

Health Reform's Impact on Charity Care

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IN BRIEF

The Affordable Care Act (ACA) is changing the traditional role of charity care programs as safety net providers. The ACA's Medicaid expansion and subsidized marketplace plans are giving millions of uninsured Americans options instead of charity care. This brief explores how four charity care programs in different states – CareLink (TX), Portico Healthnet (MN), Ingham Health Plan (MI), and Kaiser Permanente's Charitable Health Coverage program (multiple states) – are responding to the changing health care environment. It examines their benefit packages; membership and eligibility; outreach and enrollment strategies; financial models; and new roles in providing consumer assistance. These four organizations are a small sample of the participants in the *Charity Care Affinity Group (CCAG)*, a national initiative directed by the Center for Health Care Strategies (CHCS) through support from Kaiser Permanente Community Benefit. They were selected for their diverse program designs and their states' varying Medicaid and marketplace efforts.

Based on CHCS' interviews, five broad themes emerged:

- (1) The role of charity care programs is evolving;
- (2) Enrollment in charity care programs decreased, even in those located in states that are not expanding Medicaid;
- (3) In many cases, income eligibility for charity care programs has changed, and although benefit redesign is being considered, benefits largely stayed the same;
- (4) Community engagement and partnerships are of growing importance; and
- (5) Charity care programs continue to be a needed and valued part of the safety net.

Charity care programs (CCPs) have historically provided access to care and subsidized health coverage for uninsured and underinsured populations in the U.S. With the implementation of the Affordable Care Act (ACA), these safety-net programs are adjusting to the new health care environment. Many individuals who previously used charity care services now have health coverage options through the ACA's Medicaid expansion and subsidized marketplace plans. In addition, federal disproportionate share hospital (DSH) payments to states – a financial lifeline for many CCPs – are decreasing as a result of the expected reduction in uninsured individuals. At the same time, under the ACA's Section 9007, non-profit hospitals are subject to more stringent community benefit requirements, thereby creating more resources and greater transparency for charity care activities.

Although the uninsured population in the U.S. is diminishing, this change is not equally distributed across states. A proportion of individuals with income levels under 100 percent of the federal poverty level (FPL) in states that have not pursued Medicaid expansion are neither

eligible for Medicaid nor qualify for marketplace subsidies. These individuals in the so-called “coverage gap” are likely candidates for charity care services.

Since 2011, the Center for Health Care Strategies' *Charity Care Affinity Group (CCAG)*, made possible through support from Kaiser Permanente Community Benefit, has brought together leading charity care programs across the nation to share best practices for responding to the ACA's changing health coverage environment. This brief examines the activities of four CCAG members within the first year of ACA implementation and outlines key takeaways for charity care programs in adapting to the changing safety net.

The Impact of the ACA on Four Charity Care Programs

In July 2014, CHCS interviewed four charity care programs to evaluate the ACA's impact on their benefit packages, membership and eligibility, outreach and enrollment strategies, and financial models. These four organizations are a small sample of CCAG participants, selected due to their diverse program designs and their state's varying Medicaid and marketplace efforts. The organizations interviewed are CareLink in Texas, Ingham Health Plan (IHP) in Michigan, Portico Healthnet (Portico) in Minnesota, and Kaiser Permanente's Charitable Health Coverage (CHC) program in multiple states. Below is a snapshot of each of these charity care organizations and key characteristics for each model.

CareLink

CareLink is a hospital-based financial assistance and health coverage program based in San Antonio, Texas. University Health System, where CareLink is housed, is comprised of a hospital and a network of health care centers and is partially supported by the property tax of Bexar County residents. CareLink members must be Bexar County residents without any other form of insurance and with income levels at or below 200 percent FPL.⁴

Membership and Eligibility

CareLink's membership decreased from 50,000 to 38,000 enrollees after the first open enrollment period. The majority of remaining members are undocumented immigrants and individuals with income levels at or below 200 percent FPL. According to Executive Director Virginia Mika, former CareLink members eligible for subsidized marketplace plans tended to enroll in marketplace plans during the first open enrollment period. Currently, CareLink is primarily enrolling individuals who fall within the coverage gap.

Between July and September 2014, CareLink made two changes to its eligibility criteria. First, it decided that individuals eligible for subsidized coverage through the health insurance marketplace plans will no longer be eligible for CareLink; these individuals are now redirected to the marketplace to enroll. The University Health System hospitals and health centers are

About Texas

- About 24 percent of Texans are uninsured, the highest uninsured rate in the nation.¹
- Texas presently has no plans to expand Medicaid, and about one million uninsured Texans fall within the coverage gap as a result.²
- Marketplace coverage options are available for residents through the federally facilitated marketplace; 733,757 Texans have enrolled in marketplace plans as of April 2014.³

equipped with CareLink applications to assist individuals in the enrollment process and provide assistance with applications for CareLink. Second, CareLink changed its eligibility threshold from 300 percent to 200 percent FPL. With the ACA's guaranteed issue policy (the requirement for insurance plans to cover all individuals, regardless of pre-existing conditions or other health factors), the program made the decision that providing subsidized services to people in this higher income bracket is no longer necessary, as these individuals are generally subject to the individual mandate so therefore must purchase coverage through the marketplace or their employer.

Benefits Provided

CareLink has not changed its member benefits in response to the ACA. It continues to provide primary care services including women's health services and pediatric care, behavioral health, and health education. CareLink has considered reevaluating its benefits to potentially mitigate financial hardships within the health system, but has not yet done so.

Outreach and Enrollment Strategies

CareLink's outreach and enrollment activities center on training and education. The program dedicates resources to training case workers and social workers to ensure accuracy in referrals; it also trained 30 assisters to comply with ACA navigator requirements. CareLink developed a Marketplace Workshop and a Health Insurance 101 class for external referrers and consumers to improve health insurance literacy. The first Marketplace Workshop was attended by 90-100 participants. CareLink launched its first Health Insurance 101 class in conjunction with the second open enrollment period.

Business and Financial Model

CareLink maintains a successful partnership funding model, requiring its members to assume some financial responsibility for their care. Families pay a monthly fee and co-payments based on household size and income, with capped out-of-pocket costs. In addition to member payments, CareLink relies on Bexar County property taxes to sustain its program. Although CareLink continues to collect member contributions, its overall budget has been declining as membership numbers decrease.

Portico Healthnet

Portico strives to meet its mission to "reduce the number of people without coverage for health care services" through two program areas: (1) outreach and enrollment assistance into public programs; and (2) the Alternative Coverage Program.⁵ Based in St. Paul, Minnesota, Portico provides outreach and enrollment services without eligibility restrictions throughout the state. Portico's Alternative Coverage Program is for residents of Ramsey, Hennepin, Dakota, and Washington counties without other health coverage; with household incomes at or below 275 percent FPL; and who are ineligible for other state health programs.

Membership and Eligibility

The number of uninsured individuals served under Portico's two programs totaled 17,000 in FY2014, although only about 1,300 were enrolled in its Alternative Coverage Program. The remaining individuals are screened for health coverage options under Portico's Enrollment Program, which focuses on enrolling individuals into MNSure plans. Within the last year, the program has experienced a significant boost in serving individuals with assistance in the enrollment process from 2,300 to 4,200, estimated to have reached about 4,900 by the end of FY2014. Portico attributes the rise in the number of individuals served by the Enrollment Program to an increase in funding to support navigators working throughout the community, as well as to the abundant publicity around the ACA.

Conversely, participants in the Alternative Coverage Program, Portico's benefits program, decreased from 1,429 individuals in FY2013 to 1,298 in FY2014. This is partially due to members transitioning into Medicaid through the ACA's expansion as well as an increase in member utilization of services, a potential effect of the reduction in access to Emergency Medical Assistance (EMA) services in Minnesota. EMA provides emergency medical care for noncitizens who are ineligible for Medicaid. Completely funded by hospital partner contributions, the program limits enrollment to stay within the financial boundaries of their contributions when per member costs increase. However, the descending membership numbers misrepresent the actual consumer interest to enroll. The program's wait list was closed after climbing to more than 1,000 individuals in 2013, a number that Portico program managers felt would have gone even higher if the wait list remained open.

Benefits Provided

Portico's Alternative Coverage Program provides the same services as it did before the ACA. Its covered services include primary care, specialty care, urgent care, outpatient behavioral health, outpatient hospital services, and prescriptions. Based on a care coordination model, each member is assigned a social worker who offers health care system navigation assistance and advocacy, enrollment assistance, and referrals to social services.

Portico's Enrollment Program provides no health care services; it solely focuses on helping individuals to enroll in appropriate health coverage, including Portico's Alternative Coverage Program, the marketplace, or Medicaid coverage.

Outreach and Enrollment Strategies

Portico made considerable changes to its Enrollment Program to adapt to ACA requirements. It modified its enrollment assistance model by: (1) establishing group application assistance sessions to complement its traditional one-on-one approach; (2) transitioning its long-established paper and phone-based process into an in-person, electronic system; and (3) offering extensive trainings on marketplace individual plans as well as tax policies related to subsidy eligibility.

About Minnesota

- From September 2013 to June 2014, Minnesota's uninsured rate dropped from nine to five percent. This 41 percent decrease can be credited to additional enrollment into Minnesota's Medicaid program (Medical Assistance) and *MinnesotaCare*, which is a state-subsidized coverage program.⁶
- Minnesota has fully implemented Medicaid expansion for individuals at or below 138 percent FPL.
- Minnesota's state-based marketplace called *MNSure* covers more than 48,000 individuals as of April 2014.⁷

Portico also greatly increased its off-site individual and group support in multiple locations, such as local libraries, schools, and food shelf locations across the Twin Cities metropolitan area.

Between 300 and 400 community organizations continually refer individuals to the Enrollment Program. Increasingly, non-health-related social service organizations are actively referring clients and establishing enrollment partnerships with Portico. Portico has a presence in 20 non-health community organizations assisting its constituencies with navigating services, which is a significant leap from the four organizations it engaged with prior to the ACA. In addition, Portico is building relationships with county and state correctional facilities to provide enrollment services for incarcerated individuals so they may begin the process of connecting to coverage upon release.

Business and Financial Model

While Portico has largely preserved its financial model, uncertain funding is leading the organization to reconsider aspects of its program. Portico's Alternative Coverage Program is financially supported by a partnership of 13 hospitals and by participation fees. Its annual hospital allocation is typically limited to \$1.5 million a year, which caps service capacity at about 1,000 individuals. Participation fees range between \$25-50 per household per month for coverage based on household size and income, with co-payments for some services.

Portico's Enrollment Program is funded by foundations, private donors, per enrollment reimbursements from MNSure (Minnesota's state-based marketplace), and public entities. In addition to MNSure, Portico was a recipient of funding from United Way, Blue Cross Blue Shield of Minnesota, and other grant programs for training, education, and enrollment activities. For the first year of the marketplace, Portico also received \$25 per successful Medicaid enrollment and \$70 for each marketplace enrollment administered through MNSure and the Department of Human Services. In the future, Portico hopes for more sustainable funding for navigators by increasing per enrollment reimbursements or shifting entirely to MNSure-related grants. Portico also hopes to establish financial arrangements with the partner entities they conduct enrollment services for to fund navigator and assister positions.

Ingham Health Plan

IHP, based in Michigan, provides discounted health care services for low-income, uninsured Ingham County residents through contractual agreements with local hospitals. IHP's goal is to improve access to care while reducing health care costs.

Membership and Eligibility

As of September 2014, IHP serves 800 members in its charity care program, a significant decrease from the 16,000 members it had prior to the ACA. IHP's membership reduction can be attributed to the availability of new health coverage options (Medicaid and marketplace plans) and the dissolution of Michigan's Plan A coverage program, which targeted low-income adults without children who were eligible for the state's Adult Benefits Waiver (a program that was absorbed into the *Healthy Michigan* Medicaid expansion). IHP's Plan B, a community-sponsored program

for residents who do not qualify for any other public program, continues to serve about 80 percent of IHP enrollees.

IHP implemented an individual income cap of \$28,000 a year and expanded eligibility to individuals denied or waived from the marketplace. In addition, IHP disenrolled all members from its plans and required individuals to reenroll under new eligibility standards. IHP's targeted outreach is successfully drawing eligible individuals back to the program with incremental increases of 100 new enrollees per month.

After the end of the first open enrollment period, IHP also created a short-term bridge program available for uninsured individuals who did not sign up for a marketplace plan. Membership in the bridge program has been fairly low. IHP ended the program in December 2014 and is currently transitioning members into Medicaid or an appropriate marketplace plan during the second open enrollment period.

Benefits Provided

IHP has not changed its benefit package following ACA implementation. It continues to provide office and specialist visits, outpatient lab tests and X-rays, urgent care, and prescription medication. IHP is also adding primary dental benefits to its covered services.

Outreach and Enrollment Strategies

IHP has not sought any strategic changes to its outreach or enrollment efforts. It continues to fund public health departments and neighborhood network centers to refer and enroll eligible individuals into its programs. For the first time, however, IHP has hired an internal outreach and enrollment staff member to oversee these projects and activities. In addition, IHP hopes to serve as the region's hub for a network of providers and community health workers dedicated to providing coordinated clinical and social services for its members. IHP currently serves in this role for the assignment of community health workers and for expectant parent and child services programs.

Business and Financial Model

IHP has had to change its business plan due to unstable funding sources. Within the current fiscal year, it experienced a 90 percent reduction in DSH payments from \$8 million to \$940,000. With the plunge in DSH payments, IHP's primary source of program funds is expected to be the county's Health Care Service millage, or property tax, allocation. This year, the county's \$3 million millage allocation is up for renewal. Concerns for its passage are greater than in previous years due to an anticipated smaller uninsured population.

On top of its \$5-10 co-payments, IHP began requiring members to pay a \$20 administrative fee to acclimate consumers to paying for care. In Michigan, Medicaid beneficiaries between 100-138 percent FPL must engage in income-based contributions as "premiums" for care.¹¹ Similar to

About Michigan

- Twelve percent of Michigan's population was uninsured before Medicaid expansion.⁸
- On April 1, 2014, Michigan launched its Medicaid expansion program, *Healthy Michigan*, enrolling more than 300,000 individuals within the first few months.⁹
- Michigan established a partnership marketplace model with a robust group of competing health plans. More than 270,000 Michiganders are estimated to be enrolled in marketplace plans.¹⁰

Healthy Michigan, receiving services is not contingent on whether consumers pay their cost-sharing obligations.

Kaiser Permanente's Charitable Health Coverage Program

Kaiser Permanente's Charitable Health Coverage (CHC) program provides health coverage to low-income individuals and families who have no access to public or private health coverage programs. It provides a premium subsidy that pays for enrollment in a Kaiser Permanente (KP) off-exchange health benefits plan available on the individual market. This results in little to no cost for members. KP offers CHC programs in multiple states: California, Colorado, Georgia, Hawaii, Maryland, Oregon, and Virginia. Income eligibility requirements vary by region ranging from 100 percent FPL to 350 percent FPL.

Membership and Eligibility

National enrollment numbers for KP's CHC programs declined from 95,000 members in 2013 to 87,000 members as of December 2014, a downward trend experienced across most regional CHC programs. KP largely ascribes the decrease to the ACA's newly available coverage options as well as its tighter enrollment timeframe. CHC enrollment is now confined within designated open enrollment periods and special enrollment periods instead of occurring year-round, a restriction that many in the low-income population may not realize, notes Executive Director Grace Chang.

KP's CHC programs remain a last-resort option reserved for low-income individuals who have no access to any other health coverage. Most of CHC's regional programs have maintained their income eligibility standards at 300 percent FPL with one increasing its standards to 350 percent FPL. KP's Georgia region is the exception, reestablishing standards at or below 100 percent FPL to serve the most vulnerable populations, principally because the state has not expanded Medicaid. Overall, most members have income levels below 200 percent FPL, with a substantial portion being children. About 80,000 of the CHC program members are children from California and Northwest regions.

Benefits Provided

CHC regional programs have made nominal changes to their benefits following ACA implementation. Prior to the ACA, CHC plans provided a comprehensive set of benefits with low cost-sharing. Post-ACA, individuals and families eligible for CHC are enrolled in a standard Kaiser Permanente off-exchange plan approved by state regulators. The CHC plan includes the minimum essential health benefits and is equivalent to a marketplace Platinum or Gold level plan, depending on the region.

Outreach and Enrollment Strategies

Given the shortened timeframe from year-round to annual open enrollment periods, KP CHC programs have had to reassess enrollment activities. In the past, KP experienced high enrollment

About KP CHC States

- KP CHC serves individuals and families in California, Colorado, Georgia, Hawaii, Maryland, Oregon, and Virginia.
- Besides Virginia and Georgia, all of the other CHC states have expanded Medicaid.
- Georgia and Virginia have established federally facilitated marketplaces. California, Colorado, Hawaii, Maryland, and Oregon have established state-based marketplaces.¹²

during August and September through an annual “Back-to-School” enrollment campaign. While “Back-to-School” activities continue, momentum has slowed as applicants wait for January 1, the effective date of coverage. In order to maximize enrollment, KP’s CHC programs now continue outreach activities to schools and school districts throughout the annual open enrollment period.

In preparation for the second open enrollment period, CHC programs are engaging in closer collaborations with regional community-based organizations to direct eligible individuals to their programs and inform members of CHC program-related changes, including enrollment timeframes. KP continues to have a strong and stable presence within the community, providing funding and resources for organizations and entities to conduct outreach activities and provide social services and clinical care.

Business and Financial Model

KP remains the major funder of its CHC programs. Some CHC regional programs require some member monthly payment amounts based on household income and family size. However, upon enrollment, members are also provided with a Medical Financial Assistance award that lowers cost-sharing to \$0 for most covered services provided at Kaiser Permanente medical clinics and hospitals.

Unlike the other charity care programs described in this paper, prior to the ACA, KP offered a subsidized CHC health benefits plan for qualifying individuals and families (e.g., income thresholds), thereby uniquely affected by ACA provisions, such as guaranteed issue laws, which “require insurance companies to issue a health plan to any applicant – an individual or group – regardless of the applicant’s health status or other factors.”¹³ Consequently, KP had to discontinue its CHC plans and redesign its CHC program to comply with the new ACA requirements.

The CHC program now includes three enrollment components: (1) individuals must qualify for a KP premium subsidy; (2) eligible individuals are enrolled in a KP off-exchange plan; and (3) eligible individuals are awarded medical financial assistance that eliminates cost sharing for most services received at KP facilities. Consumers and KP are finding the new program complex to use and administer, motivating KP to consider ways to simplify the program.

Emerging Themes for Charity Care Programs

While the four charity care programs described in this brief all have unique program models and distinct environments in which they operate, our interviews begin to identify a set of common themes across programs. The following takeaways can help inform other charity care programs across the U.S. to help them restructure their business models to adapt to the nation’s changing health coverage landscape.

1. The role of charity care programs is evolving.

Although CCPs continue to provide care and/or subsidized coverage for uninsured and underinsured individuals, their role is reduced given the availability of publicly financed coverage options through Medicaid and the marketplaces. Increasingly, CCPs are involved in

connecting individuals to Medicaid or marketplace coverage and serving as conduits for health care eligibility screening and enrollment.

In the new health care environment, charity care programs are more likely to serve as educators, informing consumers about basic insurance design including benefit structures, cost-sharing terminology, and eligibility criteria. As more charity care recipients transition into subsidized marketplace plans, CCPs are finding that consumers need assistance in both choosing the appropriate plan and in better understanding how to access health services paid for by their plans. Charity care organizations are developing trainings and delivering workshops for both consumers and navigators to improve: (a) health insurance literacy rates; and (b) the likelihood that consumers enroll in appropriate plans. Additionally, organizations are exploring training options to familiarize navigators and other CCP staff with eligibility and structural policies that were adjusted to comply with ACA provisions and the changing environment.

2. Enrollment in charity care programs decreased, even in those states that are not expanding Medicaid.

Regardless of the Medicaid expansion status of the state(s) in which they operate, all four CCPs experienced a decrease in membership. Causal factors included the expansion of Medicaid and other public programs, new insurance options through the marketplace, and limited funding for charity care services. Some CCPs have also faced ACA-related enrollment challenges ranging from time-consuming and unfamiliar applications to state and marketplace enrollment portal glitches to long processing times that created backlogs.

CareLink and IHP found members were transitioning into Medicaid and marketplace programs when they qualified. CareLink, based in a non-expansion state, found that many members above 138 percent FPL transitioned to marketplace plans. IHP, based in an expansion state, found that 80 percent of members enrolled in Medicaid and the remaining 20 percent initially appeared eligible for marketplace plans. The large Medicaid transition may have occurred when the state's Adult Benefits Waiver, the foundation of IHP's Plan A option, was absorbed into *Healthy Michigan*. Plan A targeted low-income adults without children who were eligible for the waiver. IHP also disenrolled its entire remaining membership, requiring individuals to reenroll under new eligibility criteria. This also had a significant impact on its membership.

For Kaiser Permanente, the ACA's open enrollment timeframe shortened opportunities for consumers to sign up for its CHC programs and disrupted a heretofore successful "Back-to-School" enrollment campaign, potentially impacting membership numbers and causing Kaiser Permanente to reassess the timing of outreach activities.

3. In many cases, income eligibility for CCPs has changed, and although benefit redesign was considered, benefits packages and products largely remained the same.

Charity care programs are grappling with how to modify programs in response to unpredictable funding streams and the changing needs of the uninsured population. Three

out of the four charity care programs interviewed leaned toward modifying income eligibility standards versus making significant benefits changes as funding for CCPs decline and more individuals enroll in publicly funded and subsidized coverage programs. CareLink decreased eligible income levels from 300 to 200 percent FPL. KP's CHCs increased the financial threshold in one program to 350 percent FPL, decreased eligibility to under 100 percent FPL for a program in a non-Medicaid expansion state, and all other regional programs remained at pre-ACA levels. IHP established an individual income cap of \$28,000 per year to replace its household eligibility income of 250 percent FPL. Portico does not plan to change income eligibility guidelines, nor benefits at this time; however, the costs of providing services are increasing as access to Emergency Medical Assistance services has reduced in Minnesota. More recently, some organizations like CareLink are contemplating reducing services. However, no to very minimal changes have been made. As an exception, IHP is in the process of including dental services to the benefits it provides.

4. Community engagement and partnerships are of growing importance.

Community partnerships are becoming a vital component of CCP activities, particularly around enrollment and education. Charity care programs are relying more on community organizations to: (a) reach the remaining uninsured and hard-to-reach populations; (b) relay information on program changes and eligibility; and (c) enroll and refer eligible individuals into CCPs and other forms of health coverage. Some CCPs are also seeking to work closely with community and social service organizations to improve coordination of care and become a "one-stop shop" for consumers. Portico increased its off-site presence from four to 20 non-health settings, such as schools, WIC centers, and community organizations. It seeks to establish itself as the metro area regional center for both outreach and enrollment services as well as for training other organizations. IHP is committed to establishing itself as a local hub for community health workers and providers, thereby creating a regional network of coordinated clinical and social services for members.

5. Charity care programs continue to be a needed and valued part of the safety net.

Charity care programs continue to be important providers of health coverage. Even with the availability of new health coverage options, a significant subpopulation remains uninsured. Enrollment backlogs, unaffordable marketplace plans, and some states' decision not to expand Medicaid are maintaining or creating coverage gaps for many individuals.

CCPs are still determining the best ways to adapt to ACA provisions, assure financial viability, improve efficiency, and meet organizational goals while minimizing disruptions in care. The ability of CCPs to meet the ever-changing demands of the uninsured and underinsured population, as well as federal and state requirements, will be essential to their efficacy.

The Future of CCPs

The role of CCPs in the broader health care and coverage continuum is evolving. Although the four programs profiled in this brief have chosen to evolve to meet the changing health care

climate in their states, the response of other programs is uncertain. The reduction of DSH payments and other traditional funding sources as well as a “coverage gap” for individuals in both expansion and non-expansion states may compel charity care organizations to reevaluate the direction, design, and viability of their programs.

Still, with the second ACA open enrollment period (November 15, 2014-February 15, 2015), charity care programs continue to be necessary and relevant entities in providing safety net coverage for a large portion of the US population. Though new health plan options are now available, enrollment glitches, unaffordable plans, and state variations in Medicaid and other public programs will be barriers to comprehensive and complete coverage for all.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

ENDNOTES

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