty level) would receive the alternative benefits package but would not participate in the demonstration project and would not have to pay a monthly premium. Both groups would be required to pay co-payments for certain services. Additionally, both groups would have access to the Medicaid provider network, a work assistance benefit, and appropriate case management. Eligible adults who are determined to be “medically frail” would be enrolled in traditional Medicaid.

Healthcare services provided through these expansion programs would receive enhanced FMAP funding. The expected FMAP is: 100% from 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and beyond. If the enhanced FMAP funding levels were to drop below 90%, the expansion programs would terminate.

### The SHARE Plan | Two Groups, Based on Income

#### Group One: Waiver Demonstration Project for Higher Income Individuals

Individuals between the ages of 21 and 64 who have higher incomes (between 101 – 138% FPL)<sup>17</sup> would be eligible to participate in a Section 1115 demonstration waiver project. This demonstration would provide participants access to healthcare services through an Alternate Benefits Plan (ABP). However, through a Section 1115 waiver of certain Medicaid regulations, the State would require demonstration participants pay a monthly premium to access plan benefits.

The demonstration waiver project would include the following:

- **Eligibility requirements.** Demonstration project participants would include adults who are not medically frail, aged 21 – 64 years, with incomes between 101% - 138% FPL.
- **Access to healthcare.** Demonstration project participants receiving coverage through this program would access healthcare through Medicaid’s provider network. The State’s

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<sup>17</sup> \$11,671 - \$16,105 per year for individuals.

Medicaid program would administer this plan. Demonstration project participants would be required to pay a premium to access the plan.

- **Benefits.** Demonstration project participants would be offered a benefits package that includes the Essential Health Benefits and other benefits similar to what is offered by a commercial plan. Additionally, these participants would be offered non-emergency transportation, family planning services, and access to certain essential community health providers as required by Medicaid regulations.
- **Cost-sharing requirements.** Demonstration project participants would be required to pay a monthly premium based on their income and household size. The cost of premiums would range from slightly less than \$20 to over \$50 per month. Non-payment of the premiums for 90 days could cause dis-enrollment from the plan. Co-payments would be required as appropriate. For certain services, flexibility in Medicaid federal regulations would be utilized to charge the maximum co-payments. Required cost sharing, including premiums and co-payments, would not exceed 5% of a participant's income.
- **Premium reductions for healthy behaviors.** Demonstration project participants who complete certain health challenges throughout the year would receive a reduction in their premium contribution for the next year.
- **Medical assessment.** Demonstration project participants would complete a comprehensive health assessment in the application process and annually thereafter. This health assessment would allow the identification of the medically frail, as well as allow other participants to be served by available and appropriate resources.
- **Case Management.** Participants with more complex healthcare needs would be referred to Medicaid's health and utilization review program. The program has been successful in improving the quality of care and lowering costs by coordinating services for individuals with complex healthcare needs.
- **Work Assistance Benefit.** Participants would be enrolled in a work assistance benefit at the time of application. Work assistance benefits could include: access to a job search website, resume assistance, and skills-to-job matching services. For those that meet additional criteria, services could include job training, vocational rehabilitation, and others. These programs are already in existence and available from the Wyoming Department of Workforce Services (DWS). Enrollment in these programs would not impact Medicaid eligibility; however, enrollment in the work benefit and the Medicaid program would be integrated as much as possible.

## **Group Two: Alternative Benefits Plan for Lower Income Individuals**

Lower income individuals aged 21-64 with incomes between 0 – 100% of the FPL<sup>18</sup> who are not medically frail would be provided a Medicaid ABP. The plan would provide the ten Essential Health Benefits, similar to what is offered by a commercial plan.

The SHARE Plan would include the following:

- **Eligibility requirements.** Individuals with incomes between 0% and 100% of the Federal Poverty Level (FPL) would receive an ABP.
- **Access to healthcare.** Participants receiving coverage through this program would access healthcare through Medicaid's provider network. The State's Medicaid program would administer the plan.
- **Benefits.** Participants would be offered an ABP that includes the ten Essential Health Benefits, similar to what is offered by a commercial plan. Additionally, these participants would be offered non-emergency transportation, family planning services, and access to certain essential community health providers as required by Medicaid regulations.
- **Cost-sharing requirements.** Co-payments for certain services would be required as appropriate and as allowed by federal regulations. This lower income group would not be required to pay a premium.
- **Medical assessment.** Participants would complete a comprehensive health assessment in the application process and annually thereafter. This health assessment would allow the identification of the medically frail, as well as allow other participants to be served by available and appropriate resources.
- **Case Management.** Participants with more complex healthcare needs would be referred to Medicaid's health and utilization review program. The program has been successful in improving the quality of care and lowering costs by coordinating services for individuals with complex healthcare needs.
- **Work Assistance Benefit.** Participants would be enrolled in a work assistance benefit at the time of application. Work assistance benefits could include: access to a job search website, resume assistance, and skills-to-job matching services. For those

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<sup>18</sup> Up to \$11,670 per year for individuals.

that meet additional criteria, services could include job training, vocational rehabilitation, and others. These programs are already in existence and available from the Wyoming Department of Workforce Services (DWS). Enrollment in these programs would not impact Medicaid eligibility; however, enrollment in the work benefit and the Medicaid program would be as integrated as much as possible.

## **The SHARE Plan | Additional Considerations**

### **Traditional Medicaid for Children and the Medically Frail**

Anyone designated “medically frail” would be provided healthcare services through the traditional Medicaid program. Individuals aged 19 and 20 (who are considered children by Medicaid federal regulations) would also be covered by traditional Medicaid.

Recipients covered through traditional Medicaid would access healthcare through Medicaid’s provider network. These recipients would receive the same benefits that are currently offered by the Medicaid program. Additionally, these recipients would be required to share cost through co-payments as deemed appropriate and as allowed by federal regulations. These recipients would not be charged a premium.

### **Employer Sponsored Coverage**

Eligible working individuals with access to affordable and cost-effective employer-sponsored coverage would be offered premium assistance to assist with the costs of their employer’s health plan.

### **Expansion Program Termination “Trigger” Provision**

Any legislation authorizing the SHARE Plan for expanded healthcare coverage in Wyoming would include a “trigger” provision whereby the expansion programs would terminate if the Federal Medical Assistance Percentage (FMAP) ever falls below 90%.

### **Timeline**

If this plan for expanded healthcare coverage is passed into law during the 2015 Legislative Session of the Wyoming Legislature, it is likely that coverage of the eligible population could begin in January of 2016.

## SECTION 5: CONCLUSION AND RECOMMENDATIONS

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The SHARE Plan is the best deal for Wyoming. It supports Wyoming's healthcare system, provides healthcare coverage and access to thousands of Wyoming citizens, encourages participant and state responsibility, and provides access to employment services for those in need. Wyoming should expand its Medicaid program through the SHARE Plan for three primary reasons:

1. Medicaid expansion will increase access to healthcare for an estimated 17,600 low-income individuals. Many of these individuals fall into a healthcare coverage gap: they are not eligible for ACA subsidies to purchase health insurance, and have no other access to affordable healthcare coverage if Wyoming does not expand.
2. Medicaid expansion will strengthen Wyoming's healthcare sector and economy, adding an estimated 800 jobs to the state. Providing health coverage to this relatively healthy population is an investment in future economic productivity.
3. Medicaid expansion will save the state money. Expansion will allow a reduction in State General Fund safety net programs, and can occur in a cost-neutral framework.

Since the ACA was passed in 2010, Wyoming has responded with several measures to adapt to the changing healthcare landscape, including considering several plans from the WDH to expand Medicaid. These plans ranged from expanding traditional Medicaid to a full private-sector premium assistance approach. Led by legislative discussion and gubernatorial guidance, and through negotiations with CMS, the WDH has been able to design the SHARE Plan, which uniquely suits Wyoming. The SHARE Plan is the best deal for Wyoming.

Thousands of Wyomingites continue to go without healthcare coverage, limiting their access to preventive care and increasing their utilization of hospital emergency departments. Wyoming foregoes approximately \$100-120 million in federal funding every year that it chooses not to expand Medicaid. This funding could help reduce the administrative costs and burdens to the State in providing safety net health care programs with only state funds, and could also reduce the amount of uncompensated care experienced by healthcare providers.

Additionally, because Medicaid expansion is funded in large part with federal tax dollars, Wyoming tax payers are currently paying for Medicaid expansion in other states, and realizing no benefits themselves. For these reasons, it is clear that Wyoming citizens deserve Medicaid expansion. The state should deliver this expansion through the implementation of the SHARE Plan, and begin providing this coverage in January of 2016.

## SECTION 6: APPENDICES

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### **APPENDIX A: A Complete History of the ACA and Medicaid Expansion in Wyoming, 2010-13**

*The following appendix provides detailed accounts of the activities undertaken in Wyoming by the legislative and executive branches with regard to the implementation of the Affordable Care Act (ACA) and a potential expansion of Medicaid from 2010-2013.*

#### **2010**

The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 were passed by Congress and signed by the President in March of 2010. Together, these Acts are referred to as the Affordable Care Act or the ACA. The passage and implementation of the ACA created a new healthcare landscape nationwide, and forced states to make key decisions on many of the law's provisions, including how healthcare coverage would be delivered to consumers, how state health programs would adapt to the changing environment, and later (in 2012), the option to expand eligibility for state Medicaid programs.

#### **2011**

##### *Executive Branch*

Governor Mead was inaugurated in January of 2011. One of his first acts as governor was to instruct the Attorney General to join several states in a lawsuit challenging the constitutionality of major portions of the ACA. This lawsuit was ultimately heard by the U.S. Supreme Court in 2012.

##### *Legislative Branch*

The 2011 Legislative Session was the first session of the Wyoming Legislature since the passing of the ACA. Several bills were brought forth during the session in response to the ACA. Ultimately, the following bills were passed: Senate Enrolled Act 93, Medicaid Cost Study; House Enrolled Act 102, Health Insurance Exchanges; Senate Enrolled Joint Resolution No. 2.

**Senate Enrolled Act 93, Medicaid Cost Study.** At the time of the 2011 General Session of the Wyoming Legislature, the expansion of Medicaid was still considered mandatory.<sup>19</sup> Thus, the Legislature passed a bill requiring the governor's office, or designated agency, to conduct a study

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<sup>19</sup> The mandatory expansion of Medicaid was ruled to be unenforceable and outside of Congress' authority by the United States Supreme Court in *the National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services et. al.* on June 28, 2012. This case is detailed further in a following section.

to develop estimates of the cost of the expansion of the Medicaid program mandated by the ACA.

The WDH contracted with the consulting agency, Milliman, Inc., to conduct this study. In the 2012 report, *Wyoming Medicaid Expansion Analysis Reports Summary*, Milliman, Inc. presented its estimates for the number of individuals in Wyoming that would be eligible for a Medicaid expansion, the estimated number of eligible individuals that would enroll, and total costs for expansion.

**House Enrolled Act 102: Health Insurance Exchanges.** House Bill 0050 (hereinafter House Enrolled Act 102 or HEA102) created Wyoming’s Health Insurance Exchange Steering Committee to study the options for insurance exchanges in Wyoming and provide recommendations to the Legislature. This legislatively created steering committee took the place of the Health Benefits Exchange Task Force created by Governor Freudenthal.

The Steering Committee was directed to study the options available to the State with regard to the operation of the State’s insurance exchange:<sup>20</sup> 1) creating a Wyoming exchange, 2) joining other states in the operation of a regional exchange; 3) defaulting to the federal government to operate an exchange in Wyoming.

In the fall of 2011, the Committee provided recommendations to the governor and the legislature that the state explore the operation of a state-run exchange and apply for additional federal funding to support this exploration. These recommendations were not pursued. In 2012, the Legislature reauthorized the Steering Committee; however, the Legislature restricted the Committee’s ability to pursue additional federal funding until after the ruling on the ACA by the U.S. Supreme Court.

**Senate Enrolled Joint Resolution 0002, Health Care Freedom.** Along with the several bills brought in response to the ACA, several Joint Resolution proposals were also heard by the legislature. Ultimately, Enrolled Joint Resolution No. 2, Senate (SEJR0002) was passed. This Joint Resolution proposed to amend the Wyoming Constitution to include the rights to make healthcare decisions, pay directly for healthcare without penalty, and preserve the right to healthcare access from undue governmental infringement.<sup>21</sup> SEJR0002 was placed on the ballot for Wyoming voters in November of 2012. Wyoming voters adopted this amendment resulting in the inclusion of the above detailed rights in Article 1, Section 38 of the Wyoming Constitution.

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<sup>20</sup> The term “insurance exchange” was replaced by the term “insurance marketplace” at some point by the Obama Administration and health policy workers.

<sup>21</sup> Enrolled Joint Resolution No. 2, Senate, (SEJR0002), Sixty-First Legislature of the State of Wyoming, 2011 General Session. Retrieved from: <http://legisweb.state.wy.us/2011/Enroll/SJ0002.pdf>

## 2012

### *Legislative Branch*

**Senate Enrolled Act 0042.** During the 2012 budget session of the Wyoming Legislature, only one bill was passed that was directly related to the ACA: Senate File0058 (hereinafter Senate Enrolled Act 42 or SEA42). Senate Enrolled Act 42 amended the 2011 law that created the Wyoming Health Insurance Exchange Steering Committee. Amendments to the 2011 law included: the addition of tribal membership to the Steering Committee; instruction to identify plans for an insurance exchange that minimally, partially or completely complied with the Affordable Care Act; prohibition of any person or agency implementing a healthcare exchange before April 2013; and prohibition of the State applying for additional federal grants to study or establish a health insurance exchange until after the ruling in the U.S. Supreme Court case involving the multi-state challenge to the ACA.

The State took no action to create or implement a state-run or regional insurance exchange. This inaction led the federal government to establish an insurance exchange (now Marketplace) for the State. The Federally Facilitated Marketplace or (FFM) serves as Wyoming's insurance exchange.

**National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services et al..** In the summer of 2012, the U.S. Supreme Court issued its ruling in the multi-state challenge of the ACA. In *National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services et al.*, the Court upheld the individual mandate to purchase insurance, but struck down the ACA's requirement that states expand their Medicaid programs. Specifically, the Court ruled unconstitutional the penalty set out by the ACA that could be imposed upon states that did not expand their Medicaid programs. States interpreted this part of the decision to make the Medicaid expansion in the ACA an optional choice.

### *Executive Branch*

**Work of the WDH in 2012.** The WDH was responsible for two significant reports issued in 2012. The first was the result of a study required by legislation in 2011 on the cost to Wyoming of a Medicaid expansion. As stated previously, the WDH contracted with Milliman, Inc. to complete the study required by SEA93 (2011). The *Wyoming Medicaid Expansion Analysis Reports Summary* was released in September of 2012. This report contained Milliman's best estimates for the number of eligible people who would enroll in a Medicaid expansion, as well as Milliman's best estimates for the cost of a Medicaid expansion over time. The estimates in this report have been used by the WDH and others to more fully analyze the impacts of a Medicaid expansion to the State.

Also in 2012, the WDH issued a report entitled *The Optional Expansion of Medicaid in Wyoming: Costs, Offsets, and Considerations for Decision-Makers*. It was the first report written by the WDH on the option to expand Medicaid. The report was written to provide Wyoming's decision-makers with important information on Medicaid expansion in Wyoming. The report provided an overview of the ACA and Wyoming's uninsured, set out the costs associated with an expansion, and discussed potential savings and offsets available to the WDH if the State were to expand. The report concluded that the optional Medicaid expansion would provide a cost-effective route to increase the number of people with access to healthcare coverage.

## **2013**

### *Legislative Branch*

**House Enrolled Act 0119: Health Benefit Exchange Study and Select Committee.** The Wyoming legislature continued to act in response to the ACA in the 2013 general session. House Bill 2013 (hereinafter HEA119) was passed to create a Select Committee to study the impacts of a health insurance exchange on the State. This Act authorized a Select Committee, consisting only of legislators, to conduct this study and report.

HEA119 also included a provision that prohibited the State from expanding the Medicaid program under the ACA without legislative approval.

**SF0122.** The 2013 legislative session was the first session of the Wyoming Legislature since the U.S. Supreme Court struck down the ACA's requirement that states expand their Medicaid programs. SF0122 was introduced to allow the expansion of Medicaid. The bill was not passed.

### *Executive Branch*

In his 2013 State of the State, Governor Mead described his plan to respond to the ACA with innovative ideas suited for Wyoming. "Let's decide what we want and make the pitch to the federal government. In other words, let us try within the law that is upon us to find the best deal, the best fit for Wyoming. To do nothing puts the full brunt of the ACA upon us, everything is dictated by the federal government, without an opportunity to tailor the law to our needs. Director Forslund is prepared to offer options."

He also challenged the legislature to create a Wyoming-specific response to the ACA, including a plan for a state-run health insurance exchange and a Medicaid expansion. "This body has the opportunity to develop what it would like to see as we make our request. Perhaps the federal government will not agree to our terms. We can say no if they do not agree, but it is better we express our terms than make no request and get a package without our input. Let's take this as an opportunity for innovation."

Upon the delivery of his 2013 State of the State, Governor Mead requested Director Forslund and the WDH create options for Medicaid expansion in Wyoming.

**WDH Medicaid Options Report.** Upon the direction of the governor, the WDH began to work on different options for a plan for a Medicaid expansion in Wyoming. In the summer of 2013, the WDH released a report entitled, *The Wyoming Approach for Medicaid Expansion, Alternate Benefits Plan Options*. In this report, the WDH presented five options for a Wyoming-specific approach to provide healthcare coverage to the potential Medicaid expansion group.

## **2014**

The specific actions taken in 2014 by the legislative and executive branch are fully detailed in the body of the report.

## **APPENDIX B: The Potential Expansion Population and Wyoming’s Uninsured**

This appendix provides additional detail on the potential expansion population in Wyoming. It first discusses the methodology behind the standing projections of the size and cost of the potential expansion population. This is followed by a discussion of US Census American Community Survey (ACS) data from 2012 to illustrate the demographic characteristics of the uninsured in Wyoming under 138% of the Federal Poverty Level.

### *Estimating the size of the Wyoming expansion population*

In August 2012, Milliman Inc., a consulting firm, provided a final report to the Department of Health detailing its estimates for the optional Medicaid expansion group. Milliman’s best estimate for the number of new enrollees was 17,600 adults, with a range between 11,500 and 23,000.<sup>22</sup>

Milliman’s methodology first drew on public data sources (e.g., US Census Current Population Survey) to calculate baseline estimates for three distinct groups of Wyoming adults (ages 19 – 64):

1. The uninsured, under 138% FPL.
2. Individuals with employer-sponsored insurance, under 138% FPL.
3. Individuals with directly-purchased insurance, under 138% FPL.

In addition to the total number of people in each group, Milliman used Census data to determine a demographic breakdown, to include age group, sex, and self-reported health status (along with various assumptions; see details in the final report).<sup>22</sup>

Combining the raw population estimates with the assumptions made by Milliman, Table 1 shows the final estimates for the expansion population.

**Table 1: Milliman Optional Expansion Projections**

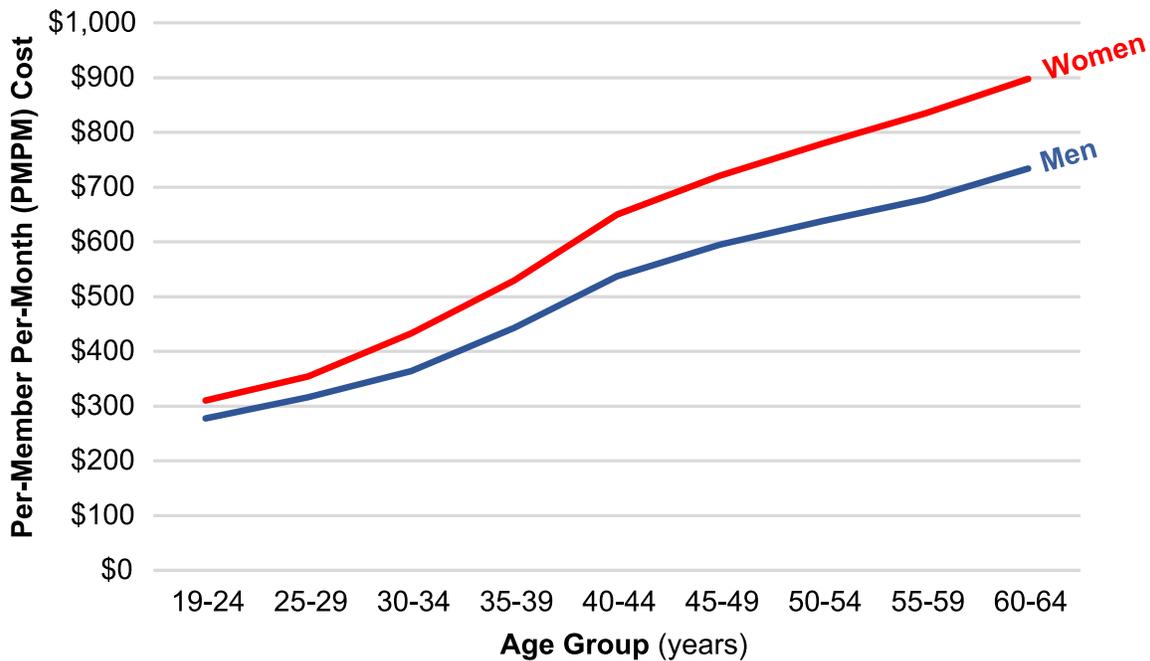
Expansion Category	Low Estimate	Best Estimate	High Estimate
Uninsured, not previously Medicaid-eligible, takes up Medicaid	8,700	12,900	14,800
Previously insured (directly-purchaser or employer-sponsored), “crowd-out”	2,800	4,600	8,000
Deliberately lowers income to qualify	0	100	200
<b>Total</b>	<b>11,500</b>	<b>17,600</b>	<b>23,000</b>

<sup>22</sup> Milliman, Inc. (2012). 23 August 2012. “Wyoming Medicaid Expansion Analysis.” August 23rd, 2012.

*Estimating the cost of the expansion population*

The demographic breakdown of the expansion population by age, sex, and health status were applied to actuarially-estimated per-member per-month (PMPM) cost projections. Milliman’s PMPMs for women and men of various age groups are shown in Figure A, below:

**Figure A: Medicaid per-member per-month (PMPM) estimates for age and sex groups**



By multiplying the number of individuals in each demographic group by its corresponding PMPM, Milliman estimated the total cost of providing traditional Medicaid coverage to the expansion group at approximately \$104 million per year (2014 dollars).

The SHARE plan presented in this report, which does not offer dental or vision coverage and includes cost-sharing, is expected to cost approximately 95% of traditional Medicaid.

Adjusting for inflation over time, assuming 50% phase-in in SFY 2016 (start date of Jan 1st), and incorporating a 4% administrative cost, the Department projects the cost of expanding Medicaid in Table 2, below:

**Table 2: Cost of optional Medicaid expansion, 2016 - 2020, State and Federal share.**

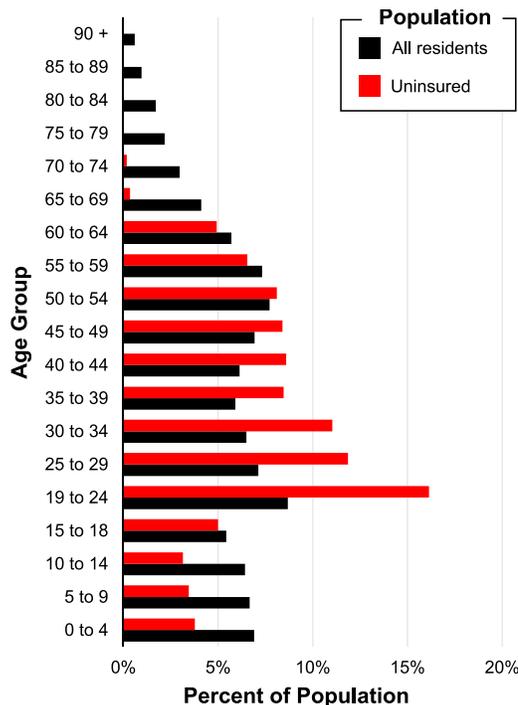
SFY	2016	2017	2018	2019	2020
<b>State</b>	\$1.5	\$6.0	\$9.8	\$11.4	\$14.5
<b>Federal</b>	\$53.7	\$110.6	\$112.5	\$116.6	\$119.5
<b>Total</b>	<b>\$55.2</b>	<b>\$116.7</b>	<b>\$122.2</b>	<b>\$127.9</b>	<b>\$134.1</b>

*Who are the uninsured in Wyoming?*

Figure B (right) <sup>23</sup> illustrates the age distribution of Wyoming’s total population compared to the uninsured population. If lack of insurance were equally distributed across all Wyoming citizens, then we would expect the black and red bars to be equal. However, the uninsured exceed expected levels in several age categories, namely ages 19 to 54.

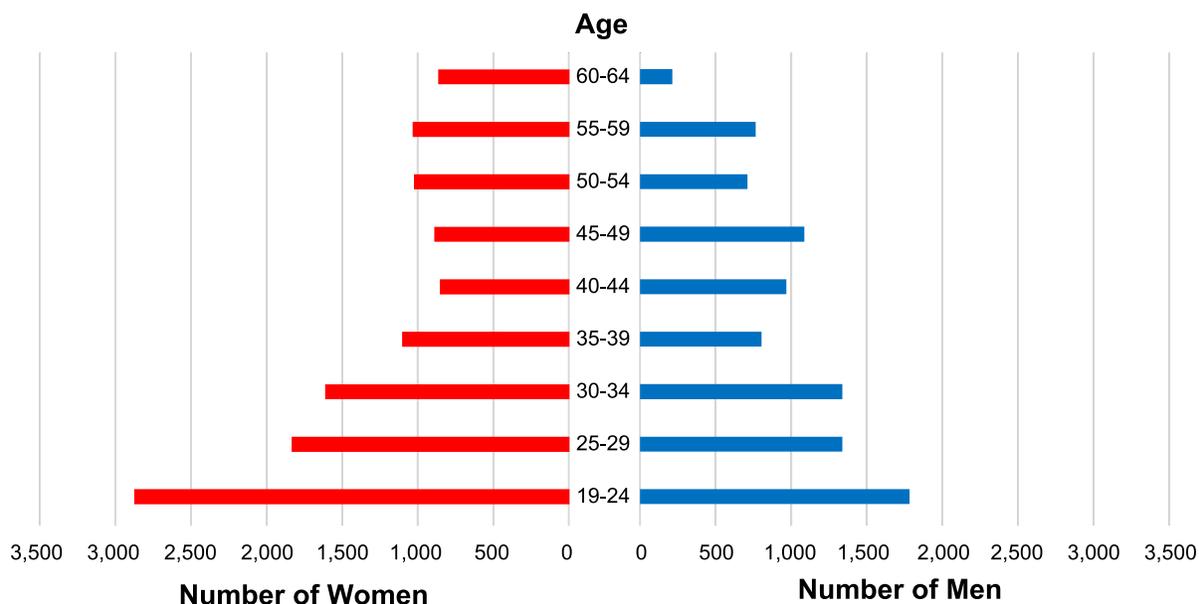
As expected, rates of uninsured are much lower among the traditional safety net populations of children (ages 0 to 18), which are covered by Medicaid and CHIP, and the elderly (ages 65 and above), which are covered by Medicare. Current restrictions in categorical eligibility in Medicaid and Medicare prevent nonelderly adults from participating.

**Figure B. Demographics of Uninsured Adults (19-64) Below 138% FPL in Wyoming**



In addition to being young, Wyoming’s uninsured tend to be female, as seen in Figure C, below.

**Figure C. Wyoming’s uninsured, below 138% FPL, by age bracket and sex**



<sup>23</sup> American Community Survey 2012 5-year estimate Public-Use Microdata Sample (released 3/6/2014). Retrieved from: [http://www.census.gov/acs/www/data\\_documentation/public\\_use\\_microdata\\_sample/](http://www.census.gov/acs/www/data_documentation/public_use_microdata_sample/)

Table 3 shows the disparities in insurance coverage by race in Wyoming. The chart compares the proportion of Wyoming’s total population in each racial category to the proportion of the uninsured represented by each group. Hispanic, Native American, and other minorities are disproportionately uninsured compared to Whites.

**Table 3. Wyoming population and uninsured, by race**

Race	Uninsured, 19-64, <138%	Entire Population
<b>White</b>	73%	86%
<b>Black</b>	2%	1%
<b>Hispanic</b>	12%	6%
<b>Native American</b>	7%	2%
<b>Asian</b>	1%	1%
<b>Other</b>	6%	5%

Table 4 summarizes the educational attainment levels among the Wyoming uninsured, the majority of which have either a high school diploma or some college education. Table 5 summarizes current student status among the Wyoming uninsured.

**Table 4. Highest level of education attained (of those uninsured under 138% FPL)**

No high school	5%
Some high school	14%
High school diploma/GED	38%
Some college	30%
Undergraduate degree	12%
Graduate degree	1%

**Table 5. Student status (of those uninsured under 138% FPL)**

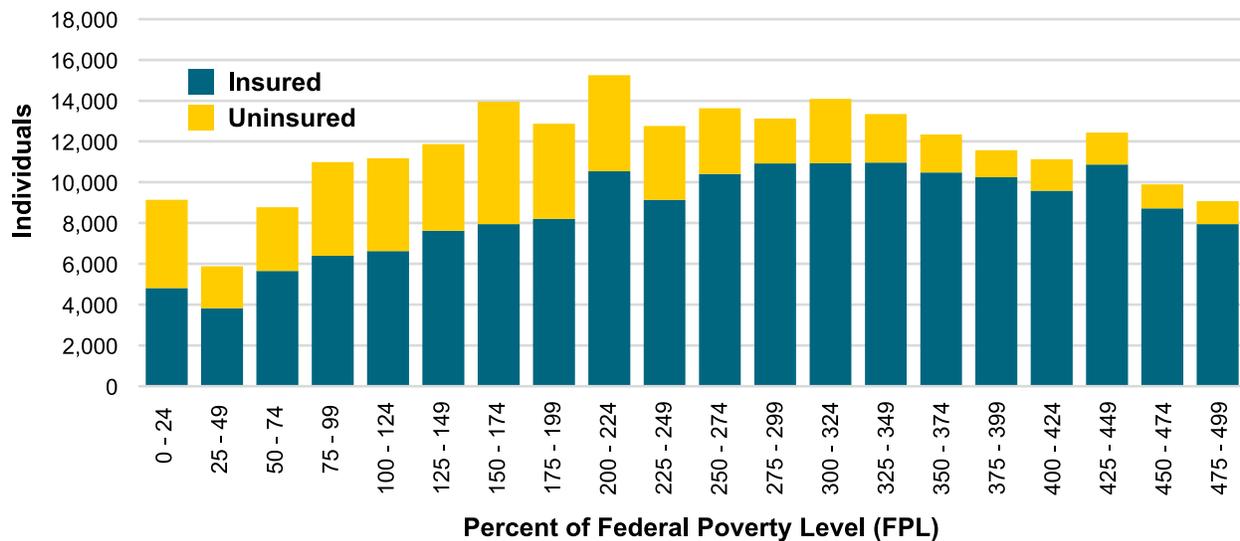
Not in school	88%
12th grade	1%
Undergraduate	10%
Graduate	1%

Health insurance plans providing dependent coverage were required to extend coverage to children under age 26 beginning September 23<sup>rd</sup>, 2010, pursuant to the ACA. Because the American Community Survey (ACS), from which this data is drawn, covers years 2008-2010, it is possible that some of the 10% who are students are now covered on a parent’s plan.

*Income*

Survey results from the Commonwealth Fund found that low-income adults are more likely than higher income groups to be either uninsured or underinsured in 2012, regardless of insurance type.<sup>24</sup> ACS data, illustrated in Figure D, show that this also holds true for the Wyoming uninsured. Fewer Wyoming citizens below 200% FPL are insured compared to those with incomes above 200% FPL. For reference, the 2014 Federal Poverty Guidelines are included in Table 6.

**Figure D. Wyoming’s Insured and Uninsured by Income**



**Table 6. 2014 HHS Federal Poverty Guidelines (100% FPL)**

Persons in family/household	2014 HHS Poverty Guideline for 48 Contiguous States
1	\$11,670
2	\$15,730
3	\$19,790
4	\$23,850
5	\$27,910
6	\$31,970
7	\$36,030
8	\$40,090

<sup>24</sup> The Commonwealth Fund. April 2013. “Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act.” Retrieved from: [http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/apr/1681\\_collins\\_insuring\\_future\\_biennial\\_survey\\_2012\\_final.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/apr/1681_collins_insuring_future_biennial_survey_2012_final.pdf)

Additionally, the Commonwealth Fund survey found that, of those adults with incomes less than 138% of FPL, 23% were underinsured.<sup>25</sup> That is, many low-income individuals with insurance continue to face out-of-pocket medical expenses which exceed 5% of income. Table 7, on the next page, shows the distribution of the Wyoming uninsured by income level between 0 and 138% FPL.

**Table 7. Income levels of uninsured, ages 19-64 under 138% FPL**

Percent of FPL	Percent of uninsured
0 - 24%	21%
25 - 49%	10%
50 - 74%	15%
75 - 99%	22%
100 - 138%	33%

The majority of the uninsured individuals in Wyoming work, doing so largely in service or seasonal industries. Table 8, below, summarizes the employment status of Wyoming’s uninsured population. Of those who are uninsured in Wyoming, 59% are currently employed.

**Table 8. Employment status among Wyoming uninsured, ages 19-64, under 138% FPL**

Sector	Percent
<b>Employed</b>	59%
<b>Unemployed</b>	12%
<b>Not in Labor Force</b>	30%

Table 9 summarizes the top ten industries in which the Wyoming uninsured work. Seasonal industries, such as construction, restaurants and food service, and traveler accommodation account for 33% of employment among the Wyoming uninsured.

Additional sectors outside of the top ten are not shown below, and account for 48% of the remaining jobs.

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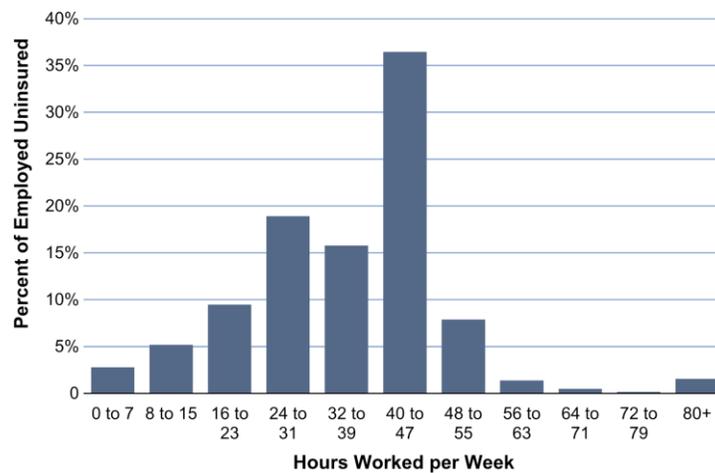
<sup>25</sup> The Commonwealth Fund. April 2013. “Insuring the Future: Current Trends in Health Coverage and the Effects of Implementing the Affordable Care Act.” Retrieved from: [http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/apr/1681\\_collins\\_insuring\\_future\\_biennial\\_survey\\_2012\\_final.pdf](http://www.commonwealthfund.org/~media/files/publications/fund-report/2013/apr/1681_collins_insuring_future_biennial_survey_2012_final.pdf)

**Table 9. Top 10 economic sectors, of those employed**

Sector	Percent
Construction	14%
Restaurants/Food Service	13%
Traveler Accommodation	6%
Grocery Stores	4%
Elementary/Secondary Schools	3%
Department/Discount Stores	3%
Colleges/Universities	3%
Individual and Family Services	2%
Private Households	2%
Animal Production	2%

Of those who are employed, many are underemployed, e.g. working less than full-time (30 hours per week). Figure E illustrates the distribution of hours worked per week among the Wyoming uninsured. For the purposes of enforcing the employer mandate, the ACA defines full-time employment as thirty (30) hours or more per week.<sup>26</sup> On average, two-thirds of the Wyoming uninsured were employed full-time, while another 35% were employed part-time.

**Figure E. Distribution of hours worked per week among uninsured, ages 19-64, under 138% FPL**



*Employer-Sponsored Insurance (ESI)*

Based on national estimates, of those employees who do have an offer of ESI, many cannot afford the rising cost of premiums (particularly for family coverage),<sup>27</sup> nor the increased cost-

<sup>26</sup> 26 U.S. Code § 4980H.

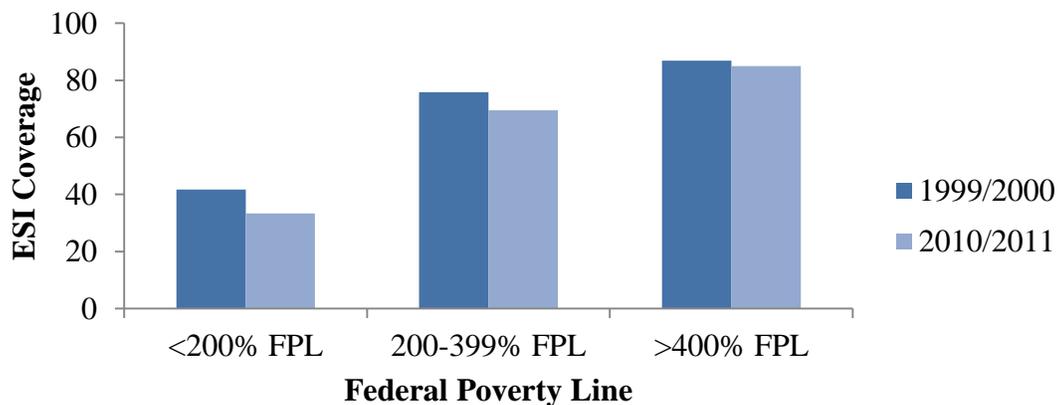
<sup>27</sup> Kaiser Family Foundation. October 2014. “Key Facts About the Uninsured Population.” Retrieved from: <http://files.kff.org/attachment/key-facts-about-the-uninsured-population-fact-sheet>

sharing as employers pass on increases in healthcare costs to employees. Nationally, 61% of the uninsured cited high costs as the primary reason for forgoing health insurance coverage, while only 1.7% of the uninsured said that they did not need health insurance in 2013.<sup>28</sup>

In addition, Wyoming has lower than average ESI coverage compared to other states, and ESI in general has been in decline. A 2013 RWJF report listed Wyoming in the bottom five states for ESI coverage; with only 42.6% of private employers offering coverage and 76.5% of the workforce eligible for ESI.<sup>29</sup> Wyoming’s average ESI coverage rate declined 5 percentage points, from 68% in 1999/2000 to 63% in 2009/2010. This decline has continued, as the state’s three year average from 2010 to 2012 dropped an additional two percentage points to 61.3%.<sup>30</sup>

Figure F, below, illustrates both the lower rates of ESI coverage among low-income compared to high-income populations in Wyoming, and that ESI coverage has been declining more rapidly among low-income populations than high-income populations. Possible explanations for the difference between low- and high-income groups are: 1) ESI is offered less frequently in low-wage jobs, and 2) ESI was offered but was unaffordable.

**Figure F. Changes in ESI Coverage Rates in Wyoming, by Income<sup>31</sup>**



<sup>28</sup> Kaiser Family Foundation. October 2014. “Key Facts About the Uninsured Population.” Retrieved from: <http://files.kff.org/attachment/key-facts-about-the-uninsured-population-fact-sheet>

<sup>29</sup> State Health Access Data Assistance Center. April 2013. “State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis. SHADAC Report. Minneapolis, MN: University of Minnesota. Retrieved from: <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405434>

<sup>30</sup> Fronstin, P. September 2013. “Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 2013 Current Population Survey.” Employee Benefit Research Institute. Retrieved from: [http://www.ebri.org/pdf/briefspdf/EBRI\\_IB\\_09-13.No390.Sources.pdf](http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-13.No390.Sources.pdf)

<sup>31</sup> Data from: State Health Access Data Assistance Center. April 2013. “State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis.” SHADAC Report. Minneapolis, MN: University of Minnesota. Table 2. Retrieved from: <http://www.rwjf.org/content/dam/farm/reports/reports/2013/rwjf405434>