Center for Consumer Information and Insurance Oversight

State Planning and Establishment Grants for the Affordable Care Act's Exchanges

Reporting Requirement

Quarterly Project Reports

Date: **July 15, 2011**

State: **Mississippi**

Project Title: **Mississippi Insurance Department Health Insurance Exchange Planning Grant Quarter III Report**

Project Quarter Reporting Period: Quarter III (04/01/2011-06/30/2011)

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Project Summary

This report covers the activities conducted in the third quarter of the grant period. Mississippi focused its efforts on in-depth research on demographics and the insurance market in Mississippi, alternate regulatory options, increased stakeholder involvement, and initial outreach as it continues to plan for a State-based Exchange.

Core Areas

I. Background Research

Mississippi completed the following background research on the State's health insurance market during the third quarter:

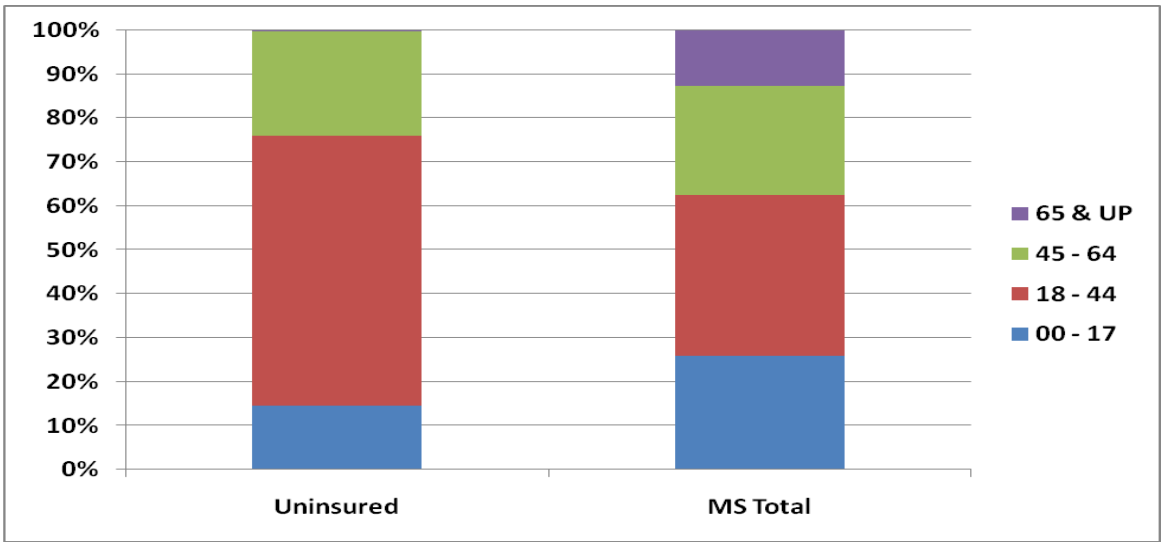
1. Name of Milestone: Background Research
Timing: Process completed in Quarter III
Description:

Mississippi's in-depth background research included a demographic analysis of the health insurance market in Mississippi. Two reports were produced and provide MID with demographic, social, and economic information for all counties and select cities in the State, as well as the economic situation in each county and sixteen select cities. Pairing this information provides a picture of the possible challenges Mississippi will face in each area as it informs, educates, and ultimately enrolls individuals in an Exchange.

Mississippi's Exchange will serve an extremely diverse audience as the needs of Mississippians differ by region, ethnicity, and socioeconomic status. Mississippi has a total population of 2,951,996 persons, with 532,993 of these currently uninsured. For the uninsured, the largest level is found in the 18-44 age category at sixty-two percent (62%), representing 327,791 people. In this age category, fifty-four percent (54%) are male and forty-six percent (46%) are female. The 18-44 age group makes up thirty-seven percent (37%) of the State's population.

Uninsured Population by Age & Gender

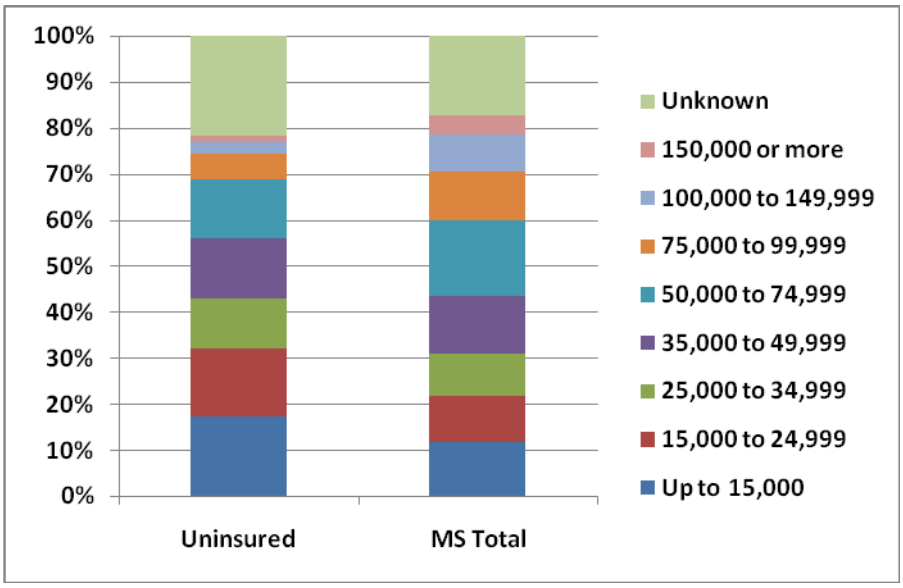
	Uninsured				MS Total			
Age	Female	Male	Total	% of Total	Female	Male	Total	% of Total
00 - 17	39,655	37,827	77,482	15%	370,306	394,161	764,467	26%
18 - 44	140,186	187,605	327,791	62%	546,439	536,894	1,083,333	37%
45 - 64	62,930	64,433	127,363	24%	377,486	351,326	728,812	25%
65 & UP	342	15	357	0%	222,576	152,808	375,384	13%
Grand Total	**243,113**	**289,880**	**532,993**		**1,516,807**	**1,435,189**	**2,951,996**	



Of Mississippi's uninsured population, seventeen percent (17%) make less than $15,000, fifteen percent (15%) make between $15,000 and $24,999, and eleven percent (11%) make between $25,000 and $34,999. Respectively, the corresponding proportions of the total Mississippi population are twelve percent (12%), ten percent (10%), and nine percent (9%) respectively. Being aware of the financial condition of the uninsured market will enable Mississippi to make more prudent decisions in engaging the uninsured population.

Uninsured Population by Family Income

	Uninsured		MS Total	
Family Income	Count	Percentage	Count	Percentage
Up to $15,000	92,460	17%	345,049	12%
$15,000 to $24,999	78,903	15%	300,423	10%
$25,000 to $34,999	56,965	11%	268,959	9%
$35,000 to $49,999	69,640	13%	372,288	13%
$50,000 to $74,999	69,479	13%	480,426	16%
$75,000 to $99,999	29,171	5%	311,765	11%
$100,000 to $149,999	13,774	3%	243,535	8%
$150,000 or more	6,646	1%	123,061	4%
Unknown	115,955	22%	506,490	17%
Grand Total	**532,993**		**2,951,996**	



The percentage of Mississippi's population living in poverty is much higher than the national average of thirteen and one half percent (13.5%). While the 0-49% Federal Poverty Level (FPL) contains twenty-two percent (22%) of the uninsured population (119,593 lives), the next highest amount of the uninsured is found in the 133%-199% FPL. The remaining data for Mississippi is evenly distributed, accounting for the twenty-four percent (24%) of the population that is over 400% FPL.

Uninsured Population by FPL Distribution

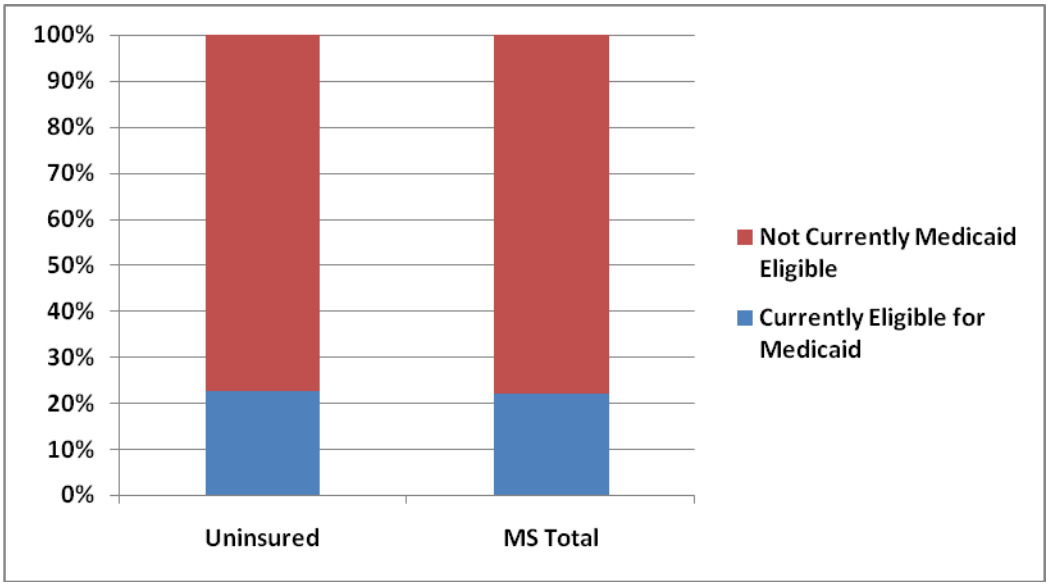
	Uninsured		MS Total	
% of FPL	Count	Percentage	Count	Percentage
0- 49	119,593	22%	377,575	13%
50- 99	91,481	17%	343,409	12%
100-132	49,010	9%	219,790	7%
133-199	99,384	19%	427,198	14%
200-300	87,919	16%	511,794	17%
300-400	41,593	8%	368,617	12%
400 PLUS	44,013	8%	703,613	24%
Grand Total	**532,993**		**2,951,996**	

The following data shows that twenty-three percent (23%) of Mississippi's uninsured population currently is eligible for Medicaid but remains uninsured, while

seventy-seven percent (77%) of the uninsured population is not currently eligible. These numbers are also representative of the total Medicaid numbers in the State.

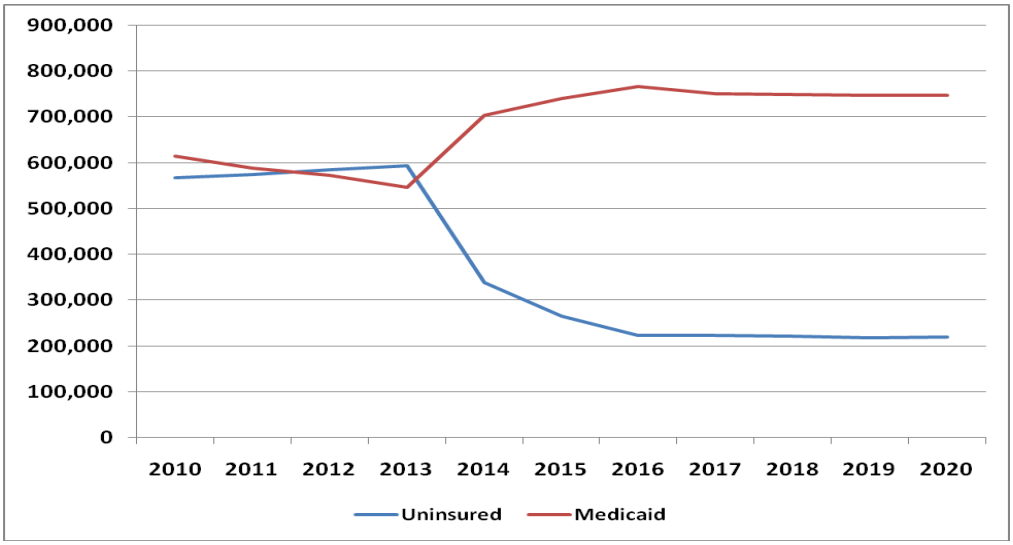
Uninsured Population by Medicaid Eligibility

Medicaid Eligibility	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
Currently Eligible for Medicaid	120,875	23%	650,077	22%
Not Currently Medicaid Eligible	412,118	77%	2,301,919	78%
Grand Total	**532,993**		**2,951,996**	



In 2014, it is estimated that twenty-four percent (24%) of Mississippi's population will be eligible for Medicaid. This number also represents the population that will be eligible in 2020, showing that after 2014, there is not projected to be an additional surge of Medicaid enrollees beyond the new base. As the Exchange bears a Medicaid eligibility requirement, Mississippi will have a special interest in this data as it indicates the areas that will have a higher degree of Medicaid growth, in both the new base and heath care reform-driven growth.

10 Year Change in Uninsured & Medicaid by Number of Lives (2010-2020)



MID will use this data to develop education and implementation strategies specific to certain areas of the State, supporting the establishment of an Exchange that meets the objectives of the State and the needs of Mississippi residents. This data is contained in reports attached hereto as Attachment "B" and Attachment "C" and will be used by MID, along with other available background research, in the Exchange planning process. MID will combine this information with health insurance coverage data to gain insight on possible challenges facing Mississippi as it informs, educates, and ultimately enrolls individuals in the Exchange.

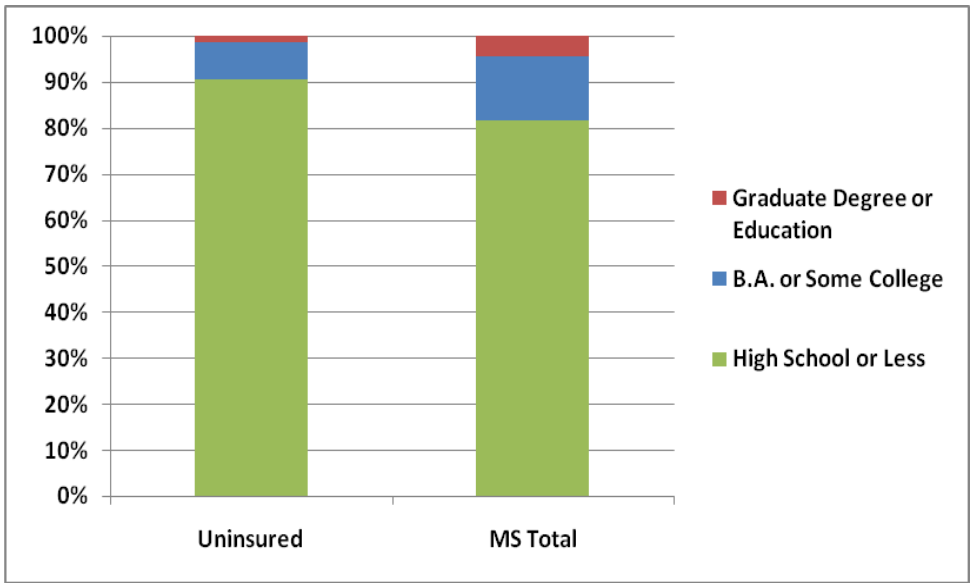
II. Stakeholder Involvement

As the State moves forward with the establishment of an Exchange, outreach efforts are critical to its success. MID continued stakeholder involvement activities by building on its previous meetings, reaching the following milestones during the third quarter:

1. **Name of Milestone: Public Awareness Planning**
   Timing: Quarter III
   Description:

Mississippi's rural population, low rates of education attainment, and relative lack of computer literacy are a few of the largest challenges for the Exchange. Mississippi's

Exchange will serve an extremely diverse audience as the needs of Mississippians differ by region, ethnicity, and socioeconomic status. Fifty-five percent (55%) of the State's residents live in rural areas and the State ranks last in the percentage of people who use the Internet inside or outside the home. Eighty-two percent (82%) of Mississippi's population has a high school diploma or less. The following table shows that ninety-one percent (91%) of the uninsured population has a high school diploma or less. Only eight percent (8%) has a Bachelor of Arts degree or some college and one percent (1%) of the uninsured has a graduate degree.



With these population challenges, gathering stakeholder input throughout the Exchange planning and establishment process continues to be critical to the successful implementation of the Exchange.

2. Name of Milestone: Report on Small Group Stakeholder Meetings
Timing: Quarter III
Description:

MID consultants prepared a detailed analysis of individual and small stakeholder sessions conducted in January 2011, over a two-day period. These sessions informed State leaders and other stakeholders as to current national issues concerning health insurance exchanges and sought their input regarding their vision for an Exchange for

Mississippi. The aforesaid analysis is detailed in a report attached hereto as Attachment "D". The following is the Executive Summary from said report:

Phase I Secondary Research and Data Analysis, Stakeholder Interviews and Mini-Focus Groups Executive Summary

A. **Health Insurance and Exchange Confusion:** Among all respondents (including health experts), there was confusion about health insurance and the health insurance Exchange. Respondents suggested that part of the confusion about health insurance and Exchanges stems from the ambiguity of the Patient Protection and Affordable Care Act ("PPACA").

B. **Exchange Design:** As an outgrowth of the confusion surrounding health insurance and Exchanges, respondents unanimously stressed the importance of simplicity in the Exchange.

C. **Marketing and Education:** Mississippi will serve an extremely diverse audience. The needs of Mississippians differ by region, ethnicity, and socioeconomic status. Those implementing the Exchange must apply tailored marketing concepts and appealing presentation to these diverse groups.

D. **Rural, Technological, and Educational Challenges:** Respondents identified Mississippi's rural population, low rates of education attainment, and relative lack of computer literacy as some of the largest challenges for the Exchange. Other respondents shared the desire for setting proper expectations that the Exchange will not immediately lower insurance costs, broadening stakeholder involvement, and developing a more manageable governing and regulatory body.

E. **A State-Sponsored Tool for Economic Development:** The consensus among respondents was that the Exchange should be viewed as a resource built by Mississippians, for Mississippians. Small business and economic development leaders explained that the Exchange should be viewed as a resource for attracting and retaining employees, rather than a tool for reducing insurance costs.

F. **Regulation, Rules, and Adverse Selection:** Brokers and small business respondents suggested the Exchange should be regulated by the Mississippi Insurance Department, with the Governing Board of Directors consisting of businesses, consumer advocates, health providers (e.g. nurses and physicians), and insurance

representatives. Respondents (excluding legislators) believed an Exchange housed within a State agency would be too slow and bureaucratic. However, legislators expressed a strong desire that the Exchange be subject to legislative oversight. While only explicitly identified by State leaders, carriers, brokers, and policy analysts, adverse risk is the greatest threat to Mississippi's Exchange. High participation rates will reduce the likelihood of adverse selection. Regulation must be balanced by the flexibility small businesses need to grow.

G. Funding: Most respondents could not identify an effective solution for funding the Exchange. Brokers and various State leaders suggested funding the health Exchange through a mechanism similar to that of the Mississippi Comprehensive Health Insurance Risk Pool Association.

H. Navigators: Consumer advocates, policy analysts, small businesses, brokers, and some State leaders communicated that navigators must have the ability to educate and enroll participants in the Exchange.

I. Brokers: All respondents voiced the critical role that brokers will play in the Exchange. Yet, most (excluding brokers) spoke of the increasingly consultative role brokers will need to assume.

J. Increasing Participation: There was confusion among respondents about whether the Exchange will immediately lead to lower insurance costs. Carriers, State leaders, and policy analysts stressed the importance of explaining that the allure of the Exchange should not be cost savings. Small business owners, who understood that the Exchange would not lead to lower premiums, spoke of the Exchange's ability to help them attract and retain employees.

K. Exchange Rollout Tests: Policy analysts, community health providers, and various State leaders suggested the Exchange be rolled out to a small group first, perhaps a government agency or small city. Depending on the outcome of the pilot test, the Exchange will have the ability to make changes before presented to the public

L. Outreach: All respondents spoke about the challenge of educating the public and small business community about the Exchange. Yet, these same respondents spoke about Mississippi's strong, existing networks for outreach and education. Outreach channels include brokers, chambers of commerce, planning and development

districts, economic development groups, industry and business associations, state health departments, community health centers (FQHCs), health care providers (e.g. nurse practitioners and physicians), churches, schools, and community/advocacy groups.

M. Communications Plan: Community health leaders, brokers, State leaders, small businesses, and policy analysts think the communications campaign should combine in-person and organizational outreach with traditional media (e.g. television, magazines, mailers, newspapers, and on the Internet).

3. Name of Milestone: Small Employer Survey and Employee Survey
Timing: Quarter III
Description:

MID consultants are currently conducting an online survey targeting small businesses, employees, and stakeholders throughout the State to seek input on their knowledge of an Exchange, views on health plans and the selection process and feedback on various features of an Exchange. MID sent invitations for survey participation in May to small group associations, including, but not limited to, chambers of commerce, community health organizations, small businesses, consumer advocacy groups, and churches. Potential respondents are asked to take the survey online or go to a location with Internet access (e.g. local libraries). To date, MID has received over 300 responses from small employers and stakeholders and 500 responses from employees. The survey contains 25 questions and takes less than 10 minutes to complete. The following are the links for each group:

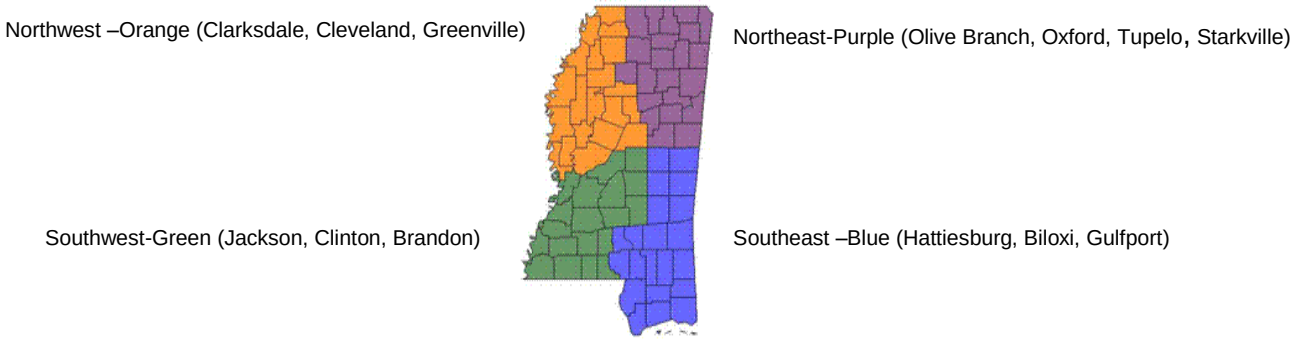
- Provider: http://cicero.qualtrics.com/SE/?SID=SV_eaNMW4ZuEJVIFjm
- Advocacy: http://cicero.qualtrics.com/SE/?SID=SV_bjXfUsbKPs90hMM
- Broker: http://cicero.qualtrics.com/SE/?SID=SV_aY7yPw9vEr74CEI
- Small business: http://cicero.qualtrics.com/SE/?SID=SV_71kt5YDXUUBvpLS
- Individual / Employee: http://cicero.qualtrics.com/SE/?SID=SV_9RlK3Y2MFHOyPFG

The results of the online survey will help guide Mississippi's efforts in the development and implementation of the Exchange. A final report on the results will be submitted in

the next quarterly report. Sample questions from the survey are attached hereto as Attachment "E".

4. Name of Milestone: Town Hall Meetings
Timing: Quarter III
Description:

In late June, MID staff and consultants conducted a weeklong series of Town Hall meetings around the State. This was a major accomplishment for obtaining stakeholder input and promoting public awareness of an Exchange. The Grant Project Director, grant staff, and Mississippi Insurance Department staff played a key role in making this project a success. The meetings included a series of 13 public forums in major cities around the State, including: Meridian, Starkville, Tupelo, Olive Branch, Oxford, Clarksdale, Cleveland, Greenville, Jackson, Pearl, Clinton, Hattiesburg, and Gulfport.



Over 500 small group representatives and individuals attended the meetings and participated in an interactive real-time survey. Participants used "response clickers" to answer various questions posed during a PowerPoint presentation. Immediate results from their responses were displayed during the presentation and discussions emerged. A formal report on the outcome from the meetings will be provided in the next quarterly report. Materials for the Town Hall meetings are attached hereto as Attachment "F".

5. Name of Milestone: Exchange Public Awareness
Timing: Quarter III
Description:

Several articles were published in local and national papers regarding Mississippi's efforts to plan for a State-based health insurance Exchange. Copies of newspaper articles are attached hereto as Attachment "G".

6. Name of Milestone: Exchange Public Awareness/Travel to Meetings
Timing: Quarter III
Description:

In April 2011, the Grant Project Director gave a presentation on Health Insurance Exchanges to over 100 participants at the third annual Mississippi Hospital Association Health Law Conference.

In May, the Grant Project Director along with two other grant staff attended the United States Department of Health and Human Services ("HHS") Exchange Planning Grantee Meeting in Denver, Colorado. This was an excellent opportunity to meet HHS staff and representatives from other states. MID's Grant Project Director shared information on Mississippi's plans for alternate regulatory authority for the establishment of a state Exchange during one of the general sessions.

MID grant staff also attended the Utah Health Exchange Invitation Only Event in Salt Lake City, Utah on May 12-13, 2011. Excellent presentations on Utah's approach and experience in building an Exchange were given by State leaders and Utah Exchange staff.

III. Program Integration

1. Name of Milestone: Meetings with the Governor's Staff
Timing: Quarter III
Description:

MID staff conferred with the Governor's health policy advisory staff several times during the third quarter to continue open communication on the Exchange planning process.

2. Name of Milestone: Meetings with Medicaid Staff
Timing: Two meetings during Quarter III
Description:

MID staff conducted two meetings with the Mississippi Division of Medicaid staff to continue discussions on the planning activities for an Exchange and the need for program integration.

IV. Resources & Capabilities

1. Name of Milestone: Assessment of Resources and Capabilities
Timing: Quarter III
Description:

MID began addressing this area with a strategic planning project in February 2011. MID consultants continue to assess Mississippi's resources and identify key planning steps to define all Exchange components, assess current staff levels and capabilities to determine the additional resources needed for Exchange implementation. MID will identify the gaps between Mississippi's resources and ideal Exchange implementation needs and provide recommendations for filling the gaps. Results will be provided in the fourth quarterly report.

V. Governance

1. Name of Milestone: Legislation/Regulatory Actions
Timing: Quarter III
Description:

The Mississippi Comprehensive Health Insurance Risk Pool Association ("Association"), a nonprofit legal entity, was created by the Mississippi Legislature in 1991. Due to the Association's infrastructure, expertise and exceptional record of providing health coverage to the citizens of this State, Mississippi believes that the Association is the logical platform for implementing and operating Mississippi's Exchange. The enabling legislation for the Association is found in Mississippi Code Annotated 83-9-201 *et.seq.*, 1972 as amended. The legislative purpose of the Association is, among other things, to establish a mechanism to allow for the availability of a health insurance program and to allow for the availability of health insurance coverage to those

citizens of Mississippi who desire to obtain or continue health insurance coverage under any state or federal program designed to enable persons to obtain or maintain health insurance coverage. The statutory authority for the Association includes authority to serve as a mechanism to provide health and accident insurance coverage to citizens of this state under any State or Federal program designed to enable persons to obtain or maintain health insurance coverage. Legal counsel for the Association, as well as outside legal counsel for MID, issued written legal opinions stating that the Association has legal authority to establish and operate an Exchange in Mississippi. The Association adopted initial amendments to its Amended and Restated Articles, Bylaws and Operating Rules approving the establishment and operation of a Mississippi Exchange, and the Commissioner approved said amendments. A copy of the amendments, along with a complete copy of the Association's Amended and Restated Articles, Bylaws and Operating Rules, are attached hereto as Attachment "H".

2. Name of Milestone: Governance
Timing: Quarter III
Description:

Special consideration has been given to ensure that the governance of the Exchange is guided by appropriate board members that possess the knowledge and experience necessary to establish, manage and operate the Exchange. The Association is operated subject to the supervision and approval of a nine-member board of directors and is subject to regulation by the Mississippi Commissioner of Insurance. The Commissioner has determined that the governing board of the Association, as currently constituted, is appropriate and highly desirable to operate Mississippi's Exchange.

By statute, the Association's board of directors consists of:

1. Four (4) members appointed by the Insurance Commissioner. Two (2) of the Commissioner's appointees shall be chosen from the general public and shall not be associated with the medical profession, a hospital or an insurer. One (1) appointee shall be a representative of medical providers. One (1) appointee shall be a representative of health insurance agents. Any board member appointed by the Commissioner may be removed and replaced by him at any time without cause.

2. Three (3) members appointed by the participating insurers, at least one (1) of whom is a domestic insurer.
3. The Chair of the Senate Insurance Committee and the Chair of the House Insurance Committee, or their designees, who shall be nonvoting, ex officio members of the board. (See Mississippi Code Section 83-9-211; Article V, Section 2 of Amended and Restated Articles, Bylaws and Operating Rules)

The Association's Amended and Restated Articles, Bylaws and Operating Rules contain a conflict of interest provision and the Association has a Conflicts of Interest and Business Ethics Policy. Article V, Section 14 of the Amended and Restated Articles, Bylaws and Operating Rules is included in Attachment "H," as well as the Association's Conflicts of Interest and Business Ethics Policy. These conflict of interest provisions are consistent with standard corporate governance principles.

3. Name of Milestone: Legal Consultants
Timing: Quarter III
Description:

Legal Consultants continued to provide advice to MID regarding PPACA and related regulations.

VI. Providing Assistance to Individuals and Small Businesses

1. Name of Milestone: Mississippi Consumer Assistance Programs
Timing: Quarter III
Description:

Current consumer assistance programs fill the void that exists between the average consumer and the complex world of insurance plans, public programs and health providers. MID has been working with an existing consumer assistance program, Health Help, that offers informative materials and presentations to groups and individuals, maintains a website at http://healthhelpms.org/, provides a toll free hotline, and has trained staff who are knowledgeable about public and private resources. They also provide links to health condition groups, medical resources, consumer organizations, and FAQs about Medicaid, CHIP and consumers' rights. Health Help frequently uses the

HHS website www.healthcare.gov to navigate consumers to health insurance options that are available to them. Health Help also works with the Mississippi Attorney General's office assisting consumers with their complaints. In addition, they provide Health Help for Kids ("HHK"), a program that provides comprehensive protection and advocacy services to parents enrolling their children in public healthcare programs, such as CHIP. The HHK program provides a detailed outreach plan to enroll eligible populations and provides materials including brochures, fact sheets and action guides to promote the availability of CHIP services.

Barriers, Lessons Learned, and Recommendations to the Program

Barriers:

The major barriers associated with the implementation of this project during the third reporting period continue to include time constraints. MID has, however, moved forward with planning an Exchange, partnering with the Mississippi Comprehensive Health Insurance Risk Pool Association to begin the process for Exchange implementation.

Lessons Learned:

MID continues to participate in weekly conference calls to stay informed of national developments and other states' activities regarding exchange issues. Information gained from other States and the NAIC continues to help with ongoing issues that continue to arise on a daily basis.

Technical Assistance

MID does not require any technical assistance at this time.

Draft Exchange Budget

MID drafted an Exchange Budget for the initial start-up costs and development of the Exchange web portal. The following draft budget was recently submitted to HHS in Mississippi's application for the *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*:

MISSISSIPPI
DRAFT EXCHANGE BUDGET

FFY 2012

A. SALARIES, WAGES	**$ 97,750**
B. FRINGE BENEFITS	
D. EQUIPMENT	**$ 37,000**
E. SUPPLIES	**$ 7,700**
F. TRAVEL	**$ 113,355**
H. CONTRACTUAL COSTS	$ 682,713
CONSULTANT COSTS	$ 5,581,700
CONSUMER ASSISTANCE PROGRAMS	$ 1,480,000
INFORMATION TECHNOLOGY	
• Web Portal	$ 1,720,000
• Business Operations	$ 1,250,000
• Financial Management	$ 815,000
• Customer Support	$ 1,600,000
• Broker Management	$ 550,000
• Governance	$ 550,000
• Small Business	$ 2,400,000
• Compliance &Reporting	$ 3,300,000
• Churn Management	$ 750,000
• Stakeholder Consultation	$ 700,000
SUB TOTAL	**$21,379,413**
I. DIRECT COSTS	**$21,635,218**
J. INDIRECT COSTS	**-0-**
TOTAL	**$21,635,218**

Work Plan

MID continues to build on its Exchange planning grant work plan (attached hereto as Attachment "A"), which reflects the accomplished milestones to date. MID recently defined the actual implementation activities and work plan in its recent application for the HHS exchange implementation funding opportunity to states. The implementation work plan builds on the activities outlined in the planning grant work plan.

Collaborations/Partnerships

MID continues to develop partnerships outside the Department and continues to collaborate with various groups and interested parties to work together for exchange planning. MID is working with the following groups:

1. **Name of Partner:** Governor's Health Policy Advisory Staff

   Organizational Type of Partner:

   - State agency

   Role of Partner in Establishing Insurance Exchange:

   The staff provides information on the Governor's views and input regarding an Exchange. The Governor has been a strong supporter for implementing a State-based health Exchange for the last three years.

   Accomplishments of Partnership:

   MID has a very strong relationship with this partner, which has helped move the grant activities forward.

   Barriers/Challenges of Partnership:

   None at this time.

2. **Name of Partner:** Division of Medicaid Executive Director and Staff

   Organizational Type of Partner:

   - State Agency

   Role of Partner in Establishing Insurance Exchange:

   Medicaid provides funding for medical services for low-income individuals. This partnership is essential in the coordination of eligibility and enrollment with other state programs and the Exchange.

   Accomplishments of Partnership:

   MID continues to meet with Medicaid staff to ensure collaboration and participation in the planning process for state health program integration with the Exchange. The Medicaid IT staff participated in the IT Gap Analysis conducted for this project.

   Barriers/Challenges of Partnership:

   None at this time.

3. **Name of Partner:** Mississippi Association of Health Underwriters ("MAHU")

Organizational Type of Partner:

- Association of licensed agents and brokers who sell and market health plans sold in Mississippi.

Role of Partner in Establishing Insurance Exchange:

MAHU is a strong advocate in ensuring continued access to the services of state-licensed health insurance agents, brokers, and consultants who assist individuals and employers of all sizes purchase health insurance.

Accomplishments of Partnership:

MID continues to utilize this group as key stakeholders.

Barriers/Challenges of Partnership:

None at this time.

4. **Name of Partner:** Blue Cross/Blue Shield of Mississippi

Organizational Type of Partner:

- Private Insurance Carrier

Role of Partner in Establishing Insurance Exchange:

This company is the administrator for the State of Mississippi's State and School Employees' Health Insurance Plan.

Accomplishments of Partnership:

The company has extensive expertise in all aspects of health program management along with a positive working relationship with MID.

Barriers/Challenges of Partnership:

None at this time.

5. **Name of Partner:** Mississippi Comprehensive Health Insurance Risk Pool Association ("Association")

Organizational Type of Partner:

- Nonprofit entity

Role of Partner in Establishing Insurance Exchange:

The Association is the entity that will establish and operate an Exchange in Mississippi. The Association provides health coverage to citizens of Mississippi that desire to purchase such

coverage but who cannot obtain it because of health conditions and to people who are Health Insurance Portability and Accountability Act ("HIPAA") eligible.

Accomplishments of Partnership:

This partnership is the most significant as Mississippi moves forward with the planning of an Exchange. The Association's Executive Director participates in the stakeholder meetings and regular weekly calls with MID and its consultants. On-going collaboration and regular communications have enabled Mississippi to move forward with the planning and future establishment of an Exchange.

Barriers/Challenges of Partnership:

None at this time.

OMB #0938-1101

ATTACHMENT A

MISSISSIPPI INSURANCE DEPARTMENT

EXCHANGE ESTABLISHMENT WORK PLAN

CORE AREA	QUARTER II 2011	QUARTER III 2011	QUARTER IV 2011
I. Background Research	▪ Research and data analysis of insurance market conducted in the second quarter.	▪ Analysis and summary completed. Recommendations from consultants provided to plan for the structure and design of an Exchange (Reports Attached).	▪ None planned.
II. Stakeholder Consultation	▪ Continued stakeholder involvement and meetings, expanding participation from groups from all regions of the State. ▪ In-depth interviews were conducted with over 60 stakeholders to ensure successful program integration. ▪ Plans are underway to identify a process for consultation with and input from the federally recognized Indian Tribal Government in Mississippi on the establishment and operation of the Exchange.	▪ Continued stakeholder involvement and meetings, expanding participation from groups from all regions of the State. ▪ Over 500 people participated in 13 Town Hall meetings conducted in regions around the State. ▪ Online Small Employer Survey and Employee Survey targeting small businesses, employees, and stakeholders throughout the State are currently underway. Over 800 responses received.	▪ Additional interviews with stakeholders in various regions of the State. ▪ Conduct Phase II Town Hall Meetings.
III. Legislative/Regulatory Action	▪ Legislative action for the establishment of an exchange was attempted in the second	▪ The Mississippi Comprehensive Health Insurance Risk Pool Association ("Association") will	

	quarter.	establish and operate the Exchange.	
IV. Governance	▪ Basic Governance for the Exchange has not been determined.	▪ The Commissioner determined that the governing board of the Association as currently constituted is appropriate and highly desirable to operate Mississippi's Exchange. ▪ The Association operates subject to the supervision and approval of a nine-member board of directors and is subject to regulation by the Mississippi Commissioner of Insurance.	
V. Program Integration	▪ In-depth research on current and past Exchanges conducted to provide recommendations for a successful Mississippi Exchange. ▪ Focus groups, individual sessions and conference calls were conducted to ensure program integration is expanded. Over 60 stakeholders participated in the March 2011 in-depth interviews.	▪ Continued to identify challenges in the program integration process, strategies for mitigating the issues, and timelines for completion. ▪ Continued to determine roles and responsibilities related to eligibility determination, verification, and enrollment. ▪ Continued to devise a strategy for limiting adverse selection between the Exchange and the outside market.	
VI.Exchange IT Systems	▪ IT Gap Analysis was completed in the second quarter.	▪ Continued review of the IT gap analysis.	▪ Develop a process to capture updates and changes to business and system requirements, development, testing, and implementation

			of the Exchange IT Systems.
VII. Financial Management	▪ This area will be more defined as the strategic planning moves forward.	▪ The Mississippi Comprehensive Health Insurance Risk Pool Association ("Association") will provide financial management activities for the Exchange.	▪ Plan for hiring experienced accountants to support financial management activities of the Exchange, which include responding to audit requests and inquiries of the Secretary and the Government Accountability Office as needed.
VIII. Oversight & Program Integrity	▪ This area will be more defined as the strategic planning moves forward.	▪ The Mississippi Comprehensive Health Insurance Risk Pool Association ("Association") will provide oversight and ensure program integrity for the Exchange.	▪ Ensure process for the prevention of waste, fraud, and abuse is in place.
IX. Health Insurance Market Reforms	▪ This area will be more defined as the strategic planning moves forward.	▪ Continued to plan and implement steps for insurance market reforms under Subtitles A and C of PPACA.	▪ Implement steps to enforce PPACA consumer protections.
X. Provide Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints	▪ This area will be more defined as the strategic planning moves forward.	▪ Worked with existing consumer assistance program to ensure services are sufficient to assist with filing of appeals and complaints, and provide information about consumer protections and alternative services.	▪ Plan to expand current consumer assistance programs in regions around the State.

XI. Business Operations of the Exchange	This area will be more defined as the strategic planning moves forward.	▪ Began addressing the minimum functions of an exchange: ▪ Call Center ▪ Exchange Website and Calculator ▪ Quality Rating System ▪ Navigator Program ▪ Eligibility Determination ▪ Enrollment Process ▪ Applications and Notices ▪ Individual Responsibility Determinations ▪ Administration of Tax Credits and Cost-sharing Reductions ▪ Mediation and Notification of Appeals ▪ IRS Reporting ▪ Outreach and Education ▪ Choice Vouchers ▪ Risk Adjustment ▪ SHOP-Specific	▪ Begin developing standards based on the identified planning activities that will be required for certification of a qualified health plan.

LEAVITT
PARTNERS

ATTACHMENT B

Mississippi Data Report I

Demographic, Social, and Economic Information for Mississippi Counties and Select Cities

Developed for the

Mississippi Insurance Department

05/27/2011

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The purpose of this report is to provide the Mississippi Insurance Department (MID) with demographic, social, and economic information for all counties and select cities in the state. These data will add to the background research being used by MID in its exchange planning process. The data presented in this report will inform MID of the demographic, social, and economic situation in each county or city. This will in turn allow the Department to develop education and implementation strategies specific to those areas, supporting the establishment of a Health Insurance Exchange that meets the objectives of the state and the needs of Mississippi residents.

Data are provided for each of Mississippi's 82 counties as well as 16 select cities. The 16 cities included in this report are the cities in which stakeholder meetings will be held in June 2011. Because more current data on health insurance coverage rates are provided in a separate report, this report focuses on the demographic, social, and economic factors outside of health that affect a population's well-being. Pairing this information with health insurance coverage data provides a complete picture of the possible challenges MID will face in each area as they inform, educate, and ultimately enroll individuals in an exchange.

About the Data

Data used in this report come from the U.S. Census Bureau's 2005-2009 American Community Survey 5-year Estimates. Survey data from five years is averaged to reduce the sampling error that arises from small county and city populations. While the five year estimate isn't ideal for showing current economic conditions, it provides complete and accurate data that can be used in county-to-county comparisons.

Demographic Data

Population

The state of Mississippi is home to about 2.9 million people. The percent of its population under 18 years of age is 26.2%, slightly above the national average of 24.6%.According to the data, Hinds County is the largest county in Mississippi, with roughly 250,000 people. Issaquena County is the smallest with just slightly more than 2,000 people. Tunica County, however, has the largest percent of the population under 18 years of age (31.3%). Other counties with a high proportion of children include Leake, Coahoma, Issaquena, and Humphreys County. Lafayette County has the smallest percent of the population under 18 years of age (19.1%).

Median Age

Median age is a single index that summarizes the age distribution of a population. It is the age that divides a population into two numerically equal groups; half of the population is younger than the median age and half are older. This provides a good general indication of whether the majority of the population is young or old.

The median age in Mississippi is 35, about two years younger than the national median age of 37. Mirroring the national trend, women in Mississippi tend to outlive men with a median age of 37 vs. 33. However, the distribution between women and men is larger in Mississippi than it is at the national level by about one year. Carroll County has highest median age at 43 and Oktibbeha has the lowest median age at 24.

Percent of Population by Race and Ethnicity

Close to 60% of Mississippi's population is White, with the second largest minority group being Black or African American (37%). This is much higher than the national average of 12%. Other minority groups only make up a small proportion of Mississippi's population, less than 1% each. Mississippi's Hispanic population is also small compared to the national average (2% vs. 15%).

Most counties have the same general racial distribution as the state; however, in 24 counties, African Americans make up the largest share of the population. In Jefferson County, for example, 87% of the population is African American. Scott County has the largest proportion of Hispanic persons in its population, roughly 10%.

Social Data

Percent of Population by Citizenship Status

Only 1.3% of Mississippi's population is not a U.S. citizen compared to 7.1% nationally. Less than 1% of the population is a U.S. citizen by naturalization, meaning there are very few immigrants in Mississippi. Scott County has the largest percent of non-U.S. citizens in its population, 5.9%. Tunica County and Tallahatchie County also have a relatively high percent for Mississippi, 3.5% and 3.2% respectively.

Population Mobility

The mobility of Mississippi's population is about average compared to other states (Mississippi's percentages roughly equal the national average). About 16% of the population moved within the last year, but the majority of those who moved, moved within the same county (9.2%). About 4% moved from a different county, but stayed in Mississippi. Close to 3% moved to Mississippi from a different state and 0.3% moved to Mississippi from abroad. These numbers indicate there is limited mobility within or to the state, which is beneficial from a program eligibility and enrollment perspective.

Lafayette County has the highest rate of mobility, with 30.6% of its population moving within the last year. Oktibbeha County and Tunica County also have high rates of mobility. Benton County has the lowest rate of mobility in Mississippi, with only 5.9% of its population moving within the last year. Noxubee County and Smith County also have low rates of mobility.

Family Status

The majority of households in Mississippi consist of married-couple families (46.5%), which is slightly lower than the national average (49.7%). About 23% of Mississippi's households are single-parent families, compared to 17% at the national level. In terms of non-family households, the majority are single person households rather than non-family households (households where the members are not related by birth, marriage, or adoption).

Greene County has the largest percent of married-couple households (64.6%). George County's proportion of married-couple households is also above 60%. Tunica County has the smallest percent of married-couple households (25.9%). There are nine counties in which the share of single-parent households is greater than the share of married-couple households (Claiborne, Coahoma, Holmes, Jefferson, Leflore, Quitman, Sunflower, Tunica, and Washington County).

Educational Attainment

In terms of educational attainment, the majority of adults in Mississippi have a high school diploma, the equivalent, or less. Only 48% of the population 18 years and over have gone onto college and 24% of the population have received a degree (an Associate's degree or higher). Close to 7% of the population have less than a 9th grade education (compared to 6% nationally) and 14% of the population attended some high school, but did not receive a diploma (10% nationally).

Tallahatchie County has the largest share of adults with less than a 9th grade education (15.1%), while Lafayette County has the smallest share (3.8%). Conversely, Lafayette has one of the highest rates of adults with a graduate or professional degree (Oktibbeha has the highest rate with 13.3%). Madison County's population has the largest share of adults with any degree.

Language Spoken At Home

A very low percent of the population in Mississippi speak English less than "very well" (1.5% vs. 8.6% nationally). This is reflective of the population's racial distribution and citizenship status. Over 96% of Mississippians speak only English at home. These numbers indicate language is not a large barrier when it comes to educating and enrolling individuals in the exchange; however, the fact that such a large share of the population in Mississippi have a high school education or less is concerning and should be accommodated for in education and enrollment strategies. Scott County has the largest share of non-English speakers in its population.

Economic Data

Poverty Rate

The percent of Mississippi's population living in poverty is much higher than the national average (21.4% vs. 13.5%). The distribution of poverty by age, however, mirrors the national trend. The Census Bureau data show 34.1% of children under five years, 28.6% of children five to 17 years, 24.8% of adults 18 to 34 years, 15% of adults 35 to 64 years, and 16.1% of adults over age 65 live in poverty.

Holmes County and Issaquena County have the highest poverty rates in Mississippi (42.7%). This is followed by Leflore County where 41.6% of its population lives in poverty. DeSoto County has the lowest poverty rate in the state (9.4%), followed by Rankin County (9.9%) and George County (12.6%). The poverty statistics in ACS adhere to the standards specified by the Office of Management and Budget. The Census Bureau uses a set of dollar value thresholds that vary by family size and composition to determine who is in poverty.

Median Household and Family Income

Mississippi's median household income is about $37,000 (in 2009 inflation-adjusted dollars). This is significantly below the national average of $51,000. DeSoto County has the highest median household income, about $58,000, which is $7,000 more than the national average. Only three counties in Mississippi have median household incomes above than the national average—DeSoto, Madison, and Rankin. Issaquena County has the lowest median household income in Mississippi ($20,000).

Median family income, while more than median household income, is still below the national average at $46,000 vs. $62,000. Household income is based on the incomes of the householder and any other people living in the same household, regardless of whether they are related. Because many households consist of one person, household income is typically less than family income. Family income is based on the incomes of the householder and any other people living in the same household who are related by birth, marriage, or adoption. Because different methodologies are used to calculate each measure, it is useful to examine both measures.

Percent of Households that Receive Food Stamps or SNAP Benefits

The percent of households that receive food stamps in Mississippi is about six percentage points higher than the national average (14.8% vs. 8.5%). Some of this difference is due to the fact that Mississippi has a much smaller population than the United States, but it also reflects the economic trends outlined above. The county with the largest percent of households that receive food stamps is Humphreys County with 33%. The county with the smallest percent is Lafayette County with 5.3%.

Unemployment Rate

Mississippi's unemployment rate is about two percentage points higher than the national average (9.2% vs. 7.2%). Noxubee County has the highest unemployment rate in the state (22.4%), while Lamar County has the lowest unemployment rate (4.6%).

Comparing the unemployment rate by age across counties shows Noxubee County has the largest share of the population age 45 to 64 that is unemployed (13.3%). Unemployment in this age group is difficult to address because people tend to be more specialized in their skills and therefore require new training to be marketable. However, training is also more difficult for this age group because they are older and have fewer career options. Franklin County has the lowest share of the population age 45 to 64 that is unemployed (1.3%)

Occupied vs. Vacant Housing Units

The condition of the housing market in a particular area is an indication of the area's overall economic viability. The number of vacant homes, for example, can indicate whether the local economy has been strong enough to support its residents. Mississippi has a slightly higher percent of vacant homes than the national average, but only by about two percentage points (13.5% vs. 11.8%). The county with the largest percent of vacant homes is Wilkinson County (31.7%). The county with the smallest percent is DeSoto County (6.4%).

Owned vs. Rented Housing Units

Of the occupied housing units in Mississippi, 70.5% are owner occupied and 29.5% are renter occupied. At the national level, 66.9% of housing units are owned and 33.1% are rented, meaning a greater share of Mississippi's population own homes than the national population. Green County has the largest share of home owners (88.6%) and Tunica County has the lowest share (47.2%). This is not surprising given Tunica County's young and mobile population.

Median Value of Occupied Housing Units

The median home value in Mississippi is lower than the national median home value ($91,400 vs. $185,400), which partly explains why the rate of home ownership in Mississippi is higher than the national rate. Median gross rent in Mississippi is also lower than the national level ($622 vs. $817). Madison County has the highest median home value, $171,400; which is still less than the national value. Quitman County has the lowest median home value in Mississippi, $44,600. DeSoto County has the highest rent ($876 per month) and Franklin County has the lowest rent ($347 per month).

Owner Costs as a Percent of Household Income

Excessive owner costs are considered to be those that exceed 30% of household income. Median selected monthly owner costs as a percent of household income in Mississippi are 23%, which is slightly lower than the national level of 25%. Three counties in Mississippi have "excessive" owner costs, or costs which exceed 30% of household income: Wilkinson County, Issaquena County, and Holmes County. Holmes County has the highest median monthly owner costs (38.4%). Warren County has the lowest median monthly owner costs (20.2%).

Selected monthly owner costs include the sum of payments for mortgages, deeds of trust, or similar debts on the property (including payments for the first mortgage, second or junior mortgages, and home equity loans); real estate taxes; fire, hazard, and flood insurance on the property; utilities (electricity, gas, water, and sewer); and fuels (oil, coal, kerosene, wood, etc.). It also includes, where appropriate, monthly condominium fees.

Population

	Population	Population under 18 years	Percent of Population under 18 years
United States	301,461,533	74,182,525	24.6%
State of Mississippi	2,922,240	764,132	26.2%
Adams County	31,475	7,834	24.9%
Alcorn County	35,583	8,442	23.7%
Amite County	13,293	3,075	23.1%
Attala County	19,558	5,032	25.7%
Benton County	7,978	2,032	25.5%
Bolivar County	37,266	9,907	26.6%
Calhoun County	14,533	3,487	24.0%
Carroll County	10,301	2,127	20.7%
Chickasaw County	18,864	5,205	27.6%
Choctaw County	9,106	2,270	24.9%
Claiborne County	10,910	2,678	24.6%
Clarke County	17,333	4,439	25.6%
Clay County	20,881	5,526	26.5%
Coahoma County	27,571	8,491	30.8%
Copiah County	29,150	7,451	25.6%
Covington County	20,315	5,560	27.4%
DeSoto County	148,795	42,516	28.6%
Forrest County	78,650	18,513	23.5%
Franklin County	8,287	2,065	24.9%
George County	21,926	6,355	29.0%
Greene County	13,699	2,985	21.8%
Grenada County	23,002	6,089	26.5%
Hancock County	41,135	9,650	23.5%
Harrison County	180,901	45,749	25.3%
Hinds County	248,782	68,369	27.5%
Holmes County	20,481	6,127	29.9%
Humphreys County	9,985	3,000	30.1%
Issaquena County	2,130	646	30.3%
Itawamba County	23,006	5,463	23.8%
Jackson County	131,713	34,513	26.2%
Jasper County	17,944	4,679	26.1%
Jefferson County	8,971	2,095	23.4%
Jefferson Davis County	12,721	3,180	25.0%
Jones County	66,877	17,127	25.6%
Kemper County	9,998	2,381	23.8%
Lafayette County	43,025	8,218	19.1%
Lamar County	47,307	12,936	27.3%
Lauderdale County	77,966	19,996	25.7%
Lawrence County	13,258	3,394	25.6%
Leake County	22,782	7,025	30.8%
Lee County	80,099	21,658	27.0%

Leflore County	35,033	9,691	27.7%
Lincoln County	34,315	8,855	25.8%
Lowndes County	59,499	15,958	26.8%
Madison County	89,151	24,499	27.5%
Marion County	25,527	6,958	27.3%
Marshall County	36,394	9,033	24.8%
Monroe County	37,089	9,277	25.0%
Montgomery County	11,412	2,878	25.2%
Neshoba County	29,949	8,489	28.3%
Newton County	22,403	5,783	25.8%
Noxubee County	11,814	3,368	28.5%
Oktibbeha County	43,630	8,621	19.8%
Panola County	35,148	9,711	27.6%
Pearl River County	56,113	13,954	24.9%
Perry County	12,087	3,233	26.8%
Pike County	39,606	10,928	27.6%
Pontotoc County	28,775	7,776	27.0%
Prentiss County	25,594	6,075	23.4%
Quitman County	8,821	2,511	28.5%
Rankin County	137,817	34,902	25.3%
Scott County	29,137	8,124	27.9%
Sharkey County	5,184	1,325	25.6%
Simpson County	27,903	7,437	26.7%
Smith County	15,889	4,294	27.0%
Stone County	15,734	3,888	24.7%
Sunflower County	30,604	7,895	25.8%
Tallahatchie County	13,201	3,516	26.6%
Tate County	26,888	6,845	25.5%
Tippah County	21,439	5,505	25.7%
Tishomingo County	19,060	4,270	22.4%
Tunica County	10,406	3,260	31.3%
Union County	26,939	7,045	26.2%
Walthall County	15,304	4,007	26.2%
Warren County	48,596	13,537	27.9%
Washington County	55,811	16,291	29.2%
Wayne County	20,892	5,669	27.1%
Webster County	9,834	2,389	24.3%
Wilkinson County	10,200	2,488	24.4%
Winston County	19,543	4,929	25.2%
Yalobusha County	13,646	3,446	25.3%
Yazoo County	28,296	7,187	25.4%

Population

	Population	Population under 18 years	Percent of Population under 18 years
Biloxi city	46,909	10,230	21.8%
Clarksdale city	18,244	5,659	31.0%
Cleveland city	12,232	2,951	24.1%
Greenville city	36,264	10,864	30.0%
Gulfport city	70,238	18,023	25.7%
Hattiesburg city	51,068	10,227	20.0%
Jackson city	176,799	50,484	28.6%
Meridian city	39,644	10,837	27.3%
Ocean Springs city	17,283	4,050	23.4%
Olive Branch city	30,476	8,424	27.6%
Philadelphia city	7,719	1,973	25.6%
Southaven city	42,370	12,692	30.0%
Starkville city	23,630	4,377	18.5%
Tunica town	1,600	221	13.8%
Tupelo city	35,824	9,798	27.4%
Vicksburg city	25,245	7,062	28.0%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Median Age

	Total	Male	Female
United States	36.5	35.2	37.9
State of Mississippi	35	33.2	36.7
Adams County	40.8	38.8	42.1
Alcorn County	38.8	36.5	40.6
Amite County	41.4	41.3	41.5
Attala County	38.7	37.2	40.2
Benton County	38.8	35.8	40.5
Bolivar County	31.6	29.3	34.2
Calhoun County	39.4	36.9	41.6
Carroll County	43.2	41.7	43.9
Chickasaw County	36.8	35.8	38
Choctaw County	39.9	41.3	38.9
Claiborne County	29.1	26.9	31.3
Clarke County	39.8	38.1	41.2
Clay County	36.8	33.6	38.8
Coahoma County	31.1	27.4	34.4
Copiah County	35.1	33	38.1
Covington County	35.5	33.8	37.7
DeSoto County	34.3	33.2	35.3
Forrest County	28.5	27.7	29.4
Franklin County	40.6	36.8	43
George County	33.5	31.2	35.6
Greene County	36	33.9	38.4
Grenada County	37.4	35.2	38.9
Hancock County	41.3	40.6	42.2
Harrison County	35.1	33.7	36.4
Hinds County	32.4	30.4	34.4
Holmes County	30.2	27.5	33.7
Humphreys County	32.5	28.8	35.1
Issaquena County	32.2	37.3	28.5
Itawamba County	38.6	37.2	39.7
Jackson County	36.6	35.9	37.1
Jasper County	37.6	35.5	39.4
Jefferson County	38.2	34.4	41.4
Jefferson Davis County	38.6	35.4	40.9
Jones County	36.1	33.5	38.4
Kemper County	37.9	36.2	39.9
Lafayette County	26.4	25.4	27.3
Lamar County	32.8	31.5	34.2
Lauderdale County	35.4	33.2	38.3
Lawrence County	37.5	35	40.5
Leake County	32.5	29.9	33.9
Lee County	35.6	33.9	36.7

Leflore County	30.9	28.7	34.1
Lincoln County	37.3	35.4	38.9
Lowndes County	34.8	32.8	36.6
Madison County	34.8	33.3	36.1
Marion County	36	32.8	38.6
Marshall County	36	34.4	38
Monroe County	38.5	36.2	39.9
Montgomery County	39.9	36.5	41.8
Neshoba County	35.1	33.2	36.6
Newton County	36.2	33.3	39
Noxubee County	35.3	30	38
Oktibbeha County	24.3	23.8	24.7
Panola County	34.4	32.4	36.4
Pearl River County	37.8	36.9	38.5
Perry County	38.8	38.4	39.1
Pike County	36.1	33.9	38.3
Pontotoc County	35.7	34.5	37.4
Prentiss County	38	35.7	39.9
Quitman County	34.5	29.5	39.4
Rankin County	35.1	33.9	36.2
Scott County	34.6	32.2	37.2
Sharkey County	35.1	30.4	39.7
Simpson County	36.5	34.1	37.6
Smith County	37.3	35.3	38
Stone County	35.4	34.2	37.9
Sunflower County	32.1	30.1	34.3
Tallahatchie County	35.7	34.4	37.6
Tate County	35.5	32.9	37.7
Tippah County	37.7	36.4	38.8
Tishomingo County	42.1	40.9	43.6
Tunica County	30.4	31.6	28.9
Union County	36.7	34.5	38.2
Walthall County	36.2	33.8	38.3
Warren County	35.7	34.1	37.4
Washington County	33.9	30.8	36
Wayne County	36	33.9	38.1
Webster County	39.7	37.8	40.7
Wilkinson County	35.4	31.6	43
Winston County	38	35.2	40.6
Yalobusha County	40.2	37.7	41.7
Yazoo County	34.8	34	36.6

Median Age

	Total	Male	Female
Biloxi city	35.7	33.5	38.5
Clarksdale city	30.3	25.3	34.7
Cleveland city	28.6	27.6	30.9
Greenville city	33.5	29.5	35.5
Gulfport city	33.5	31.8	35.1
Hattiesburg city	25.9	25	27.2
Jackson city	31.1	29.1	33
Meridian city	34.4	32.9	36.1
Ocean Springs city	42.3	41.6	42.9
Olive Branch city	35.5	34.8	36.3
Philadelphia city	35.4	34.8	35.6
Southaven city	32	30.1	33.7
Starkville city	23.9	23.7	24.2
Tunica town	53.8	48	57.5
Tupelo city	34.9	33.6	36.2
Vicksburg city	34.5	31.1	36.7

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of Population by Race and Ethnicity

	Race							Ethnicity
	White	Black or African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Pacific Islander	Some other race	Two or more races	Hispanic or Latino
United States	74.5%	12.4%	0.8%	4.4%	0.1%	5.6%	2.2%	15.1%
State of Mississippi	60.0%	37.0%	0.4%	0.8%	0.0%	0.8%	0.9%	2.1%
Adams County	43.0%	56.4%	0.3%	0.1%	0.0%	0.1%	0.2%	1.2%
Alcorn County	87.4%	11.5%	0.1%	0.2%	0.0%	0.1%	0.8%	2.2%
Amite County	55.1%	43.9%	0.5%	0.1%	0.0%	0.2%	0.2%	0.5%
Attala County	56.7%	41.5%	0.0%	0.1%	0.0%	1.2%	0.4%	1.9%
Benton County	62.4%	37.1%	0.0%	0.1%	0.0%	0.2%	0.2%	0.3%
Bolivar County	32.1%	66.2%	0.1%	0.5%	0.0%	0.4%	0.6%	1.6%
Calhoun County	69.8%	29.7%	0.1%	0.0%	0.0%	0.2%	0.2%	4.1%
Carroll County	64.7%	34.2%	0.0%	0.7%	0.0%	0.0%	0.4%	0.8%
Chickasaw County	56.3%	40.2%	0.2%	0.3%	0.0%	1.7%	1.2%	4.2%
Choctaw County	66.9%	32.4%	0.0%	0.6%	0.0%	0.0%	0.0%	0.0%
Claiborne County	14.3%	85.2%	0.0%	0.1%	0.0%	0.1%	0.3%	0.1%
Clarke County	63.5%	35.3%	0.0%	0.5%	0.0%	0.2%	0.5%	0.3%
Clay County	41.5%	56.6%	0.1%	0.2%	0.0%	0.3%	1.3%	0.2%
Coahoma County	24.3%	74.3%	0.2%	0.1%	0.0%	0.6%	0.4%	1.5%
Copiah County	46.7%	51.0%	0.1%	0.5%	0.0%	1.2%	0.5%	1.8%
Covington County	62.5%	35.4%	0.3%	0.6%	0.0%	0.6%	0.6%	1.1%
DeSoto County	76.3%	19.6%	0.2%	1.1%	0.1%	1.0%	1.7%	4.2%
Forrest County	61.3%	35.3%	0.3%	1.4%	0.0%	1.1%	0.7%	2.2%
Franklin County	61.5%	38.1%	0.1%	0.3%	0.0%	0.0%	0.0%	0.1%
George County	88.5%	9.9%	0.1%	0.2%	0.0%	0.1%	1.3%	2.5%
Greene County	70.7%	27.0%	0.1%	0.0%	0.0%	0.7%	1.5%	0.9%
Grenada County	56.7%	42.0%	0.0%	0.4%	0.0%	0.5%	0.3%	0.9%
Hancock County	89.6%	7.0%	0.2%	0.8%	0.3%	0.3%	1.7%	2.4%
Harrison County	70.0%	22.5%	0.5%	3.0%	0.1%	1.3%	2.6%	3.9%
Hinds County	32.4%	65.2%	0.2%	0.9%	0.1%	0.6%	0.8%	1.4%
Holmes County	18.1%	80.9%	0.3%	0.2%	0.0%	0.3%	0.3%	0.1%
Humphreys County	24.5%	74.0%	1.3%	0.0%	0.0%	0.0%	0.2%	0.9%
Issaquena County	38.7%	61.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Itawamba County	91.4%	6.9%	0.0%	0.3%	0.0%	0.5%	0.8%	1.2%
Jackson County	73.5%	22.2%	0.2%	2.0%	0.1%	0.7%	1.3%	3.5%
Jasper County	46.6%	52.4%	0.3%	0.0%	0.0%	0.0%	0.7%	0.2%
Jefferson County	13.2%	86.8%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Jefferson Davis County	41.3%	56.2%	0.0%	2.3%	0.0%	0.0%	0.2%	0.2%
Jones County	68.8%	26.9%	0.4%	0.3%	0.0%	2.7%	1.0%	5.0%
Kemper County	37.4%	58.3%	2.2%	1.1%	0.0%	0.0%	1.1%	0.4%
Lafayette County	71.5%	24.4%	0.4%	1.8%	0.0%	1.0%	0.8%	1.5%
Lamar County	82.0%	15.0%	0.3%	0.7%	0.0%	1.0%	1.0%	1.5%
Lauderdale County	57.2%	41.0%	0.3%	0.7%	0.0%	0.4%	0.4%	1.7%

Lawrence County	66.8%	32.7%	0.1%	0.0%	0.0%	0.2%	0.2%	0.9%
Leake County	52.6%	37.7%	4.9%	1.1%	0.0%	2.9%	0.8%	3.9%
Lee County	71.4%	26.4%	0.2%	0.6%	0.0%	0.8%	0.7%	1.7%
Leflore County	26.5%	72.4%	0.1%	0.2%	0.0%	0.3%	0.5%	0.8%
Lincoln County	68.5%	30.7%	0.2%	0.1%	0.0%	0.1%	0.4%	0.8%
Lowndes County	55.2%	42.7%	0.2%	0.7%	0.0%	0.3%	0.9%	1.7%
Madison County	59.7%	37.8%	0.1%	1.6%	0.0%	0.4%	0.4%	1.7%
Marion County	65.4%	33.5%	0.1%	0.1%	0.0%	0.2%	0.6%	0.5%
Marshall County	49.2%	48.2%	0.2%	0.2%	0.0%	1.3%	1.0%	1.8%
Monroe County	68.2%	30.6%	0.2%	0.0%	0.0%	0.0%	1.0%	0.9%
Montgomery County	52.9%	45.7%	0.0%	0.3%	0.0%	0.1%	1.0%	0.3%
Neshoba County	62.8%	21.1%	13.7%	0.5%	0.0%	0.6%	1.4%	1.9%
Newton County	64.3%	30.2%	4.3%	0.0%	0.1%	0.5%	0.6%	1.4%
Noxubee County	27.9%	69.8%	0.0%	0.0%	0.0%	0.0%	2.2%	0.2%
Oktibbeha County	58.8%	36.2%	0.0%	2.8%	0.0%	0.8%	1.4%	1.5%
Panola County	50.3%	47.8%	0.2%	0.1%	0.0%	1.2%	0.3%	1.4%
Pearl River County	84.7%	12.7%	0.5%	0.5%	0.0%	0.7%	0.7%	2.0%
Perry County	75.5%	23.9%	0.1%	0.2%	0.0%	0.2%	0.1%	0.1%
Pike County	49.7%	48.8%	0.2%	0.5%	0.0%	0.0%	0.7%	1.0%
Pontotoc County	82.2%	13.4%	0.8%	0.3%	0.0%	1.7%	1.6%	3.3%
Prentiss County	85.2%	13.0%	0.3%	1.1%	0.0%	0.0%	0.4%	1.1%
Quitman County	29.4%	69.8%	0.0%	0.2%	0.0%	0.6%	0.1%	0.6%
Rankin County	77.7%	19.4%	0.2%	1.0%	0.0%	0.7%	1.0%	2.1%
Scott County	57.5%	38.2%	0.1%	0.1%	0.0%	3.8%	0.2%	9.7%
Sharkey County	27.3%	72.5%	0.0%	0.1%	0.0%	0.0%	0.2%	0.2%
Simpson County	63.0%	36.5%	0.0%	0.1%	0.0%	0.2%	0.2%	0.7%
Smith County	74.8%	24.9%	0.0%	0.0%	0.0%	0.3%	0.1%	0.8%
Stone County	79.1%	19.8%	0.3%	0.0%	0.0%	0.4%	0.3%	1.6%
Sunflower County	26.8%	71.8%	0.1%	0.3%	0.1%	0.7%	0.3%	1.8%
Tallahatchie County	38.4%	58.1%	0.1%	0.3%	0.0%	2.5%	0.7%	3.7%
Tate County	67.0%	30.4%	0.0%	0.4%	0.0%	0.9%	1.3%	1.4%
Tippah County	80.7%	16.0%	0.1%	0.0%	0.0%	1.2%	1.9%	5.1%
Tishomingo County	94.8%	3.4%	0.2%	0.2%	0.0%	0.8%	0.6%	3.2%
Tunica County	27.5%	70.6%	0.7%	0.6%	0.0%	0.1%	0.6%	3.2%
Union County	81.5%	14.9%	0.2%	0.1%	0.1%	2.1%	1.3%	3.5%
Walthall County	53.5%	45.3%	0.5%	0.1%	0.0%	0.3%	0.3%	1.5%
Warren County	51.0%	46.3%	0.2%	0.9%	0.0%	0.7%	0.8%	1.5%
Washington County	30.6%	66.5%	0.1%	0.9%	0.0%	0.9%	0.9%	1.7%
Wayne County	60.3%	38.1%	0.0%	0.2%	0.4%	0.2%	0.9%	0.4%
Webster County	77.6%	19.9%	0.5%	0.1%	0.0%	0.9%	1.0%	2.1%
Wilkinson County	30.1%	68.8%	0.2%	0.1%	0.0%	0.2%	0.7%	0.7%
Winston County	52.5%	46.4%	0.8%	0.0%	0.0%	0.1%	0.1%	0.3%
Yalobusha County	59.5%	40.2%	0.0%	0.0%	0.0%	0.0%	0.3%	0.8%
Yazoo County	38.8%	58.2%	0.5%	0.1%	0.0%	0.8%	1.6%	2.1%

Percent of Population by Race and Ethnicity

	Race							Ethnicity
	White	Black or African American	American Indian/ Alaska Native	Asian	Native Hawaiian/ Pacific Islander	Some other race	Two or more races	Hispanic or Latino
Biloxi city	70.3%	18.3%	0.9%	5.1%	0.2%	2.3%	3.1%	5.9%
Clarksdale city	21.8%	76.8%	0.3%	0.1%	0.0%	0.3%	0.6%	1.6%
Cleveland city	45.2%	53.8%	0.2%	0.5%	0.0%	0.0%	0.3%	2.2%
Greenville city	24.5%	73.1%	0.1%	1.1%	0.0%	0.1%	1.1%	1.3%
Gulfport city	58.4%	36.0%	0.4%	1.5%	0.0%	1.2%	2.5%	4.0%
Hattiesburg city	46.9%	48.4%	0.2%	1.9%	0.0%	1.8%	0.7%	2.7%
Jackson city	21.8%	76.1%	0.1%	0.7%	0.1%	0.7%	0.6%	1.7%
Meridian city	41.1%	57.0%	0.3%	0.6%	0.0%	0.6%	0.5%	1.3%
Ocean Springs city	82.3%	10.6%	0.0%	4.1%	0.0%	0.7%	2.2%	2.9%
Olive Branch city	78.0%	20.2%	0.1%	0.7%	0.0%	0.4%	0.7%	4.0%
Philadelphia city	51.5%	41.8%	5.7%	0.0%	0.0%	0.9%	0.1%	2.6%
Southaven city	73.9%	20.7%	0.2%	2.0%	0.1%	0.8%	2.3%	3.2%
Starkville city	59.9%	33.5%	0.0%	3.6%	0.0%	1.1%	1.9%	1.9%
Tunica town	59.2%	37.3%	0.5%	1.4%	0.0%	0.0%	1.6%	5.8%
Tupelo city	63.8%	32.8%	0.1%	0.8%	0.0%	1.5%	0.9%	3.0%
Vicksburg city	31.4%	65.6%	0.4%	1.5%	0.0%	0.4%	0.7%	0.9%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of Population by Citizenship Status

	U.S. citizen	U.S. citizen by naturalization	Not a U.S. citizen
United States	87.6%	5.3%	7.1%
State of Mississippi	98.1%	0.7%	1.3%
Adams County	99.1%	0.4%	0.5%
Alcorn County	98.5%	0.5%	1.0%
Amite County	99.7%	0.1%	0.2%
Attala County	98.8%	0.3%	0.9%
Benton County	97.9%	1.8%	0.2%
Bolivar County	99.1%	0.4%	0.5%
Calhoun County	97.4%	0.7%	1.9%
Carroll County	99.1%	0.9%	0.0%
Chickasaw County	97.6%	0.5%	2.0%
Choctaw County	99.3%	0.4%	0.3%
Claiborne County	99.7%	0.2%	0.1%
Clarke County	99.4%	0.2%	0.4%
Clay County	99.8%	0.2%	0.0%
Coahoma County	99.4%	0.2%	0.4%
Copiah County	98.4%	0.4%	1.2%
Covington County	99.7%	0.1%	0.2%
DeSoto County	96.7%	1.2%	2.1%
Forrest County	97.0%	0.7%	2.3%
Franklin County	99.5%	0.5%	0.0%
George County	98.9%	0.3%	0.8%
Greene County	99.6%	0.3%	0.2%
Grenada County	98.9%	0.2%	0.9%
Hancock County	97.2%	0.7%	2.1%
Harrison County	95.5%	2.0%	2.5%
Hinds County	98.4%	0.5%	1.1%
Holmes County	99.7%	0.1%	0.2%
Humphreys County	99.8%	0.1%	0.1%
Issaquena County	100.0%	0.0%	0.0%
Itawamba County	99.5%	0.3%	0.2%
Jackson County	96.7%	1.7%	1.6%
Jasper County	99.9%	0.0%	0.1%
Jefferson County	100.0%	0.0%	0.0%
Jefferson Davis County	98.5%	0.2%	1.3%
Jones County	96.6%	0.3%	3.1%
Kemper County	98.6%	0.9%	0.5%
Lafayette County	96.1%	1.3%	2.7%
Lamar County	98.3%	0.7%	1.0%
Lauderdale County	98.3%	0.5%	1.2%
Lawrence County	99.7%	0.1%	0.2%

Leake County	97.8%	1.0%	1.2%
Lee County	98.5%	0.5%	0.9%
Leflore County	99.2%	0.3%	0.5%
Lincoln County	99.3%	0.2%	0.5%
Lowndes County	98.4%	0.9%	0.7%
Madison County	97.3%	0.9%	1.8%
Marion County	99.3%	0.2%	0.4%
Marshall County	98.5%	0.3%	1.2%
Monroe County	99.5%	0.0%	0.5%
Montgomery County	99.3%	0.4%	0.3%
Neshoba County	99.3%	0.2%	0.5%
Newton County	99.2%	0.3%	0.5%
Noxubee County	99.9%	0.0%	0.1%
Oktibbeha County	97.2%	0.9%	1.9%
Panola County	99.3%	0.1%	0.6%
Pearl River County	98.7%	0.8%	0.5%
Perry County	99.8%	0.2%	0.0%
Pike County	98.8%	0.5%	0.7%
Pontotoc County	97.6%	0.6%	1.8%
Prentiss County	98.6%	0.4%	1.0%
Quitman County	99.4%	0.1%	0.4%
Rankin County	98.3%	0.7%	1.0%
Scott County	93.5%	0.5%	5.9%
Sharkey County	100.0%	0.0%	0.0%
Simpson County	99.3%	0.3%	0.4%
Smith County	99.7%	0.2%	0.1%
Stone County	99.1%	0.9%	0.1%
Sunflower County	99.0%	0.4%	0.7%
Tallahatchie County	96.5%	0.3%	3.2%
Tate County	98.7%	0.3%	1.0%
Tippah County	96.7%	0.8%	2.5%
Tishomingo County	97.2%	1.1%	1.6%
Tunica County	96.0%	0.5%	3.5%
Union County	97.2%	0.7%	2.1%
Walthall County	99.8%	0.1%	0.1%
Warren County	98.3%	0.6%	1.1%
Washington County	99.0%	0.3%	0.7%
Wayne County	99.6%	0.3%	0.1%
Webster County	98.9%	0.1%	1.0%
Wilkinson County	99.6%	0.3%	0.1%
Winston County	99.8%	0.1%	0.0%
Yalobusha County	99.9%	0.1%	0.0%
Yazoo County	98.1%	0.2%	1.7%

Percent of Population by Citizenship Status

	U.S. citizen	U.S. citizen by naturalization	Not a U.S. citizen
Biloxi city	92.4%	2.8%	4.7%
Clarksdale city	99.3%	0.3%	0.5%
Cleveland city	99.2%	0.3%	0.6%
Greenville city	98.8%	0.4%	0.8%
Gulfport city	96.2%	1.7%	2.1%
Hattiesburg city	95.9%	0.8%	3.3%
Jackson city	98.3%	0.5%	1.1%
Meridian city	98.7%	0.4%	0.9%
Ocean Springs city	95.9%	3.1%	1.0%
Olive Branch city	96.4%	1.6%	2.0%
Philadelphia city	99.7%	0.2%	0.2%
Southaven city	96.7%	0.9%	2.4%
Starkville city	96.6%	1.3%	2.1%
Tunica town	90.8%	1.6%	7.6%
Tupelo city	98.3%	0.5%	1.2%
Vicksburg city	98.2%	0.8%	1.0%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Population Mobility:
Percent of population (1 year and over) that moved within the last year

	Did not move: Live in the same house as 1 year ago	Moved within the same county	Moved from a different county, but within the same state	Moved from a different state	Moved from abroad
United States	83.8%	9.6%	3.4%	2.5%	0.6%
State of Mississippi	83.7%	9.2%	4.1%	2.8%	0.3%
Adams County	87.3%	7.1%	2.3%	3.0%	0.4%
Alcorn County	86.1%	8.5%	3.1%	2.2%	0.1%
Amite County	91.5%	4.0%	2.6%	1.9%	0.1%
Attala County	85.7%	9.3%	2.4%	1.8%	0.7%
Benton County	94.1%	0.5%	4.5%	0.8%	0.0%
Bolivar County	81.8%	12.3%	3.3%	2.3%	0.4%
Calhoun County	85.9%	10.0%	2.5%	1.5%	0.2%
Carroll County	90.7%	5.6%	2.8%	0.8%	0.0%
Chickasaw County	85.9%	9.2%	3.5%	1.0%	0.4%
Choctaw County	88.3%	6.4%	3.1%	2.0%	0.2%
Claiborne County	85.8%	5.8%	5.8%	2.7%	0.0%
Clarke County	92.3%	4.2%	3.3%	0.2%	0.0%
Clay County	85.3%	9.0%	3.6%	1.9%	0.1%
Coahoma County	86.3%	9.0%	2.9%	1.5%	0.4%
Copiah County	89.8%	5.6%	3.2%	1.4%	0.0%
Covington County	92.1%	4.4%	2.9%	0.6%	0.0%
DeSoto County	84.2%	7.5%	1.9%	6.1%	0.4%
Forrest County	77.9%	10.1%	8.3%	3.3%	0.4%
Franklin County	92.2%	4.7%	0.8%	2.1%	0.1%
George County	87.5%	6.8%	2.9%	2.8%	0.1%
Greene County	80.0%	5.5%	11.4%	2.9%	0.3%
Grenada County	79.2%	13.4%	4.5%	2.7%	0.2%
Hancock County	78.9%	14.5%	3.7%	2.8%	0.1%
Harrison County	77.4%	12.6%	3.8%	5.4%	0.8%
Hinds County	80.3%	13.7%	3.5%	2.4%	0.2%
Holmes County	91.0%	4.5%	2.4%	1.9%	0.2%
Humphreys County	84.4%	11.8%	2.5%	1.0%	0.2%
Issaquena County	79.0%	5.6%	15.2%	0.2%	0.0%
Itawamba County	87.8%	4.8%	4.8%	2.5%	0.1%
Jackson County	83.9%	9.3%	2.9%	3.7%	0.2%
Jasper County	92.9%	3.5%	3.2%	0.4%	0.0%
Jefferson County	88.7%	4.1%	6.6%	0.5%	0.0%
Jefferson Davis County	91.7%	2.5%	4.4%	1.1%	0.2%
Jones County	86.4%	9.7%	2.5%	1.3%	0.1%
Kemper County	90.8%	3.1%	4.8%	1.2%	0.0%
Lafayette County	69.4%	14.7%	8.7%	6.7%	0.4%
Lamar County	78.3%	9.2%	10.1%	2.2%	0.3%
Lauderdale County	78.8%	11.7%	3.2%	6.1%	0.3%

Lawrence County	90.7%	4.3%	4.3%	0.7%	0.0%
Leake County	87.3%	5.5%	6.4%	0.8%	0.0%
Lee County	82.7%	10.1%	5.5%	1.4%	0.3%
Leflore County	86.9%	9.5%	2.2%	1.2%	0.1%
Lincoln County	91.1%	5.7%	2.0%	1.2%	0.0%
Lowndes County	79.9%	12.6%	3.0%	4.2%	0.3%
Madison County	84.6%	6.9%	5.9%	2.5%	0.1%
Marion County	84.5%	9.7%	3.5%	2.2%	0.0%
Marshall County	88.2%	6.1%	3.7%	2.0%	0.0%
Monroe County	88.5%	7.4%	3.0%	1.0%	0.2%
Montgomery County	90.8%	5.5%	2.2%	1.3%	0.1%
Neshoba County	87.3%	6.8%	4.6%	1.3%	0.0%
Newton County	86.2%	7.5%	5.2%	1.0%	0.1%
Noxubee County	93.9%	4.1%	1.2%	0.8%	0.0%
Oktibbeha County	71.2%	15.6%	9.2%	3.8%	0.2%
Panola County	86.7%	6.6%	3.7%	2.4%	0.6%
Pearl River County	85.0%	7.8%	2.8%	4.3%	0.1%
Perry County	93.3%	3.8%	1.8%	0.6%	0.5%
Pike County	84.9%	8.0%	2.9%	3.9%	0.3%
Pontotoc County	86.2%	8.1%	4.1%	1.2%	0.5%
Prentiss County	87.6%	5.6%	5.2%	1.5%	0.2%
Quitman County	87.0%	7.5%	1.8%	3.6%	0.1%
Rankin County	82.9%	8.3%	6.4%	2.4%	0.1%
Scott County	86.1%	8.9%	2.7%	1.2%	1.1%
Sharkey County	85.7%	10.4%	3.2%	0.8%	0.0%
Simpson County	88.0%	5.8%	4.8%	1.2%	0.3%
Smith County	93.9%	1.9%	3.4%	0.7%	0.1%
Stone County	84.3%	5.1%	7.6%	3.0%	0.0%
Sunflower County	83.2%	7.9%	7.0%	1.7%	0.3%
Tallahatchie County	88.6%	6.1%	1.8%	3.5%	0.0%
Tate County	88.5%	5.7%	4.6%	1.1%	0.1%
Tippah County	86.6%	10.2%	2.2%	0.9%	0.0%
Tishomingo County	86.0%	8.4%	1.0%	3.8%	0.9%
Tunica County	74.4%	11.9%	9.1%	4.4%	0.2%
Union County	85.1%	8.1%	4.4%	2.2%	0.3%
Walthall County	88.6%	5.3%	2.5%	3.5%	0.0%
Warren County	82.6%	11.5%	2.9%	2.6%	0.4%
Washington County	81.9%	13.3%	2.0%	2.7%	0.1%
Wayne County	91.6%	5.0%	2.4%	0.7%	0.3%
Webster County	84.4%	7.0%	6.9%	1.0%	0.8%
Wilkinson County	86.7%	3.2%	6.7%	3.4%	0.0%
Winston County	89.9%	6.4%	1.5%	2.1%	0.1%
Yalobusha County	85.3%	9.2%	4.2%	1.3%	0.0%
Yazoo County	84.4%	9.4%	3.1%	2.7%	0.3%

Population Mobility:
Percent of population (1 year and over) that moved within the last year

	Did not move: Live in the same house as 1 year ago	Moved within the same county	Moved from a different county, but within the same state	Moved from a different state	Moved from abroad
Biloxi city	74.1%	12.6%	4.7%	7.4%	1.2%
Clarksdale city	84.0%	10.3%	3.7%	1.5%	0.5%
Cleveland city	72.4%	17.2%	5.2%	4.4%	0.8%
Greenville city	80.9%	13.8%	2.0%	3.2%	0.1%
Gulfport city	74.5%	14.2%	4.0%	6.5%	0.9%
Hattiesburg city	69.2%	12.9%	13.2%	4.1%	0.5%
Jackson city	78.5%	15.1%	3.4%	2.7%	0.2%
Meridian city	78.6%	13.7%	3.9%	3.5%	0.3%
Ocean Springs city	82.1%	8.5%	5.0%	4.4%	0.1%
Olive Branch city	89.5%	4.4%	0.8%	5.2%	0.2%
Philadelphia city	81.9%	10.0%	7.1%	0.9%	0.1%
Southaven city	78.4%	11.2%	3.0%	7.1%	0.3%
Starkville city	67.8%	19.2%	9.9%	2.8%	0.2%
Tunica town	84.6%	6.6%	7.2%	0.9%	0.8%
Tupelo city	78.7%	12.3%	7.0%	1.5%	0.5%
Vicksburg city	80.3%	12.3%	3.1%	3.7%	0.6%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of households by family status

	Family Households		Non-Family Households	
	Married-couple family	Single-parent family	Householder living alone	Householder not living alone
United States	49.7%	17.0%	27.3%	6.0%
State of Mississippi	46.5%	22.8%	26.7%	4.0%
Adams County	36.3%	26.5%	34.1%	3.1%
Alcorn County	53.5%	15.1%	29.1%	2.3%
Amite County	40.1%	25.0%	33.9%	1.0%
Attala County	46.5%	20.8%	30.5%	2.1%
Benton County	45.0%	22.6%	30.3%	2.0%
Bolivar County	34.8%	28.9%	31.1%	5.2%
Calhoun County	47.3%	22.1%	27.7%	2.9%
Carroll County	51.5%	21.4%	25.5%	1.5%
Chickasaw County	43.4%	25.7%	29.5%	1.4%
Choctaw County	49.7%	16.6%	30.1%	3.6%
Claiborne County	30.3%	31.0%	36.7%	2.0%
Clarke County	50.2%	24.0%	23.7%	2.1%
Clay County	45.2%	26.1%	27.1%	1.6%
Coahoma County	32.4%	37.3%	27.6%	2.6%
Copiah County	43.5%	22.7%	30.5%	3.4%
Covington County	51.9%	21.0%	25.6%	1.5%
DeSoto County	57.8%	18.8%	19.5%	3.9%
Forrest County	38.2%	21.4%	32.4%	8.0%
Franklin County	48.7%	18.5%	32.1%	0.7%
George County	62.2%	15.6%	19.3%	2.9%
Greene County	64.6%	14.0%	20.8%	0.6%
Grenada County	41.4%	27.0%	27.8%	3.7%
Hancock County	56.8%	16.5%	22.6%	4.1%
Harrison County	45.5%	22.2%	25.9%	6.4%
Hinds County	35.9%	29.1%	30.4%	4.6%
Holmes County	29.7%	36.1%	31.6%	2.6%
Humphreys County	35.3%	31.2%	32.0%	1.5%
Issaquena County	39.4%	26.0%	29.3%	5.3%
Itawamba County	58.3%	16.3%	23.8%	1.6%
Jackson County	53.1%	20.1%	22.5%	4.3%
Jasper County	44.1%	23.6%	31.7%	0.6%
Jefferson County	31.1%	37.5%	31.1%	0.2%
Jefferson Davis County	42.4%	24.0%	32.7%	0.9%
Jones County	50.4%	22.0%	23.8%	3.7%
Kemper County	46.2%	28.1%	24.6%	1.1%
Lafayette County	40.9%	14.9%	32.7%	11.5%
Lamar County	55.9%	14.7%	23.3%	6.1%
Lauderdale County	42.0%	25.6%	28.9%	3.4%

Lawrence County	51.7%	17.5%	27.5%	3.3%
Leake County	51.5%	23.2%	24.2%	1.1%
Lee County	49.2%	20.8%	26.5%	3.5%
Leflore County	31.8%	34.4%	31.4%	2.4%
Lincoln County	54.1%	20.8%	22.4%	2.7%
Lowndes County	47.5%	22.3%	27.0%	3.2%
Madison County	49.5%	18.2%	27.9%	4.3%
Marion County	49.8%	20.3%	27.0%	2.8%
Marshall County	44.3%	26.0%	26.3%	3.4%
Monroe County	49.3%	23.6%	24.4%	2.7%
Montgomery County	47.2%	22.2%	28.1%	2.6%
Neshoba County	45.4%	23.8%	27.3%	3.5%
Newton County	54.2%	21.0%	23.6%	1.2%
Noxubee County	37.9%	29.5%	30.7%	1.9%
Oktibbeha County	36.5%	16.9%	29.9%	16.8%
Panola County	45.3%	26.8%	24.8%	3.2%
Pearl River County	54.9%	18.0%	22.4%	4.7%
Perry County	54.9%	21.1%	22.4%	1.5%
Pike County	45.4%	22.1%	29.5%	3.0%
Pontotoc County	56.1%	18.0%	22.8%	3.1%
Prentiss County	53.8%	19.8%	24.5%	1.9%
Quitman County	30.0%	37.7%	25.8%	6.4%
Rankin County	54.3%	17.5%	24.3%	3.9%
Scott County	45.4%	24.9%	25.5%	4.2%
Sharkey County	35.7%	29.1%	32.4%	2.8%
Simpson County	51.5%	20.1%	25.3%	3.2%
Smith County	59.8%	17.7%	22.1%	0.3%
Stone County	56.3%	23.5%	17.6%	2.6%
Sunflower County	34.1%	36.5%	27.5%	1.9%
Tallahatchie County	40.4%	31.9%	23.4%	4.2%
Tate County	51.1%	21.5%	24.2%	3.2%
Tippah County	51.8%	21.0%	24.4%	2.7%
Tishomingo County	55.0%	14.9%	27.0%	3.1%
Tunica County	25.9%	31.0%	36.1%	6.9%
Union County	57.8%	16.6%	23.9%	1.7%
Walthall County	50.4%	18.3%	28.5%	2.7%
Warren County	42.1%	23.9%	30.6%	3.3%
Washington County	33.8%	34.1%	28.7%	3.4%
Wayne County	51.8%	22.5%	23.7%	2.0%
Webster County	53.2%	18.2%	26.6%	2.1%
Wilkinson County	40.2%	30.4%	25.7%	3.7%
Winston County	47.8%	20.1%	30.8%	1.3%
Yalobusha County	41.8%	25.4%	30.0%	2.7%
Yazoo County	40.0%	30.6%	27.0%	2.4%

Percent of households by family status

	Family Households		Non-Family Households	
	Married-couple family	Single-parent family	Householder living alone	Householder not living alone
Biloxi city	39.0%	19.9%	32.5%	8.6%
Clarksdale city	28.0%	42.1%	27.6%	2.3%
Cleveland city	36.0%	22.2%	34.7%	7.1%
Greenville city	31.0%	35.4%	29.8%	3.8%
Gulfport city	39.9%	27.9%	26.4%	5.8%
Hattiesburg city	26.7%	24.3%	37.6%	11.4%
Jackson city	30.1%	32.9%	31.9%	5.1%
Meridian city	31.3%	30.3%	34.0%	4.5%
Ocean Springs city	56.8%	19.6%	19.9%	3.7%
Olive Branch city	65.4%	14.5%	16.9%	3.2%
Philadelphia city	35.2%	28.2%	30.8%	5.8%
Southaven city	48.9%	21.9%	24.2%	5.0%
Starkville city	30.5%	15.2%	33.3%	20.9%
Tunica town	39.2%	5.9%	47.9%	7.0%
Tupelo city	44.2%	22.5%	29.8%	3.5%
Vicksburg city	29.1%	29.8%	37.2%	4.0%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Educational Attainment: Percent of population (18 years and over) by education level

	Less than 9th grade	9th to 12th grade, no diploma	High school graduate, GED, or alternative	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
United States	5.9%	9.8%	29.7%	22.5%	7.1%	16.2%	8.9%
State of Mississippi	6.7%	14.4%	31.3%	23.2%	7.2%	11.4%	5.7%
Adams County	6.8%	15.3%	31.1%	21.9%	7.1%	11.0%	6.7%
Alcorn County	7.8%	16.1%	37.0%	17.8%	7.7%	10.2%	3.6%
Amite County	10.6%	17.2%	40.1%	18.2%	4.7%	6.5%	2.6%
Attala County	10.2%	18.8%	28.7%	20.8%	7.0%	9.6%	5.0%
Benton County	8.6%	23.4%	37.7%	15.2%	6.0%	5.4%	3.7%
Bolivar County	11.4%	17.2%	28.1%	19.3%	5.6%	11.9%	6.5%
Calhoun County	12.2%	18.7%	34.9%	18.2%	6.5%	7.1%	2.4%
Carroll County	6.5%	18.9%	37.6%	19.3%	5.8%	9.2%	2.7%
Chickasaw County	11.7%	16.3%	37.3%	20.9%	4.8%	6.8%	2.2%
Choctaw County	9.5%	11.9%	35.3%	24.9%	7.7%	7.0%	3.7%
Claiborne County	5.1%	8.1%	37.5%	29.4%	6.3%	6.7%	7.0%
Clarke County	9.3%	15.7%	40.1%	20.5%	5.7%	6.8%	1.8%
Clay County	6.6%	16.7%	34.3%	23.9%	5.7%	8.3%	4.4%
Coahoma County	10.2%	15.6%	30.8%	21.6%	9.5%	8.9%	3.4%
Copiah County	8.1%	16.5%	30.8%	24.6%	7.7%	8.6%	3.7%
Covington County	6.2%	15.4%	37.1%	20.3%	7.8%	9.8%	3.3%
DeSoto County	3.8%	10.1%	33.3%	26.1%	7.7%	13.6%	5.4%
Forrest County	4.5%	10.0%	27.0%	29.5%	7.4%	13.3%	8.4%
Franklin County	4.4%	18.3%	36.2%	21.2%	7.0%	11.4%	1.5%
George County	6.5%	15.0%	41.4%	20.7%	5.2%	7.4%	3.7%
Greene County	7.4%	20.6%	42.3%	18.0%	5.0%	4.9%	1.7%
Grenada County	10.4%	19.5%	29.4%	20.5%	5.2%	9.6%	5.4%
Hancock County	5.3%	11.8%	33.1%	22.8%	7.5%	13.1%	6.5%
Harrison County	4.8%	12.5%	30.8%	26.6%	7.9%	11.1%	6.2%
Hinds County	4.2%	11.9%	25.2%	26.6%	7.2%	16.3%	8.6%
Holmes County	10.2%	19.1%	33.9%	21.1%	5.7%	6.8%	3.2%
Humphreys County	14.5%	23.1%	27.4%	18.0%	6.0%	7.3%	3.7%
Issaquena County	8.9%	31.9%	33.5%	16.8%	2.8%	4.4%	1.8%
Itawamba County	8.7%	19.7%	33.6%	20.3%	6.9%	6.6%	4.3%
Jackson County	3.9%	12.3%	34.7%	24.4%	8.5%	10.8%	5.4%
Jasper County	5.7%	17.5%	40.7%	20.2%	6.8%	5.5%	3.6%
Jefferson County	7.5%	17.0%	37.5%	17.8%	4.6%	10.5%	5.0%
Jefferson Davis County	7.2%	19.6%	33.6%	22.5%	7.1%	6.4%	3.6%
Jones County	9.2%	15.2%	33.0%	21.3%	8.1%	7.7%	5.4%
Kemper County	9.0%	17.8%	38.1%	18.3%	7.3%	6.1%	3.3%
Lafayette County	3.8%	7.7%	20.9%	31.3%	6.2%	17.0%	13.1%
Lamar County	4.9%	10.3%	24.0%	27.5%	7.8%	16.9%	8.6%
Lauderdale County	5.7%	13.2%	32.1%	24.2%	8.0%	11.4%	5.4%

Lawrence County	6.2%	15.5%	39.3%	23.0%	6.9%	5.0%	4.1%
Leake County	10.1%	17.3%	37.3%	22.6%	4.5%	5.9%	2.2%
Lee County	5.7%	14.4%	29.0%	23.9%	7.5%	13.4%	6.0%
Leflore County	10.6%	19.9%	29.5%	22.6%	3.4%	9.6%	4.3%
Lincoln County	6.5%	14.3%	34.9%	21.8%	7.6%	10.6%	4.3%
Lowndes County	7.1%	12.7%	30.7%	22.8%	7.6%	13.2%	6.0%
Madison County	4.3%	9.5%	21.3%	19.9%	7.5%	25.7%	11.8%
Marion County	9.9%	17.0%	37.2%	18.2%	6.8%	6.8%	4.2%
Marshall County	10.5%	21.7%	36.1%	17.9%	4.7%	6.7%	2.5%
Monroe County	9.0%	18.7%	35.1%	21.0%	4.8%	7.7%	3.7%
Montgomery County	8.8%	18.2%	29.4%	23.8%	6.1%	10.5%	3.4%
Neshoba County	8.6%	17.4%	32.0%	23.6%	7.3%	6.9%	4.2%
Newton County	5.5%	14.5%	34.7%	26.8%	8.4%	6.6%	3.5%
Noxubee County	12.8%	23.5%	32.2%	15.9%	6.9%	5.2%	3.5%
Oktibbeha County	3.8%	9.3%	21.0%	32.1%	6.2%	14.3%	13.3%
Panola County	10.7%	18.3%	32.1%	18.8%	8.6%	7.9%	3.6%
Pearl River County	7.4%	13.1%	33.0%	24.3%	9.1%	9.5%	3.6%
Perry County	8.6%	13.1%	41.2%	19.0%	9.2%	5.4%	3.5%
Pike County	5.6%	16.7%	34.2%	21.4%	8.0%	9.4%	4.7%
Pontotoc County	9.0%	17.3%	37.1%	19.0%	7.8%	6.0%	3.9%
Prentiss County	8.6%	15.2%	31.8%	21.8%	9.9%	8.2%	4.6%
Quitman County	14.4%	21.8%	29.1%	17.2%	6.7%	8.4%	2.4%
Rankin County	4.1%	9.2%	27.3%	25.2%	8.2%	18.2%	7.7%
Scott County	10.7%	20.5%	35.2%	19.3%	6.2%	5.4%	2.6%
Sharkey County	10.2%	19.2%	33.9%	17.5%	5.4%	9.9%	3.9%
Simpson County	8.0%	15.5%	36.0%	22.0%	5.9%	8.9%	3.7%
Smith County	7.5%	17.2%	37.4%	16.3%	7.1%	9.7%	4.9%
Stone County	7.5%	15.7%	30.4%	25.5%	9.7%	7.6%	3.5%
Sunflower County	9.8%	20.3%	31.6%	21.2%	5.5%	8.6%	3.0%
Tallahatchie County	15.1%	20.5%	33.2%	15.6%	6.6%	7.0%	2.1%
Tate County	7.5%	14.3%	33.3%	26.5%	7.3%	7.5%	3.6%
Tippah County	11.8%	17.9%	34.9%	18.1%	8.2%	6.1%	3.1%
Tishomingo County	9.6%	17.3%	37.2%	17.6%	7.2%	7.2%	3.9%
Tunica County	13.3%	18.8%	31.9%	14.3%	9.4%	9.6%	2.7%
Union County	6.8%	19.4%	35.2%	19.5%	6.7%	8.9%	3.5%
Walthall County	9.0%	17.0%	35.5%	18.0%	7.5%	10.5%	2.5%
Warren County	6.1%	15.2%	27.0%	24.1%	7.3%	12.8%	7.5%
Washington County	8.9%	21.1%	29.3%	19.7%	5.3%	10.0%	5.8%
Wayne County	7.5%	21.1%	37.6%	18.1%	6.9%	5.5%	3.4%
Webster County	9.2%	17.6%	36.2%	19.3%	5.1%	8.4%	4.2%
Wilkinson County	12.7%	18.0%	43.3%	15.9%	3.1%	4.8%	2.4%
Winston County	7.5%	14.9%	37.8%	20.4%	6.5%	8.7%	4.2%
Yalobusha County	9.5%	19.4%	35.7%	20.3%	4.4%	6.2%	4.5%
Yazoo County	9.3%	18.5%	34.3%	21.6%	6.3%	6.9%	3.1%

Educational Attainment: Percent of population (18 years and over) by education level

	Less than 9th grade	9th to 12th grade, no diploma	High school graduate, GED, or alternative	Some college, no degree	Associate's degree	Bachelor's degree	Graduate or professional degree
Biloxi city	4.2%	9.9%	29.5%	28.5%	8.3%	12.6%	6.9%
Clarksdale city	9.8%	14.3%	31.7%	21.5%	10.0%	9.0%	3.9%
Cleveland city	8.4%	11.7%	22.7%	21.1%	5.9%	18.4%	11.9%
Greenville city	8.0%	19.9%	30.4%	19.4%	5.0%	10.7%	6.6%
Gulfport city	5.2%	14.1%	31.8%	25.6%	7.1%	10.8%	5.5%
Hattiesburg city	4.4%	8.5%	22.5%	32.8%	7.8%	14.7%	9.3%
Jackson city	4.6%	13.3%	26.0%	26.1%	6.0%	15.2%	8.8%
Meridian city	6.2%	13.7%	27.4%	25.0%	8.3%	12.8%	6.7%
Ocean Springs city	2.7%	7.9%	27.0%	23.2%	7.8%	18.6%	12.9%
Olive Branch city	2.7%	7.2%	32.5%	25.1%	8.6%	17.8%	6.1%
Philadelphia city	9.2%	14.2%	26.3%	25.0%	8.9%	10.1%	6.4%
Southaven city	2.8%	9.7%	34.4%	27.1%	8.0%	13.7%	4.4%
Starkville city	2.9%	7.5%	16.9%	34.8%	6.4%	17.0%	14.5%
Tunica town	14.8%	18.2%	26.8%	20.0%	4.1%	14.4%	1.6%
Tupelo city	4.2%	12.1%	24.1%	24.4%	8.1%	18.3%	8.7%
Vicksburg city	6.0%	17.0%	26.6%	23.7%	7.3%	12.0%	7.3%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Language Spoken At Home:
Percent of population (5 years and over) who speak English less than "very well"

	Speak Only English at home	Speak English less than "very well"
United States	80.4%	8.6%
State of Mississippi	96.4%	1.5%
Adams County	97.8%	0.7%
Alcorn County	97.5%	1.1%
Amite County	99.0%	0.4%
Attala County	97.5%	1.2%
Benton County	98.7%	1.1%
Bolivar County	98.0%	1.2%
Calhoun County	96.2%	2.6%
Carroll County	99.0%	0.1%
Chickasaw County	95.5%	2.1%
Choctaw County	98.1%	0.1%
Claiborne County	99.5%	0.1%
Clarke County	99.3%	0.0%
Clay County	98.4%	0.2%
Coahoma County	98.4%	0.3%
Copiah County	97.5%	1.5%
Covington County	98.7%	0.5%
DeSoto County	94.1%	2.3%
Forrest County	95.4%	1.8%
Franklin County	99.2%	0.0%
George County	97.5%	0.9%
Greene County	96.8%	0.9%
Grenada County	98.2%	0.6%
Hancock County	97.2%	1.1%
Harrison County	93.0%	2.7%
Hinds County	97.0%	1.2%
Holmes County	99.0%	0.3%
Humphreys County	97.2%	1.0%
Issaquena County	100.0%	0.0%
Itawamba County	98.9%	0.3%
Jackson County	94.7%	2.2%
Jasper County	99.5%	0.0%
Jefferson County	99.8%	0.2%
Jefferson Davis County	97.5%	0.2%
Jones County	94.9%	3.3%
Kemper County	94.6%	2.9%
Lafayette County	94.6%	1.7%
Lamar County	97.2%	0.8%
Lauderdale County	96.7%	1.1%

Lawrence County	98.8%	0.6%
Leake County	91.3%	4.2%
Lee County	97.4%	0.9%
Leflore County	97.9%	0.6%
Lincoln County	98.4%	0.3%
Lowndes County	97.1%	1.3%
Madison County	95.8%	1.6%
Marion County	98.4%	0.5%
Marshall County	96.9%	1.5%
Monroe County	97.8%	0.8%
Montgomery County	98.9%	0.3%
Neshoba County	87.2%	3.3%
Newton County	95.5%	2.6%
Noxubee County	98.2%	0.5%
Oktibbeha County	94.8%	1.8%
Panola County	98.5%	0.8%
Pearl River County	97.6%	0.9%
Perry County	99.7%	0.0%
Pike County	97.7%	0.8%
Pontotoc County	97.0%	2.2%
Prentiss County	96.9%	2.0%
Quitman County	98.5%	1.0%
Rankin County	96.7%	1.2%
Scott County	90.6%	7.4%
Sharkey County	98.3%	1.5%
Simpson County	98.6%	0.6%
Smith County	99.1%	0.4%
Stone County	98.4%	0.3%
Sunflower County	96.9%	1.4%
Tallahatchie County	96.2%	2.3%
Tate County	98.2%	1.1%
Tippah County	94.7%	2.9%
Tishomingo County	95.4%	1.7%
Tunica County	93.7%	3.4%
Union County	95.8%	1.9%
Walthall County	97.6%	1.2%
Warren County	95.7%	1.2%
Washington County	96.4%	1.8%
Wayne County	99.3%	0.2%
Webster County	97.7%	1.2%
Wilkinson County	98.8%	0.7%
Winston County	98.7%	0.6%
Yalobusha County	99.5%	0.1%
Yazoo County	96.1%	1.9%

Language Spoken At Home:
Percent of population (5 years and over) who speak English less than "very well"

	Speak Only English at home	Speak English less than "very well"
Biloxi city	89.2%	4.4%
Clarksdale city	98.1%	0.4%
Cleveland city	98.1%	1.1%
Greenville city	97.2%	1.5%
Gulfport city	93.4%	2.6%
Hattiesburg city	94.1%	2.4%
Jackson city	97.0%	1.3%
Meridian city	97.0%	1.0%
Ocean Springs city	93.7%	2.3%
Olive Branch city	93.9%	1.7%
Philadelphia city	94.7%	1.8%
Southaven city	94.9%	2.3%
Starkville city	93.1%	2.1%
Tunica town	87.1%	10.0%
Tupelo city	96.5%	1.3%
Vicksburg city	95.3%	1.2%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Poverty Rate:
Percent of population by age with income in the past 12 months below the poverty level

	Total	Under 5 years	5 to 17 years	18 to 34 years	35 to 64 years	65 years and over
United States	13.5%	21.5%	17.4%	17.1%	9.4%	9.8%
State of Mississippi	21.4%	34.1%	28.6%	24.8%	15.0%	16.1%
Adams County	28.1%	53.9%	40.9%	34.8%	18.0%	19.9%
Alcorn County	17.0%	27.0%	22.7%	19.7%	12.4%	14.7%
Amite County	26.7%	41.9%	44.2%	29.5%	18.1%	21.5%
Attala County	23.6%	38.4%	30.4%	23.9%	18.3%	20.9%
Benton County	26.9%	18.8%	34.1%	21.9%	25.9%	31.1%
Bolivar County	37.9%	60.8%	52.6%	42.7%	26.4%	21.5%
Calhoun County	21.6%	24.6%	30.0%	20.2%	17.5%	23.4%
Carroll County	23.3%	51.7%	29.4%	28.3%	19.1%	13.5%
Chickasaw County	25.1%	52.4%	33.7%	28.0%	15.5%	19.0%
Choctaw County	22.8%	30.5%	28.9%	26.8%	16.0%	24.5%
Claiborne County	38.6%	58.6%	51.5%	43.8%	27.6%	27.5%
Clarke County	22.1%	31.8%	33.7%	20.9%	16.1%	20.7%
Clay County	24.1%	43.4%	31.3%	26.7%	16.7%	19.8%
Coahoma County	36.0%	62.5%	52.0%	33.7%	24.6%	23.5%
Copiah County	23.8%	33.3%	32.5%	25.7%	19.8%	14.5%
Covington County	25.7%	40.7%	32.7%	33.5%	14.8%	24.7%
DeSoto County	9.4%	14.7%	13.5%	11.0%	5.7%	8.0%
Forrest County	25.8%	38.8%	33.7%	32.7%	17.3%	11.4%
Franklin County	23.7%	37.2%	38.9%	31.0%	16.2%	9.1%
George County	12.6%	13.1%	16.7%	13.0%	10.1%	12.5%
Greene County	18.6%	11.9%	25.3%	24.0%	14.8%	13.5%
Grenada County	24.7%	40.4%	37.3%	28.4%	13.8%	24.5%
Hancock County	14.3%	17.7%	19.1%	16.4%	12.2%	10.9%
Harrison County	14.8%	25.2%	17.6%	16.7%	11.9%	10.2%
Hinds County	22.5%	37.4%	31.9%	24.9%	15.0%	14.6%
Holmes County	42.7%	58.3%	55.4%	45.8%	30.2%	37.3%
Humphreys County	39.0%	64.0%	47.3%	48.3%	25.0%	28.4%
Issaquena County	42.7%	73.9%	50.4%	59.9%	27.8%	19.7%
Itawamba County	14.7%	27.2%	17.5%	16.6%	8.9%	19.3%
Jackson County	14.8%	22.5%	21.5%	15.1%	11.8%	9.3%
Jasper County	21.7%	26.0%	27.1%	26.7%	13.8%	26.0%
Jefferson County	32.8%	52.9%	39.7%	32.1%	27.4%	30.9%
Jefferson Davis County	29.0%	60.3%	37.4%	38.7%	20.3%	14.5%
Jones County	24.1%	42.2%	33.9%	25.9%	17.5%	15.9%
Kemper County	24.6%	29.3%	31.5%	26.6%	20.5%	22.7%
Lafayette County	25.2%	26.8%	14.6%	44.6%	14.6%	14.1%
Lamar County	13.8%	12.0%	12.6%	22.6%	9.1%	13.1%
Lauderdale County	22.6%	42.6%	30.7%	26.0%	15.1%	14.6%
Lawrence County	20.1%	25.2%	32.9%	19.3%	15.5%	15.7%

Leake County	20.0%	38.3%	19.8%	19.2%	16.1%	20.1%
Lee County	19.2%	34.2%	27.2%	20.6%	13.4%	12.7%
Leflore County	41.6%	55.3%	58.3%	42.8%	32.2%	25.6%
Lincoln County	20.5%	34.9%	32.3%	21.1%	13.9%	14.4%
Lowndes County	21.3%	31.8%	31.3%	24.0%	14.8%	14.5%
Madison County	14.0%	18.5%	20.0%	16.8%	8.7%	13.2%
Marion County	25.9%	35.4%	35.8%	25.8%	19.3%	24.3%
Marshall County	22.6%	45.6%	29.2%	24.4%	16.0%	17.2%
Monroe County	20.9%	31.7%	30.3%	24.8%	13.7%	18.1%
Montgomery County	26.4%	49.6%	30.5%	36.7%	17.9%	20.6%
Neshoba County	21.9%	43.3%	24.7%	22.9%	16.3%	16.8%
Newton County	18.4%	36.2%	28.0%	22.0%	11.6%	10.0%
Noxubee County	32.3%	51.2%	45.6%	28.0%	25.4%	26.4%
Oktibbeha County	33.3%	33.8%	29.6%	54.2%	13.5%	9.5%
Panola County	28.3%	48.7%	41.1%	30.9%	16.6%	25.8%
Pearl River County	21.6%	32.7%	26.6%	26.3%	18.0%	12.6%
Perry County	21.9%	25.3%	22.9%	25.0%	19.7%	21.5%
Pike County	28.0%	56.6%	32.7%	30.4%	20.8%	20.6%
Pontotoc County	16.3%	28.4%	19.6%	15.2%	11.1%	21.7%
Prentiss County	21.7%	33.4%	28.3%	18.5%	18.4%	22.0%
Quitman County	33.7%	64.5%	35.6%	39.9%	27.0%	23.4%
Rankin County	9.9%	14.5%	14.1%	10.9%	7.0%	7.6%
Scott County	24.8%	43.6%	34.0%	26.0%	17.8%	17.0%
Sharkey County	33.3%	49.0%	44.5%	40.1%	23.7%	24.0%
Simpson County	23.6%	27.3%	34.2%	19.1%	21.9%	18.9%
Smith County	18.6%	41.2%	22.5%	21.2%	13.3%	12.5%
Stone County	18.2%	25.4%	24.2%	20.4%	12.0%	19.4%
Sunflower County	35.0%	53.0%	40.7%	37.7%	25.4%	33.1%
Tallahatchie County	33.3%	48.9%	43.4%	33.8%	24.5%	35.5%
Tate County	17.6%	35.6%	23.7%	20.3%	10.9%	13.9%
Tippah County	24.1%	32.6%	35.2%	22.9%	21.8%	13.7%
Tishomingo County	22.2%	39.2%	26.4%	25.9%	17.8%	18.7%
Tunica County	30.8%	68.4%	37.7%	31.8%	16.8%	20.6%
Union County	17.8%	19.6%	25.4%	17.4%	14.4%	16.1%
Walthall County	23.2%	24.0%	34.5%	23.3%	16.4%	25.5%
Warren County	19.4%	27.9%	28.1%	21.5%	12.6%	18.1%
Washington County	33.2%	50.7%	45.5%	37.5%	23.7%	21.1%
Wayne County	23.5%	27.5%	31.5%	25.2%	18.1%	22.0%
Webster County	26.5%	36.4%	38.0%	26.4%	21.4%	20.9%
Wilkinson County	30.6%	58.8%	40.4%	37.6%	22.3%	14.2%
Winston County	21.2%	37.8%	31.7%	21.3%	15.6%	15.6%
Yalobusha County	28.1%	46.1%	37.3%	35.9%	21.2%	16.7%
Yazoo County	31.4%	47.6%	45.6%	29.1%	23.9%	25.6%

Poverty Rate:
Percent of population by age with income in the past 12 months below the poverty level

	Total	Under 5 years	5 to 17 years	18 to 34 years	35 to 64 years	65 years and over
Biloxi city	12.6%	21.4%	12.6%	12.1%	12.3%	10.0%
Clarksdale city	37.7%	64.8%	55.4%	34.4%	25.7%	22.6%
Cleveland city	33.1%	55.8%	38.9%	37.7%	22.9%	21.3%
Greenville city	33.1%	49.2%	45.1%	37.7%	22.4%	23.3%
Gulfport city	18.2%	32.5%	22.3%	21.6%	12.3%	12.6%
Hattiesburg city	31.8%	44.5%	42.2%	39.8%	21.2%	10.6%
Jackson city	26.9%	43.8%	37.5%	28.2%	18.5%	17.4%
Meridian city	29.2%	53.0%	40.9%	32.7%	19.7%	15.4%
Ocean Springs city	9.0%	5.8%	6.2%	12.6%	7.9%	12.6%
Olive Branch city	5.2%	4.7%	7.8%	5.4%	4.2%	3.7%
Philadelphia city	23.6%	48.0%	22.2%	27.9%	18.1%	18.2%
Southaven city	12.5%	25.1%	18.8%	13.4%	6.5%	6.7%
Starkville city	37.1%	33.9%	27.4%	55.1%	13.2%	10.6%
Tunica town	28.7%	70.1%	73.4%	29.5%	15.8%	19.1%
Tupelo city	19.7%	41.5%	26.2%	22.2%	12.4%	10.9%
Vicksburg city	24.1%	36.3%	31.9%	24.3%	17.4%	23.4%

Poverty statistics in ACS products adhere to the standards specified by the Office of Management and Budget in Statistical Policy Directive 14. The Census Bureau uses a set of dollar value thresholds that vary by family size and composition to determine who is in poverty.

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Median Household and Family Income (in 2009-inflation adjusted dollars)

	Median Household Income	Median Family Income
United States	$51,425	$62,363
State of Mississippi	$36,796	$45,700
Adams County	$28,868	$35,700
Alcorn County	$31,826	$44,148
Amite County	$27,728	$32,982
Attala County	$30,096	$38,273
Benton County	$28,667	$36,183
Bolivar County	$24,920	$31,921
Calhoun County	$27,078	$32,914
Carroll County	$28,100	$36,013
Chickasaw County	$29,581	$42,314
Choctaw County	$30,054	$39,091
Claiborne County	$24,104	$29,511
Clarke County	$31,029	$39,889
Clay County	$30,765	$37,461
Coahoma County	$25,489	$29,034
Copiah County	$35,342	$43,681
Covington County	$30,483	$39,202
DeSoto County	$57,995	$63,691
Forrest County	$33,143	$42,761
Franklin County	$34,236	$39,756
George County	$46,849	$52,025
Greene County	$38,252	$48,118
Grenada County	$31,909	$42,515
Hancock County	$44,025	$51,250
Harrison County	$44,570	$52,067
Hinds County	$38,541	$48,266
Holmes County	$21,821	$24,529
Humphreys County	$22,259	$30,951
Issaquena County	$20,250	$24,550
Itawamba County	$37,660	$45,702
Jackson County	$47,767	$55,293
Jasper County	$29,628	$39,926
Jefferson County	$21,964	$33,446
Jefferson Davis County	$24,679	$31,517
Jones County	$34,269	$39,054
Kemper County	$29,833	$42,788
Lafayette County	$40,202	$63,622
Lamar County	$48,328	$61,119
Lauderdale County	$33,354	$43,023

Lawrence County	$34,643	$42,465
Leake County	$32,396	$42,609
Lee County	$37,894	$50,124
Leflore County	$20,490	$23,620
Lincoln County	$38,276	$44,726
Lowndes County	$37,314	$48,073
Madison County	$56,938	$71,123
Marion County	$30,699	$39,475
Marshall County	$31,831	$41,148
Monroe County	$33,116	$40,450
Montgomery County	$29,243	$36,758
Neshoba County	$33,445	$38,292
Newton County	$35,527	$42,744
Noxubee County	$22,974	$30,762
Oktibbeha County	$26,449	$47,167
Panola County	$35,355	$39,726
Pearl River County	$38,458	$46,219
Perry County	$34,423	$38,464
Pike County	$29,981	$39,848
Pontotoc County	$38,909	$47,324
Prentiss County	$29,250	$38,450
Quitman County	$24,491	$26,818
Rankin County	$53,240	$64,138
Scott County	$32,114	$38,209
Sharkey County	$29,495	$39,116
Simpson County	$34,187	$42,436
Smith County	$36,762	$42,072
Stone County	$43,524	$45,273
Sunflower County	$24,333	$28,889
Tallahatchie County	$23,557	$26,543
Tate County	$38,194	$43,891
Tippah County	$29,872	$35,940
Tishomingo County	$29,740	$37,940
Tunica County	$29,420	$29,940
Union County	$35,955	$44,167
Walthall County	$32,475	$36,913
Warren County	$38,917	$51,648
Washington County	$27,588	$32,352
Wayne County	$30,375	$35,726
Webster County	$31,533	$41,929
Wilkinson County	$25,478	$28,009
Winston County	$30,406	$41,250
Yalobusha County	$28,578	$35,080
Yazoo County	$27,404	$36,202

Median Household and Family Income (in 2009-inflation adjusted dollars)

	Median Household Income	Median Family Income
Biloxi city	$44,519	$58,022
Clarksdale city	$24,387	$26,039
Cleveland city	$30,325	$47,527
Greenville city	$27,830	$32,775
Gulfport city	$39,253	$44,489
Hattiesburg city	$28,119	$35,672
Jackson city	$33,505	$41,339
Meridian city	$29,391	$33,893
Ocean Springs city	$59,364	$68,542
Olive Branch city	$66,181	$73,373
Philadelphia city	$29,835	$34,177
Southaven city	$53,230	$58,064
Starkville city	$21,427	$50,667
Tunica town	$31,875	$62,589
Tupelo city	$38,507	$51,620
Vicksburg city	$29,799	$39,858

Family income is based on the incomes of the householder and any other people living in the same household who are related by birth, marriage, or adoption. Family income does not count single person households. Household income is based on the incomes of the householder and any other people living in the same household, regardless of whether they are related. Because many households consist of one person, household income is typically less than family income.

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of Households that Received Food Stamps or SNAP Benefits in the past 12 months

	Total Households	Households that received Food Stamps/SNAP	Percent of Households that received Food Stamps/SNAP
United States	112,611,029	9,555,026	8.5%
State of Mississippi	1,085,836	160,239	14.8%
Adams County	12,915	1,912	14.8%
Alcorn County	13,637	1,272	9.3%
Amite County	5,178	1,128	21.8%
Attala County	7,526	1,036	13.8%
Benton County	2,898	535	18.5%
Bolivar County	13,666	3,450	25.2%
Calhoun County	6,148	1,017	16.5%
Carroll County	4,019	345	8.6%
Chickasaw County	7,418	1,531	20.6%
Choctaw County	3,712	781	21.0%
Claiborne County	3,634	444	12.2%
Clarke County	7,096	1,375	19.4%
Clay County	7,998	1,391	17.4%
Coahoma County	10,037	2,564	25.5%
Copiah County	10,012	1,616	16.1%
Covington County	7,447	1,202	16.1%
DeSoto County	53,982	3,043	5.6%
Forrest County	29,666	4,113	13.9%
Franklin County	3,065	448	14.6%
George County	7,064	1,127	16.0%
Greene County	4,285	667	15.6%
Grenada County	9,291	1,440	15.5%
Hancock County	15,812	2,590	16.4%
Harrison County	67,681	10,555	15.6%
Hinds County	91,222	12,516	13.7%
Holmes County	7,082	2,262	31.9%
Humphreys County	3,727	1,229	33.0%
Issaquena County	738	241	32.7%
Itawamba County	9,115	990	10.9%
Jackson County	48,332	7,200	14.9%
Jasper County	6,548	1,319	20.1%
Jefferson County	3,162	478	15.1%
Jefferson Davis County	5,094	1,031	20.2%
Jones County	25,462	3,101	12.2%
Kemper County	3,914	857	21.9%
Lafayette County	14,835	784	5.3%
Lamar County	15,171	1,704	11.2%
Lauderdale County	30,988	5,274	17.0%

Lawrence County	4,900	815	16.6%
Leake County	7,335	843	11.5%
Lee County	29,670	3,210	10.8%
Leflore County	12,853	3,322	25.8%
Lincoln County	13,044	1,871	14.3%
Lowndes County	23,460	3,252	13.9%
Madison County	33,582	3,441	10.2%
Marion County	9,045	1,924	21.3%
Marshall County	12,611	2,130	16.9%
Monroe County	15,333	2,057	13.4%
Montgomery County	4,931	795	16.1%
Neshoba County	10,690	1,641	15.4%
Newton County	8,117	926	11.4%
Noxubee County	4,385	1,088	24.8%
Oktibbeha County	17,285	1,711	9.9%
Panola County	12,404	1,590	12.8%
Pearl River County	21,465	4,178	19.5%
Perry County	4,722	1,023	21.7%
Pike County	14,683	2,470	16.8%
Pontotoc County	9,914	904	9.1%
Prentiss County	9,703	1,037	10.7%
Quitman County	3,432	1,089	31.7%
Rankin County	50,855	3,180	6.3%
Scott County	10,046	1,184	11.8%
Sharkey County	2,063	515	25.0%
Simpson County	10,324	1,681	16.3%
Smith County	5,958	822	13.8%
Stone County	5,273	1,010	19.2%
Sunflower County	9,499	2,413	25.4%
Tallahatchie County	5,071	1,089	21.5%
Tate County	9,989	1,601	16.0%
Tippah County	8,247	968	11.7%
Tishomingo County	7,574	621	8.2%
Tunica County	3,823	853	22.3%
Union County	10,096	803	8.0%
Walthall County	5,346	834	15.6%
Warren County	19,272	2,401	12.5%
Washington County	21,191	6,076	28.7%
Wayne County	8,659	1,589	18.4%
Webster County	3,718	605	16.3%
Wilkinson County	3,703	1,069	28.9%
Winston County	7,513	1,093	14.5%
Yalobusha County	5,432	1,243	22.9%
Yazoo County	9,043	2,704	29.9%

Percent of Households that Received Food Stamps or SNAP Benefits in the past 12 months

	Total Households	Households that received Food Stamps/SNAP	Percent of Households that received Food Stamps/SNAP
Biloxi city	18,558	2,617	14.1%
Clarksdale city	6,646	1,839	27.7%
Cleveland city	4,410	672	15.2%
Greenville city	13,754	3,870	28.1%
Gulfport city	26,304	4,825	18.3%
Hattiesburg city	19,845	3,122	15.7%
Jackson city	64,725	10,847	16.8%
Meridian city	17,424	3,761	21.6%
Ocean Springs city	6,306	448	7.1%
Olive Branch city	11,100	411	3.7%
Philadelphia city	2,892	513	17.7%
Southaven city	15,982	1,039	6.5%
Starkville city	10,244	1,089	10.6%
Tunica town	716	63	8.8%
Tupelo city	13,762	1,712	12.4%
Vicksburg city	10,670	1,603	15.0%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of Population that is Unemployed by Age (for the population 16 years and over)

	Total	16 to 19 years	20 to 29 years	30 to 44 years	45 to 64 years	65 and over
United States	7.2%	22.5%	10.1%	5.8%	5.0%	4.4%
State of Mississippi	9.2%	31.0%	14.7%	6.8%	5.1%	3.8%
Adams County	11.6%	45.8%	19.0%	10.3%	6.3%	5.6%
Alcorn County	8.1%	19.8%	16.2%	7.8%	3.4%	0.0%
Amite County	10.0%	54.2%	12.2%	7.5%	8.2%	0.0%
Attala County	12.2%	43.7%	20.1%	9.8%	6.2%	4.2%
Benton County	12.7%	26.3%	32.4%	12.3%	3.1%	0.0%
Bolivar County	16.8%	40.2%	29.1%	9.8%	8.5%	2.7%
Calhoun County	8.2%	26.9%	18.4%	5.8%	2.6%	0.0%
Carroll County	13.6%	81.6%	22.4%	6.7%	5.2%	0.0%
Chickasaw County	12.3%	31.3%	20.6%	13.0%	4.9%	0.0%
Choctaw County	12.7%	49.6%	20.0%	6.5%	9.3%	0.0%
Claiborne County	10.5%	16.6%	19.6%	8.7%	4.3%	1.2%
Clarke County	11.7%	47.6%	28.1%	9.4%	2.7%	0.0%
Clay County	14.6%	44.1%	20.9%	8.9%	12.0%	0.0%
Coahoma County	15.3%	37.1%	27.3%	14.9%	5.1%	8.3%
Copiah County	8.0%	13.6%	16.3%	6.8%	3.8%	2.2%
Covington County	8.0%	30.7%	13.1%	9.3%	2.2%	2.5%
DeSoto County	6.7%	21.3%	10.9%	4.8%	4.2%	4.4%
Forrest County	8.8%	30.8%	8.6%	8.7%	4.2%	3.3%
Franklin County	9.9%	78.4%	17.9%	8.5%	1.3%	0.0%
George County	10.6%	31.0%	11.3%	12.1%	6.5%	0.0%
Greene County	7.1%	31.8%	6.3%	3.2%	6.9%	16.3%
Grenada County	13.5%	65.5%	14.1%	7.3%	6.6%	19.8%
Hancock County	7.5%	19.0%	7.2%	6.4%	7.2%	8.0%
Harrison County	8.9%	26.6%	11.5%	7.3%	5.8%	6.4%
Hinds County	8.6%	32.0%	12.8%	5.9%	5.2%	5.7%
Holmes County	19.2%	47.1%	31.9%	11.9%	11.8%	5.8%
Humphreys County	18.1%	82.4%	32.8%	10.1%	11.0%	0.0%
Issaquena County	14.1%	25.0%	35.0%	14.7%	6.8%	0.0%
Itawamba County	6.6%	20.6%	8.5%	5.4%	4.3%	2.8%
Jackson County	9.1%	29.4%	15.7%	6.5%	5.3%	2.8%
Jasper County	9.0%	33.5%	13.8%	6.6%	5.4%	0.0%
Jefferson County	11.9%	29.9%	26.2%	10.6%	5.4%	0.0%
Jefferson Davis County	11.2%	29.5%	26.5%	5.9%	5.3%	0.0%
Jones County	5.6%	11.4%	6.9%	6.5%	2.9%	6.7%
Kemper County	10.5%	21.3%	21.5%	11.6%	2.8%	7.3%
Lafayette County	6.9%	22.3%	10.3%	3.9%	3.2%	0.0%
Lamar County	4.6%	10.5%	7.5%	3.9%	2.7%	2.7%
Lauderdale County	9.3%	33.3%	16.8%	5.4%	5.6%	2.1%
Lawrence County	11.2%	15.3%	20.9%	14.6%	4.6%	1.1%

Leake County	7.0%	36.6%	5.7%	4.4%	6.5%	0.0%
Lee County	7.0%	24.3%	14.0%	4.7%	3.4%	1.6%
Leflore County	18.0%	50.2%	30.4%	11.6%	9.2%	2.0%
Lincoln County	8.4%	40.6%	12.1%	6.3%	4.4%	3.1%
Lowndes County	10.2%	36.6%	16.1%	9.1%	4.6%	4.5%
Madison County	6.4%	27.2%	11.9%	3.9%	3.7%	1.3%
Marion County	8.1%	29.6%	14.1%	4.8%	5.0%	5.6%
Marshall County	11.6%	53.4%	14.2%	10.0%	7.1%	2.4%
Monroe County	8.8%	21.3%	19.0%	5.2%	4.4%	8.1%
Montgomery County	11.3%	53.1%	21.9%	4.5%	6.7%	0.0%
Neshoba County	9.1%	22.6%	15.7%	9.1%	3.3%	9.2%
Newton County	6.7%	25.5%	10.8%	1.9%	4.8%	2.8%
Noxubee County	22.4%	43.3%	44.6%	12.7%	13.3%	0.0%
Oktibbeha County	10.1%	22.2%	14.3%	4.1%	5.7%	1.8%
Panola County	11.7%	34.2%	18.3%	10.9%	5.0%	3.0%
Pearl River County	8.4%	34.3%	13.1%	5.5%	4.1%	2.1%
Perry County	8.8%	46.3%	17.8%	3.5%	3.8%	8.8%
Pike County	9.0%	42.1%	15.0%	5.8%	4.0%	4.0%
Pontotoc County	7.0%	25.5%	13.9%	3.7%	4.3%	2.2%
Prentiss County	7.3%	19.7%	9.4%	4.8%	6.4%	0.5%
Quitman County	14.7%	30.8%	24.3%	15.3%	6.5%	8.4%
Rankin County	4.9%	20.5%	7.6%	3.9%	3.1%	0.6%
Scott County	5.9%	34.1%	7.3%	3.8%	2.8%	5.6%
Sharkey County	20.2%	85.0%	34.6%	13.7%	7.5%	0.0%
Simpson County	9.2%	25.9%	15.2%	9.5%	4.0%	6.9%
Smith County	7.1%	25.7%	6.8%	8.7%	3.4%	8.8%
Stone County	8.5%	23.9%	19.7%	6.2%	2.6%	0.0%
Sunflower County	15.1%	49.4%	24.6%	12.4%	5.2%	0.0%
Tallahatchie County	13.6%	25.4%	20.3%	10.9%	8.8%	23.0%
Tate County	6.5%	27.6%	13.1%	4.3%	1.6%	0.4%
Tippah County	13.0%	37.9%	21.2%	11.4%	6.6%	2.5%
Tishomingo County	9.1%	12.6%	11.9%	13.1%	4.1%	4.9%
Tunica County	13.2%	75.9%	15.3%	8.1%	4.9%	0.0%
Union County	7.6%	23.1%	12.7%	3.8%	6.9%	4.4%
Walthall County	6.3%	5.1%	12.3%	3.8%	5.9%	0.0%
Warren County	7.8%	29.9%	14.0%	3.7%	4.9%	8.1%
Washington County	19.9%	69.6%	35.5%	13.0%	9.9%	4.4%
Wayne County	7.1%	11.9%	12.3%	8.1%	3.1%	0.0%
Webster County	10.1%	22.6%	19.8%	7.9%	6.0%	0.0%
Wilkinson County	17.4%	37.9%	28.0%	14.2%	10.5%	0.0%
Winston County	9.4%	51.8%	8.9%	10.2%	5.2%	0.0%
Yalobusha County	15.8%	62.8%	22.7%	8.4%	13.1%	14.7%
Yazoo County	14.8%	43.8%	24.7%	9.0%	9.0%	6.5%

Percent of Population that is Unemployed by Age (for the population 16 years and over)

	Total	16 to 19 years	20 to 29 years	30 to 44 years	45 to 64 years	65 and over
Biloxi city	7.3%	23.1%	6.5%	6.2%	6.3%	2.0%
Clarksdale city	14.7%	36.3%	26.0%	12.9%	5.5%	8.8%
Cleveland city	13.2%	26.6%	21.3%	7.4%	5.7%	0.0%
Greenville city	18.4%	78.1%	34.9%	11.1%	6.4%	0.9%
Gulfport city	10.4%	28.9%	13.0%	9.3%	6.1%	7.7%
Hattiesburg city	10.0%	28.7%	9.7%	10.4%	5.2%	4.2%
Jackson city	9.8%	34.5%	14.2%	6.7%	6.3%	7.3%
Meridian city	12.0%	40.4%	20.1%	7.7%	7.3%	2.4%
Ocean Springs city	6.5%	27.2%	10.1%	6.4%	2.9%	0.0%
Olive Branch city	5.4%	12.9%	10.6%	3.6%	3.3%	5.6%
Philadelphia city	9.7%	15.9%	11.9%	11.5%	5.7%	0.0%
Southaven city	7.0%	14.8%	12.9%	4.7%	4.2%	4.3%
Starkville city	10.8%	29.9%	13.2%	5.3%	6.7%	3.1%
Tunica town	1.5%	0.0%	1.4%	0.0%	3.1%	0.0%
Tupelo city	8.0%	29.7%	16.6%	5.4%	3.5%	0.0%
Vicksburg city	9.3%	29.2%	15.6%	3.1%	6.9%	13.5%

The unemployment rate represents the number of unemployed people as a percentage of the civilian labor force.

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of Housing Units that are Occupied vs. Vacant

	Occupied	Vacant
United States	88.2%	11.8%
State of Mississippi	86.5%	13.5%
Adams County	83.4%	16.6%
Alcorn County	82.7%	17.3%
Amite County	75.9%	24.1%
Attala County	82.3%	17.7%
Benton County	80.0%	20.0%
Bolivar County	87.9%	12.1%
Calhoun County	85.3%	14.7%
Carroll County	77.5%	22.5%
Chickasaw County	88.5%	11.5%
Choctaw County	83.4%	16.6%
Claiborne County	81.0%	19.0%
Clarke County	83.0%	17.0%
Clay County	87.5%	12.5%
Coahoma County	85.8%	14.2%
Copiah County	86.7%	13.3%
Covington County	87.7%	12.3%
DeSoto County	93.6%	6.4%
Forrest County	89.5%	10.5%
Franklin County	70.4%	29.6%
George County	88.3%	11.7%
Greene County	82.6%	17.4%
Grenada County	88.9%	11.1%
Hancock County	81.4%	18.6%
Harrison County	84.0%	16.0%
Hinds County	86.1%	13.9%
Holmes County	79.5%	20.5%
Humphreys County	88.1%	11.9%
Issaquena County	81.8%	18.2%
Itawamba County	87.9%	12.1%
Jackson County	85.6%	14.4%
Jasper County	81.0%	19.0%
Jefferson County	77.9%	22.1%
Jefferson Davis County	82.4%	17.6%
Jones County	90.9%	9.1%
Kemper County	81.7%	18.3%
Lafayette County	78.6%	21.4%
Lamar County	91.1%	8.9%
Lauderdale County	88.0%	12.0%
Lawrence County	82.8%	17.2%

Leake County	81.0%	19.0%
Lee County	88.5%	11.5%
Leflore County	85.5%	14.5%
Lincoln County	88.9%	11.1%
Lowndes County	87.8%	12.2%
Madison County	92.8%	7.2%
Marion County	83.3%	16.7%
Marshall County	86.4%	13.6%
Monroe County	90.9%	9.1%
Montgomery County	80.9%	19.1%
Neshoba County	84.3%	15.7%
Newton County	83.3%	16.7%
Noxubee County	79.8%	20.2%
Oktibbeha County	86.8%	13.2%
Panola County	84.5%	15.5%
Pearl River County	87.1%	12.9%
Perry County	88.9%	11.1%
Pike County	83.6%	16.4%
Pontotoc County	86.0%	14.0%
Prentiss County	86.2%	13.8%
Quitman County	86.1%	13.9%
Rankin County	93.2%	6.8%
Scott County	85.8%	14.2%
Sharkey County	81.7%	18.3%
Simpson County	87.8%	12.2%
Smith County	80.6%	19.4%
Stone County	89.7%	10.3%
Sunflower County	88.4%	11.6%
Tallahatchie County	84.2%	15.8%
Tate County	92.4%	7.6%
Tippah County	87.9%	12.1%
Tishomingo County	76.0%	24.0%
Tunica County	85.1%	14.9%
Union County	89.8%	10.2%
Walthall County	78.3%	21.7%
Warren County	89.8%	10.2%
Washington County	84.3%	15.7%
Wayne County	91.4%	8.6%
Webster County	81.6%	18.4%
Wilkinson County	68.3%	31.7%
Winston County	85.1%	14.9%
Yalobusha County	81.5%	18.5%
Yazoo County	87.2%	12.8%

Percent of Housing Units that are Occupied vs. Vacant

	Occupied	Vacant
Biloxi city	81.6%	18.4%
Clarksdale city	84.8%	15.2%
Cleveland city	91.1%	8.9%
Greenville city	85.6%	14.4%
Gulfport city	83.2%	16.8%
Hattiesburg city	88.3%	11.7%
Jackson city	83.6%	16.4%
Meridian city	88.6%	11.4%
Ocean Springs city	90.8%	9.2%
Olive Branch city	94.2%	5.8%
Philadelphia city	86.5%	13.5%
Southaven city	93.6%	6.4%
Starkville city	87.1%	12.9%
Tunica town	93.5%	6.5%
Tupelo city	88.8%	11.2%
Vicksburg city	89.3%	10.7%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Percent of Occupied Housing Units that are Owned vs. Rented

	Owner occupied	Renter occupied
United States	66.9%	33.1%
State of Mississippi	70.5%	29.5%
Adams County	68.0%	32.0%
Alcorn County	73.2%	26.8%
Amite County	81.4%	18.6%
Attala County	74.4%	25.6%
Benton County	77.6%	22.4%
Bolivar County	54.9%	45.1%
Calhoun County	68.3%	31.7%
Carroll County	82.2%	17.8%
Chickasaw County	71.3%	28.7%
Choctaw County	77.5%	22.5%
Claiborne County	72.9%	27.1%
Clarke County	77.2%	22.8%
Clay County	68.8%	31.2%
Coahoma County	56.3%	43.7%
Copiah County	75.8%	24.2%
Covington County	85.1%	14.9%
DeSoto County	78.6%	21.4%
Forrest County	56.6%	43.4%
Franklin County	84.3%	15.7%
George County	85.0%	15.0%
Greene County	88.6%	11.4%
Grenada County	65.6%	34.4%
Hancock County	74.9%	25.1%
Harrison County	65.3%	34.7%
Hinds County	60.9%	39.1%
Holmes County	72.2%	27.8%
Humphreys County	61.3%	38.7%
Issaquena County	64.4%	35.6%
Itawamba County	79.7%	20.3%
Jackson County	72.4%	27.6%
Jasper County	85.0%	15.0%
Jefferson County	72.9%	27.1%
Jefferson Davis County	81.1%	18.9%
Jones County	73.2%	26.8%
Kemper County	77.6%	22.4%
Lafayette County	61.6%	38.4%
Lamar County	75.3%	24.7%
Lauderdale County	64.9%	35.1%
Lawrence County	84.6%	15.4%

Leake County	78.0%	22.0%
Lee County	69.6%	30.4%
Leflore County	51.1%	48.9%
Lincoln County	76.7%	23.3%
Lowndes County	65.1%	34.9%
Madison County	70.2%	29.8%
Marion County	78.6%	21.4%
Marshall County	77.9%	22.1%
Monroe County	76.8%	23.2%
Montgomery County	75.5%	24.5%
Neshoba County	73.8%	26.2%
Newton County	80.3%	19.7%
Noxubee County	75.3%	24.7%
Oktibbeha County	48.9%	51.1%
Panola County	76.5%	23.5%
Pearl River County	78.0%	22.0%
Perry County	84.9%	15.1%
Pike County	73.0%	27.0%
Pontotoc County	78.9%	21.1%
Prentiss County	79.4%	20.6%
Quitman County	64.6%	35.4%
Rankin County	77.1%	22.9%
Scott County	80.0%	20.0%
Sharkey County	66.8%	33.2%
Simpson County	77.3%	22.7%
Smith County	85.8%	14.2%
Stone County	78.1%	21.9%
Sunflower County	55.6%	44.4%
Tallahatchie County	73.1%	26.9%
Tate County	76.9%	23.1%
Tippah County	75.3%	24.7%
Tishomingo County	79.5%	20.5%
Tunica County	47.2%	52.8%
Union County	76.3%	23.7%
Walthall County	83.9%	16.1%
Warren County	65.6%	34.4%
Washington County	55.8%	44.2%
Wayne County	82.1%	17.9%
Webster County	72.9%	27.1%
Wilkinson County	75.0%	25.0%
Winston County	79.1%	20.9%
Yalobusha County	72.2%	27.8%
Yazoo County	63.6%	36.4%

Percent of Occupied Housing Units that are Owned vs. Rented

	Owner occupied	Renter occupied
Biloxi city	56.8%	43.2%
Clarksdale city	53.5%	46.5%
Cleveland city	48.4%	51.6%
Greenville city	54.7%	45.3%
Gulfport city	61.5%	38.5%
Hattiesburg city	41.3%	58.7%
Jackson city	54.3%	45.7%
Meridian city	52.3%	47.7%
Ocean Springs city	73.8%	26.2%
Olive Branch city	84.9%	15.1%
Philadelphia city	59.0%	41.0%
Southaven city	69.0%	31.0%
Starkville city	36.9%	63.1%
Tunica town	58.4%	41.6%
Tupelo city	62.6%	37.4%
Vicksburg city	52.9%	47.1%

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Median Value for Occupied Housing Units

	Median Home Value	Median Gross Rent
United States	$185,400	$817
State of Mississippi	$91,400	$622
Adams County	$72,400	$533
Alcorn County	$83,800	$437
Amite County	$68,400	$550
Attala County	$71,100	$478
Benton County	$61,800	$533
Bolivar County	$74,200	$574
Calhoun County	$61,300	$474
Carroll County	$64,400	$558
Chickasaw County	$58,700	$467
Choctaw County	$70,300	$497
Claiborne County	$52,500	$517
Clarke County	$60,200	$561
Clay County	$72,700	$554
Coahoma County	$55,900	$562
Copiah County	$72,400	$539
Covington County	$76,700	$522
DeSoto County	$148,800	$876
Forrest County	$97,600	$610
Franklin County	$77,300	$347
George County	$88,100	$488
Greene County	$65,400	$530
Grenada County	$81,700	$534
Hancock County	$149,900	$729
Harrison County	$133,400	$811
Hinds County	$102,200	$733
Holmes County	$48,000	$460
Humphreys County	$64,300	$448
Issaquena County	$60,300	$368
Itawamba County	$76,100	$529
Jackson County	$120,500	$754
Jasper County	$63,200	$472
Jefferson County	$67,100	$388
Jefferson Davis County	$63,900	$465
Jones County	$75,400	$578
Kemper County	$61,600	$491
Lafayette County	$143,400	$697
Lamar County	$148,100	$772
Lauderdale County	$79,800	$584
Lawrence County	$68,200	$537

Leake County	$67,200	$579
Lee County	$105,200	$548
Leflore County	$60,700	$443
Lincoln County	$77,400	$517
Lowndes County	$96,300	$570
Madison County	$171,400	$777
Marion County	$76,300	$525
Marshall County	$80,300	$520
Monroe County	$76,500	$485
Montgomery County	$67,200	$503
Neshoba County	$70,800	$548
Newton County	$69,400	$488
Noxubee County	$50,700	$445
Oktibbeha County	$109,600	$599
Panola County	$73,300	$595
Pearl River County	$116,700	$641
Perry County	$70,900	$483
Pike County	$83,100	$532
Pontotoc County	$81,300	$568
Prentiss County	$67,400	$458
Quitman County	$44,600	$413
Rankin County	$139,000	$808
Scott County	$61,400	$548
Sharkey County	$68,100	$451
Simpson County	$72,900	$572
Smith County	$74,500	$551
Stone County	$96,000	$614
Sunflower County	$62,600	$487
Tallahatchie County	$45,500	$453
Tate County	$93,400	$630
Tippah County	$65,500	$522
Tishomingo County	$71,900	$437
Tunica County	$74,300	$651
Union County	$79,200	$528
Walthall County	$78,700	$602
Warren County	$96,900	$629
Washington County	$70,500	$574
Wayne County	$55,300	$455
Webster County	$69,700	$461
Wilkinson County	$52,900	$452
Winston County	$71,700	$609
Yalobusha County	$64,200	$453
Yazoo County	$70,400	$559

Median Value for Occupied Housing Units

	Median Home Value	Median Gross Rent
Biloxi city	$150,100	$775
Clarksdale city	$58,300	$552
Cleveland city	$102,100	$630
Greenville city	$73,600	$588
Gulfport city	$118,800	$821
Hattiesburg city	$97,800	$608
Jackson city	$87,700	$727
Meridian city	$78,600	$568
Ocean Springs city	$161,400	$987
Olive Branch city	$161,500	$952
Philadelphia city	$82,400	$586
Southaven city	$133,600	$866
Starkville city	$124,400	$590
Tunica town	$115,500	$549
Tupelo city	$118,300	$536
Vicksburg city	$87,900	$596

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

Median selected monthly owner costs as a percent of household income (in the past 12 months)

	Total	Housing units with a mortgage	Housing units without a mortgage
United States	21.4%	24.8%	12.7%
State of Mississippi	18.7%	22.9%	12.4%
Adams County	18.0%	22.8%	12.9%
Alcorn County	16.7%	20.8%	12.1%
Amite County	17.9%	24.3%	14.7%
Attala County	17.1%	21.8%	13.0%
Benton County	23.2%	29.7%	17.3%
Bolivar County	22.1%	26.1%	16.1%
Calhoun County	17.1%	22.0%	13.1%
Carroll County	18.0%	23.9%	15.6%
Chickasaw County	18.1%	25.2%	9.6%
Choctaw County	19.5%	24.8%	12.3%
Claiborne County	24.9%	30.0%	19.6%
Clarke County	17.0%	21.7%	13.3%
Clay County	18.9%	22.0%	14.4%
Coahoma County	22.0%	26.0%	16.4%
Copiah County	17.3%	20.4%	12.3%
Covington County	18.2%	22.8%	13.0%
DeSoto County	21.1%	23.2%	10.4%
Forrest County	18.7%	23.4%	13.1%
Franklin County	15.8%	20.8%	12.0%
George County	14.2%	20.4%	9.6%
Greene County	16.4%	21.1%	12.4%
Grenada County	18.4%	21.4%	13.6%
Hancock County	19.1%	24.0%	11.9%
Harrison County	19.3%	23.8%	11.2%
Hinds County	20.0%	23.4%	12.1%
Holmes County	26.1%	38.4%	18.9%
Humphreys County	23.8%	28.4%	18.0%
Issaquena County	24.7%	35.4%	20.5%
Itawamba County	16.5%	21.2%	11.3%
Jackson County	18.1%	22.0%	10.8%
Jasper County	17.5%	23.9%	13.7%
Jefferson County	20.9%	28.8%	15.1%
Jefferson Davis County	20.2%	29.4%	13.7%
Jones County	17.2%	22.1%	12.1%
Kemper County	17.3%	20.4%	12.6%
Lafayette County	17.8%	21.5%	10.8%
Lamar County	17.6%	21.2%	10.5%
Lauderdale County	18.7%	22.6%	12.3%

Lawrence County	17.5%	21.3%	12.1%
Leake County	18.2%	24.0%	12.6%
Lee County	18.2%	21.7%	11.6%
Leflore County	20.1%	24.6%	14.4%
Lincoln County	16.5%	21.2%	11.6%
Lowndes County	19.3%	22.6%	11.1%
Madison County	19.6%	21.6%	11.3%
Marion County	18.0%	22.8%	13.5%
Marshall County	19.9%	23.3%	15.1%
Monroe County	17.8%	22.3%	11.4%
Montgomery County	19.8%	26.0%	15.5%
Neshoba County	17.1%	22.1%	12.0%
Newton County	16.8%	21.4%	12.4%
Noxubee County	22.4%	26.3%	17.1%
Oktibbeha County	18.1%	22.0%	10.6%
Panola County	19.4%	22.7%	14.9%
Pearl River County	18.5%	24.8%	11.8%
Perry County	18.2%	24.4%	11.3%
Pike County	18.7%	24.0%	13.0%
Pontotoc County	17.2%	23.1%	10.1%
Prentiss County	17.5%	24.3%	12.4%
Quitman County	19.0%	26.5%	13.3%
Rankin County	18.4%	21.2%	9.4%
Scott County	18.7%	22.7%	14.5%
Sharkey County	18.2%	26.1%	14.1%
Simpson County	18.0%	23.9%	13.2%
Smith County	16.4%	21.1%	13.3%
Stone County	17.1%	20.8%	10.2%
Sunflower County	20.7%	28.4%	14.7%
Tallahatchie County	19.0%	28.9%	14.4%
Tate County	20.8%	23.8%	13.6%
Tippah County	17.2%	24.8%	11.7%
Tishomingo County	15.1%	23.2%	10.5%
Tunica County	20.0%	24.4%	11.7%
Union County	18.5%	23.0%	11.5%
Walthall County	19.3%	26.5%	14.4%
Warren County	18.1%	20.2%	12.2%
Washington County	20.4%	24.9%	14.3%
Wayne County	18.0%	24.1%	13.3%
Webster County	17.8%	20.6%	13.2%
Wilkinson County	23.6%	35.7%	13.7%
Winston County	19.2%	23.2%	14.4%
Yalobusha County	19.0%	25.8%	13.4%
Yazoo County	20.5%	26.9%	15.3%

Median selected monthly owner costs as a percent of household income (in the past 12 months)

	Total	Housing units with a mortgage	Housing units without a mortgage
Biloxi city	17.3%	22.7%	9.7%
Clarksdale city	22.3%	25.9%	16.4%
Cleveland city	18.9%	21.1%	14.7%
Greenville city	21.1%	25.2%	14.5%
Gulfport city	20.8%	24.0%	12.7%
Hattiesburg city	19.2%	24.5%	13.3%
Jackson city	20.9%	24.1%	13.3%
Meridian city	20.2%	24.2%	13.1%
Ocean Springs city	19.6%	21.9%	11.4%
Olive Branch city	20.7%	22.7%	9.2%
Philadelphia city	18.5%	20.7%	14.0%
Southaven city	20.9%	23.2%	9.7%
Starkville city	17.8%	19.8%	8.7%
Tunica town	13.1%	16.6%	8.8%
Tupelo city	19.2%	21.9%	10.9%
Vicksburg city	19.9%	22.1%	15.5%

Selected monthly owner costs include the sum of payments for mortgages, deeds of trust, or similar debts on the property (including payments for the first mortgage, second or junior mortgages, and home equity loans); real estate taxes; fire, hazard, and flood insurance on the property; utilities (electricity, gas, water, and sewer); and fuels (oil, coal, kerosene, wood, etc.). It also includes, where appropriate, monthly condominium fees.

Excessive owner costs are those that exceed 30% of household income.

Source: U.S. Census Bureau, 2005-2009 American Community Survey 5-year Estimates.

LEAVITT PARTNERS

ATTACHMENT C

Mississippi Data Report II

Demographic, Cost, & Growth Projections for the Uninsured & General Mississippi Population

Created for the

Mississippi Insurance Department

05/27/2011

Table of Contents

The purpose of this report is to provide the Mississippi Insurance Department (MID) with projections and estimates for the state regarding certain demographic, cost, and growth projections for the uninsured and general population of Mississippi. Some of these analyses are time-series projections that estimate changing characteristics and compositions while other analyses are intended to provide a snap-shot to MID of the current environment in which implementation is likely to take place. This data is designed to enable MID to continue planning and designing an exchange that best serves the changing environment of the state.

County-level data encompasses each of Mississippi's 82 counties. Other data regarding demographics, social variables, and economic information are included in an ancillary report that also encompasses Mississippi's 82 counties along with 16 select cities.

About the Data

Data used in this report comes from Thomson Reuters. Thomson Reuters uses a myriad of public and private database sources to collect, synthesize, and model data. The attached Excel spreadsheet includes all data elements acquired by Leavitt Partners. The attached spreadsheet contains 17 tables and 3 charts. The data are located on different tabs in spreadsheet. The title of each tab with the corresponding table or chart title will be used as reference points below.

Uninsured Population Information

Table 1: Uninsured Population by Industry

This table is labeled under "Industry" in the spreadsheet and contains the current count of the uninsured by industry in the state of Mississippi with a corresponding percentage of the total population. The top industries that employ the uninsured are entertainment (12%), construction (10%), manufacturing (9%), and services (5%). The total uninsured count in the state is 532,993. The table goes on to list the total population composition of the state by industry. The biggest industries in the state are entertainment (6%), education (5%), construction (4%), and professional services (3%). The total count for industry is 2,951,996 bringing the percentage of unemployed accounted for in industry to 18.1%. There is a rather large "Other" category that merits further investigation.

Table 2: Uninsured Population by Age & Gender

This table is labeled under "Age & Gender" in the spreadsheet and contains an age and gender distribution for the uninsured and total Mississippi population. For the uninsured, the largest level is found in the 18-44 category at 62%, representing 327,791 people. In this category, 54% are male and 46% are female. The uninsured are not as prevalent in lower or higher age groups. The uninsured can be compared to the total state population showing that the 18-44 category makes up 37% of the state's population. These numbers infer that the 18-44 age-bracket represent a sizable opportunity for Mississippi.

Table 3: Uninsured Population by FPL Distribution

This table is labeled under "% of FPL" in the spreadsheet and shows a distribution of uninsured and total population by the Federal Poverty Level. The aprioriexpectation of these metrics would be a decreasing rate of incidence in being uninsured as the percentage of FPL level grows. This is interestingly not the case. While the 0-49% level contains 22% of the uninsured population (119,593 lives), the next highest amount of the uninsured is found in the 133%-199% FPL level. The remaining data for Mississippi are fairly evenly distributed, accounting for the 24% of the population that is over 400% FPL.

Table 4: Uninsured Population by Ethnicity

This table is labeled under "Ethnicity" in the spreadsheet and shows the distribution of ethnic groups with respect to the uninsured and total populations of Mississippi. Mississippi has a fairly even split in both

populations with Caucasians making up 49% and African Americans making up 44% of the uninsured market. These make up 59% and 38% of the state's total population respectively. Additionally, Hispanics constitute 5% of the uninsured population while making up 2% of the total in the state.

Table 5: Uninsured Population by Medicaid Eligibility

This table is labeled under "Medicaid Eligibility" in the spreadsheet and shows separation of those who are and are not eligible for Medicaid in both the uninsured and total population. The data shows that 23% of the uninsured population currently is eligible for Medicaid but remains uninsured, while 77% of the uninsured population is not currently eligible. These numbers are representative of the total Medicaid numbers in the state.

Table 6: Uninsured Population by Education

This table is labeled under "Education" in the spreadsheet and shows the distribution of the level of educational attainment by both the uninsured and total population in Mississippi. This is a very illuminating metric as it shows that 91% of the uninsured market has a high school diploma or less. Additionally, only 8% of the uninsured have a B.A. or some college and 1% of the uninsured have a graduate degree. In comparison, 82% of the population of Mississippi has a high school diploma or less.

Table 7: Uninsured Population by Marital Status

This table is labeled under "Marital Status" in the spreadsheet and shows the marital status of the uninsured and total Mississippi populations. These numbers show that 72% of the uninsured population is unmarried while only 58% of the total Mississippi population is unmarried. Conversely, 28% of the uninsured market is married.

Table 8: Uninsured Population by Household Work Status

This table is labeled under "Household Work Status" in the spreadsheet and shows numbers reflecting the work status of households in both the uninsured and broader Mississippi populations. Some of the most interesting elements of this table are as follows:

- Female led households with no husband present, with the woman employed in in the labor forcemake up 16% of the uninsured market
- Households with both a wife and husband in the labor force who are both employed make up 14% of the uninsured market
- Households with the husband in the labor force and the wife not in the labor force with the husband unemployed make up 13% of the uninsured market
- Female led households with no husband present, and the female not in the labor force make up 11% of the uninsured market

What makes these results interesting is that 3 of the 4 selected data points show that someone in the family is in the labor force and employed have a higher incidence of being uninsured. Overall, 27% of Mississippi's population is made up of households where both the husband and wife are in the labor force and employed. There is an implication here that either the employer insurance offer rate is an opportunity for the state or there is a higher degree of part time workers in the state.

Table 9: Uninsured Population by Family Income

This table is labeled under "Family Income" in the spreadsheet and shows the distribution of family income for both the uninsured and aggregate populations. While this can be somewhat contrasted to the distribution of households in percentage to FPL, these income numbers present a more holistic snapshot of the Mississippi landscape as it details a more precise income picture. Of particular note, 17% of the uninsured make less than $15,000, 15% make between $15,000 and $24,999, and 11% make between $25,000 and $34,999. Respectively, the corresponding proportion of the total Mississippi population are 12%, 10%, and 9% respectively. There is an almost symmetric distribution of income in the middle income brackets ($35,000 to $99,999). When paired with the FPL data in the spreadsheet, this can paint a clarifying picture on the financial condition of the uninsured market and can enable the state to make more prudent decisions in engaging the uninsured population.

Table 10: House Income Distribution by County

This table is labeled under "Household Income by County" and is designed to show how income breaks down across the state's different localities. This table provides a population count by county for income in $5k increments (except for the first and last entries). If made to show relative and comparative population with the uninsured and percentage to FPL metrics in tandem, this analysis could enable the state to have a very targeted study that will help decision makes know the areas that Navigators must focus in on.

Table 11: Uninsured Population Trend (1987-2009)

This table and corresponding chart are labeled under "Trended Uninsured". While the data is simple, it has strong implications when examined in the context of state and national policy decisions. The uninsured population for the state stayed fairly steady, ranging from 17% to 20%, from 1987 to 1998. In 1999 the uninsured rate began to plummet, ultimately bottoming out at 13% in 2000. After this, it crept back up to the 15% area and remained somewhat flat until seeing another spike in 2007. Interestingly, today's unemployment trend is lower than that of the 1990s. Policy makers should investigate the circumstances related to the drop in 2000 and overlay this to federal requirements related to PPACA for the benefit of understanding what is driving insurance purchasing decisions of the uninsured. While economic drivers could have been an explanatory variable to the falling uninsured numbers in this time period, it demonstrates that the uninsured are aware of their options but lack the financial resources to take advantage of them.

Health Care Cost Data

Table 12: Commercial Cost Characteristics (2008)

This table is labeled under "Comm Cost" and is designed to capture commercial costs associated with different types of treatment. This information is taken over 2007 and 2008 and examines Medical and Rx Per Capita Costs, Inpatient Hospital, Outpatient Hospital, Outpatient Radiology, Outpatient Laboratory, Emergency Department, Rx, and the general Relative Risk Score. The data is derived from claims data and information from commercial carriers. While limited in scope, the data is intended to be directional in assisting MID to more fully understand the drivers and drainers of commercial cost in the state.

Table 13: Commercial Population Chronic Conditions Profile (2008)

This table is labeled under "Chronic Conditions Profile" and examines patient and cost statistics related to different medical episodes such as Coronary Artery Disease, Osteoarthritis, Hypertension, Diabetes, Breast Cancer, Spinal/Back Disorder, Colon Cancer, Asthma, Depression, Lung Cancer, Skin Cancer, COPD, Overweigh/Obesity, Cervical Cancer, HIV Infection, Congestive Heart Failure, and Cirrhosis of the Liver. The profiling of these chronic conditions is done with respect to Allowed Amount Med and Rx, Patients Episodes, Episodes, Admits Episodes, Allowed Amount/Episode, Episodes/1000, and Admits Episodes/1000. While this data may not be as beneficial in formal exchange planning and implementation, it should assist MID in better understanding chronic condition trends in the state and their associated costs. Additionally, there are care and utilization management tools that could be built into the exchange through carriers to assist those with chronic conditions in managing cost. The state can use this data to better inform such tools whether they are employed inside of or outside of the exchange.

Mississippi County Projections

Table 14: Projected Population by County

This table is labeled under "Total Population" and projects the total population count of the state for each year between 2010 and 2020 by county. The state's population is projected to grow 3.7% over the next decade. However, there will be a significant amount of population shifting within the state. This changing population composition is something that MID will want to pay close attention to.

Population centers that will experience the greatest degree growth are DeSoto County (32%), Lamar County (19%) Madison County (19%), Rankin County (17%) Stone County (16%), and Pearl River County (15%). This data should be used to assist MID in understanding the geographic reordering of the state over the next 10 years and reallocating resources accordingly. Also, due to the rural nature of some areas of the state, a shrewd understanding of changing population characteristics will enable MID to identify the right set of resources that are most advantageous to a select population group.

Table 15: Projected Medicaid Covered Lives by County (2010-2020)

This table is labeled under "Medicaid" and shows the projected number of lives that will be covered for each year between 2010 and 2020 by county. As the exchange bears a Medicaid eligibility requirement, MID will have a special interest in this data as it indicates the areas that will have a higher degree of Medicaid growth, in both base and PPACA driven growth. A second associated table breaks down the raw population data and shows the estimation as a percentage of population. In 2014, it is estimated that 24% of Mississippi's population will be eligible for Medicaid (though the data does not directly account for the dual-eligible Medicare population). This number also represents the population that will be eligible in 2020, showing that after 2014 there is not projected to be an additional surge of Medicaid enrollees beyond the new base.

Table 16: Projected Uninsured Lives by County (2010 – 2020)

This table is labeled under "Uninsured" and shows the projected number of uninsured lives for each year between 2010 and 2020 by county. When compared and contrasted to the thorough demographic information on the uninsured, this data can be very helpful in a directional analysis of what counties have a higher concentration of uninsured. There is expected to be a portion of the population that remains "strategically uninsured", meaning that they will make a conscious decision to not purchase insurance. MID should use this information to focus on the core uninsured that may not be aware of their options regarding the premium subsidy or Medicaid eligibility.

Table 17: Projected Payor Composition (2010 – 2020)

This table is labeled under "Payor Composition" and shows howMississippi's population is covered between 2010 and 2020. The payor types are Medicaid – Capitated, Medicaid – Non Capitated, Medicare – Capitated, Medicare – Dual, Medicare – Non Capitated, Private – Direct, Private – Employer Sponsored, and Private – Exchange. This information will provide MID with an accurate snapshot of the driving elements for payor sources within the state. More specifically, Medicaid and Private - Exchange information should help to inform decisions related to the AHBE, while information on the Private – Employer Sponsored Market should help in informing SHOP exchange related decision making.

Chart 1: Mississippi Historic Unemployment Rate (Trended)

This chart is labeled under "Trended Unemployment Rate" and shows a graphical representation of Mississippi's unemployment over time. The state has followed that national trend line and has recently seen a drawing down of its unemployment. However, other exogenous events such as the Gulf oil spill in 2010 and the weather damage related to storms and flooding in the state will likely continue to delineate Mississippi's unemployment patters from the aggregate.

Chart 2: 10 Year Change in Uninsured & Medicaid by Number of Lives (2010-2020)

This chart is labeled under "10 Yr Change No of Lives" in the spreadsheet and is intended to show a graphical representation of the shift in lives between the uninsured and Medicaid over the next 10 years. As expected, the shift is almost symmetric as a healthy majority of the currently uninsured will naturally go into the Medicaid market.

Chart 3: 10 Year Change in Uninsured & Medicaid by Percentage of Population (2010-2020)

This chart is labeled under "10 Yr Change % of Total" in the spreadsheet and shows a similar graphic representation as that of Chart 2 in the shifting proportion of uninsured and Medicaid insured over the next 10 years. However, instead of portraying number of lives, this chart shows the results as a percentage of population.

Table 1: Uninsured Population by Industry

Industry	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
ADM	4,377	1%	78,446	3%
AGR	12,338	2%	30,451	1%
CON	55,734	10%	131,507	4%
EDU	13,582	3%	141,656	5%
ENT	62,000	12%	171,297	6%
EXT	1,897	0%	14,148	0%
FIN	9,990	2%	75,428	3%
INF	2,837	1%	19,338	1%
MED	22,402	4%	172,154	6%
MFG	46,122	9%	201,488	7%
MIL	640	0%	16,706	1%
OTH	153,173	29%	1,333,939	45%
PRF	26,576	5%	101,112	3%
RET	51,586	10%	200,318	7%
SCA	9,551	2%	34,296	1%
SRV	26,205	5%	79,102	3%
TRN	14,432	3%	71,321	2%
UNE	11,313	2%	25,448	1%
UTL	1,553	0%	14,924	1%
WHL	6,685	1%	38,917	1%
Grand Total	**532,993**		**2,951,996**	

Table 2: Uninsured Population by Age & Gender

	Uninsured				MS Total			
Age	Female	Male	Total	% of Total	Female	Male	Total	% of Total
00 - 17	39,655	37,827	77,482	15%	370,306	394,161	764,467	26%
18 - 44	140,186	187,605	327,791	62%	546,439	536,894	1,083,333	37%
45 - 64	62,930	64,433	127,363	24%	377,486	351,326	728,812	25%
65 & UP	342	15	357	0%	222,576	152,808	375,384	13%
Grand Total	**243,113**	**289,880**	**532,993**		**1,516,807**	**1,435,189**	**2,951,996**	

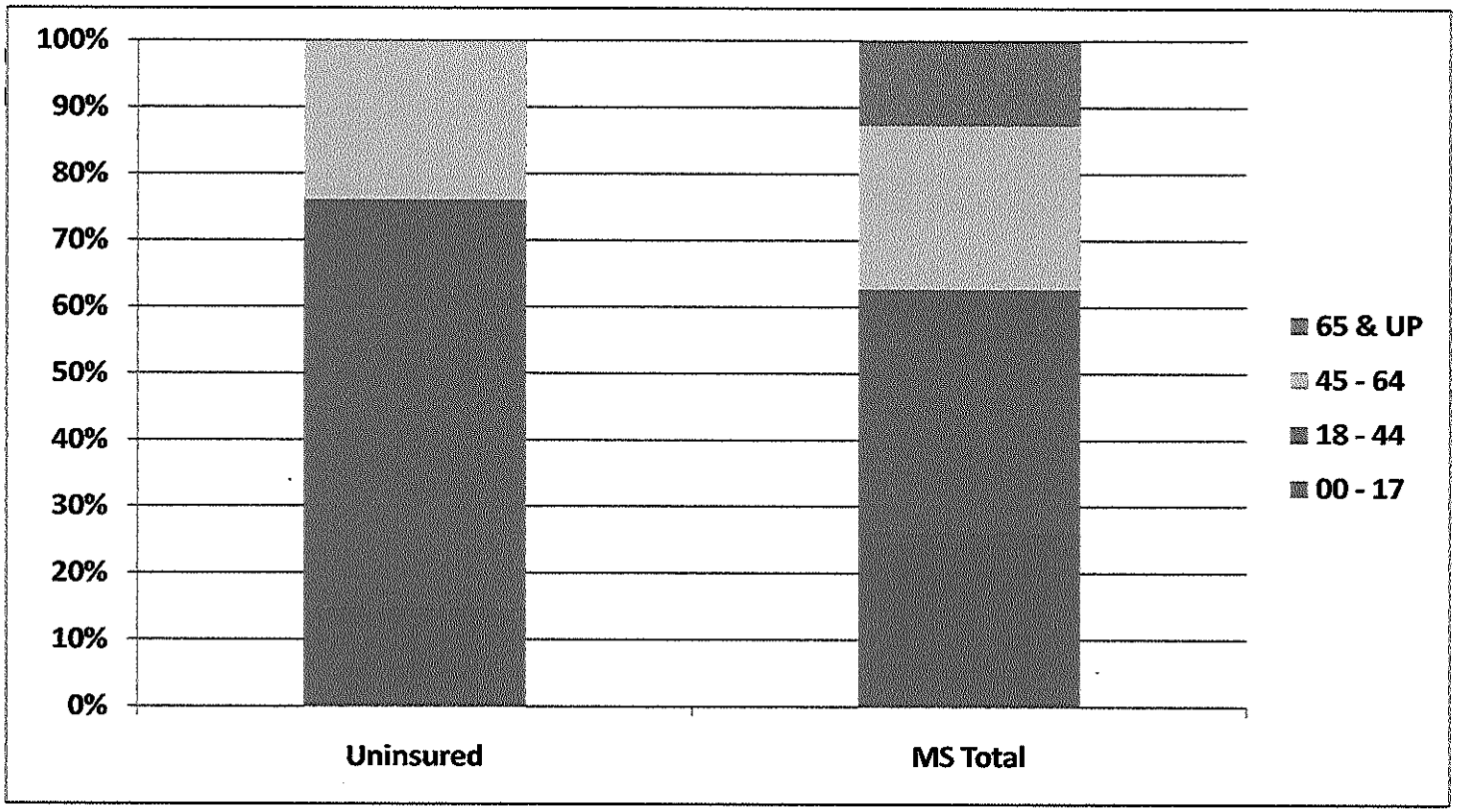


Table 3: Uninsured Population by FPL Distribution

% of FPL	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
0- 49	119,593	22%	377,575	13%
50- 99	91,481	17%	343,409	12%
100-132	49,010	9%	219,790	7%
133-199	99,384	19%	427,198	14%
200-300	87,919	16%	511,794	17%
300-400	41,593	8%	368,617	12%
400 PLUS	44,013	8%	703,613	24%
Grand Total	**532,993**		**2,951,996**	

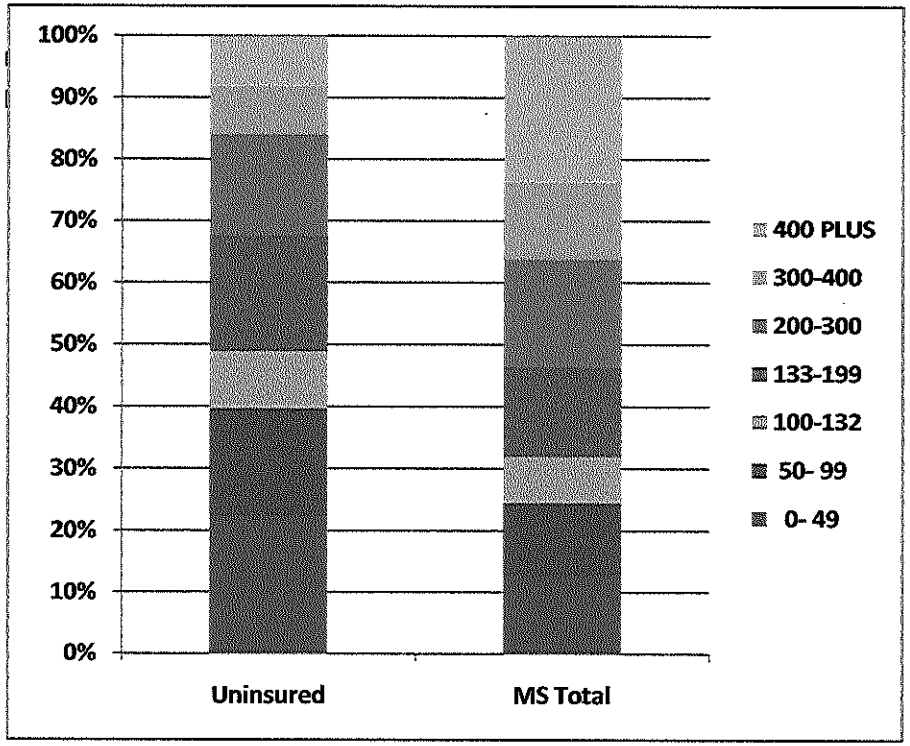


Table 4: Uninsured Population by Ethnicity

Ethnicity	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
African American	233,970	44%	1,112,525	38%
Asian	5,070	1%	24,080	1%
Caucasian	260,265	49%	1,733,427	59%
Hispanic	28,064	5%	65,619	2%
Other	5,624	1%	16,345	1%
Grand Total	**532,993**		**2,951,996**	

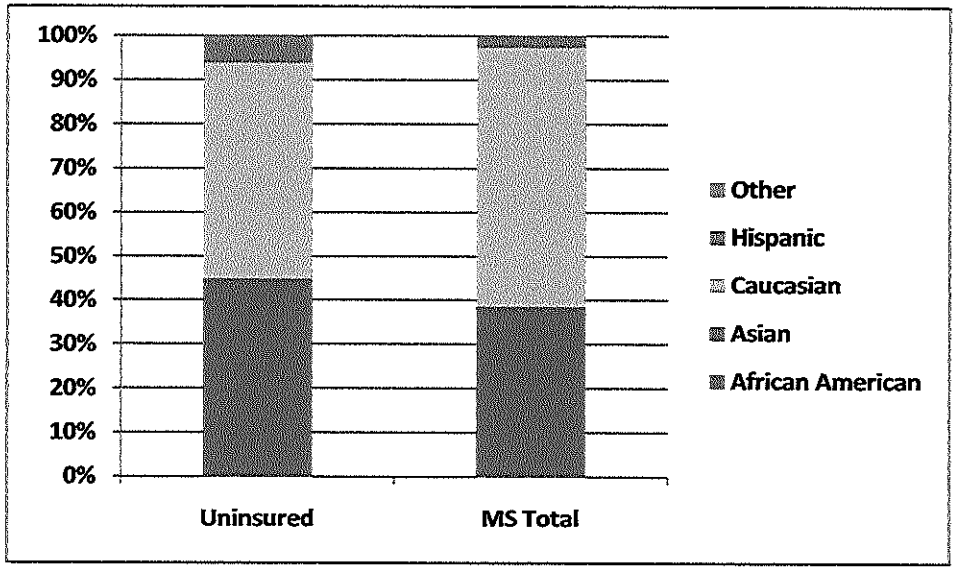


Table 5: Uninsured Population by Medicaid Eligibility

Medicaid Eligibility	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
Currently Eligible for Medicaid	120,875	23%	650,077	22%
Not Currently Medicaid Eligible	412,118	77%	2,301,919	78%
Grand Total	**532,993**		**2,951,996**	

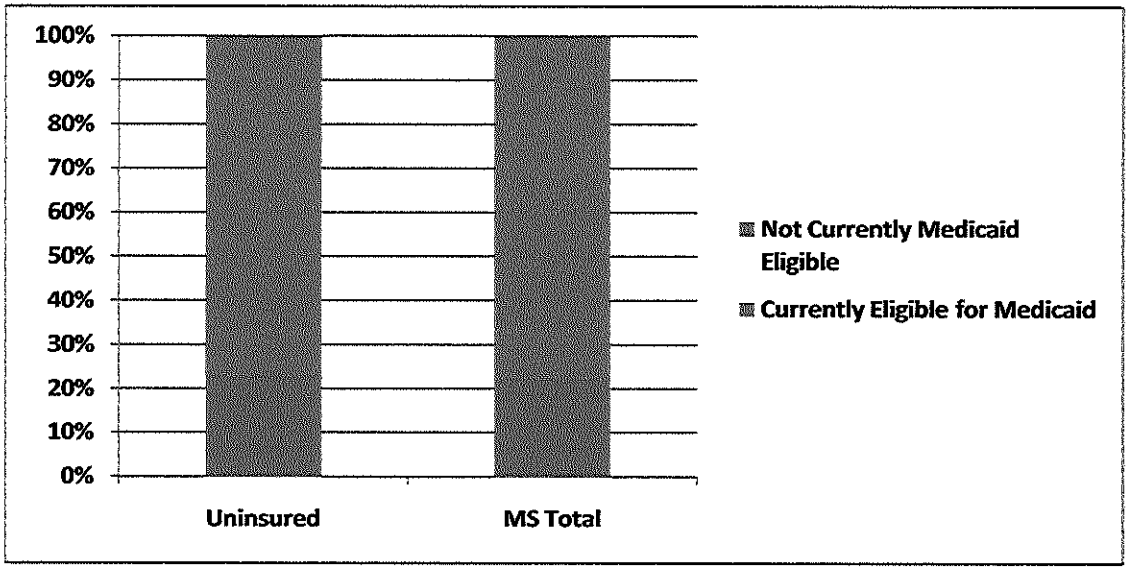


Table 6: Uninsured Population by Education

Education	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
B.A. or Some College	43,452	8%	403,515	14%
Graduate Degree or Education	6,703	1%	135,511	5%
High School or Less	482,838	91%	2,412,970	82%
Grand Total	**532,993**		**2,951,996**	

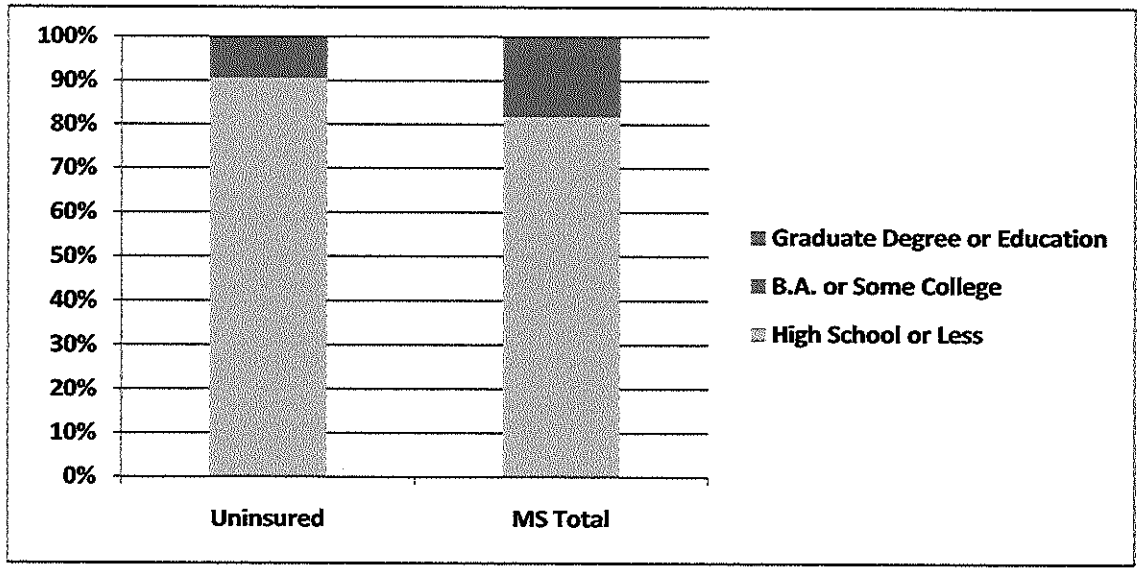


Table 7: Uninsured Population by Marital Status

Marital Status	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
Married	148,348	28%	1,245,447	42%
Unmarried	384,645	72%	1,706,549	58%
Grand Total	**532,993**		**2,951,996**	

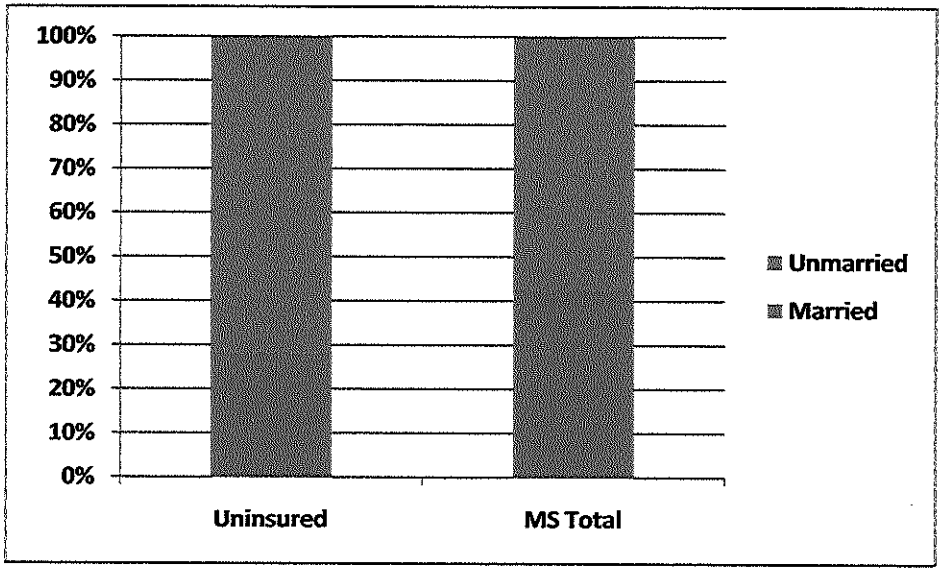


Table 8: Uninsured Population by Household Work Status

Household Work Status	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
Female householder with no husband present, in labor force and unemployed	13,762	3%	49,644	2%
Female householder with no husband present, in labor force, employed	86,626	16%	373,485	13%
Female householder with no husband present, not in labor force	56,197	11%	234,325	8%
Husband and wife both in labor force, both employed	76,462	14%	786,644	27%
Husband and wife both in labor force, husband employed, wife unemployed	8,073	2%	40,930	1%
Husband and wife both in labor force, husband unemployed, wife employed	9,969	2%	36,790	1%
Husband and wife both in labor force, husband unemployed, wife unemployed	2,147	0%	8,731	0%
Husband in labor force and wife not in labor force, husband employed	67,661	13%	341,972	12%
Husband in labor force, husband unemployed, wife not in labor force	4,978	1%	16,405	1%
Husband not in labor force, wife in labor force, wife employed	15,207	3%	126,788	4%
Husband not in labor force, wife in labor force, wife unemployed	2,563	0%	6,311	0%
Male householder with no wife present, in labor force and unemployed	3,981	1%	9,306	0%
Male householder with no wife present, in labor force, employed	37,536	7%	134,609	5%
Male householder with no wife present, not in labor force	10,661	2%	45,999	2%
Neither husband nor wife in labor force	21,816	4%	234,386	8%
Other	115,354	22%	505,671	17%
Grand Total	**532,993**		**2,951,996**	

Table 9: Uninsured Population by Family Income

Family Income	Uninsured		MS Total	
	Count	Percentage	Count	Percentage
Up to 15,000	92,460	17%	345,049	12%
15,000 to 24,999	78,903	15%	300,423	10%
25,000 to 34,999	56,965	11%	268,959	9%
35,000 to 49,999	69,640	13%	372,288	13%
50,000 to 74,999	69,479	13%	480,426	16%
75,000 to 99,999	29,171	5%	311,765	11%
100,000 to 149,999	13,774	3%	243,535	8%
150,000 or more	6,646	1%	123,061	4%
Unknown	115,955	22%	506,490	17%
Grand Total	**532,993**		**2,951,996**	

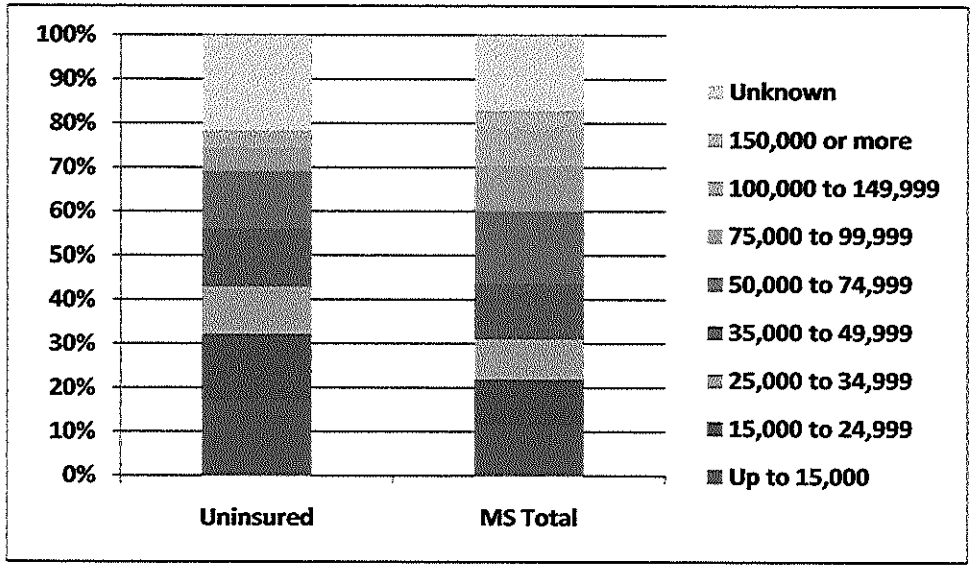


Table 10: Household Income Distribution by County

County	Household Income (Number of Households)																	
	0-$10K	$10K-$15K	$15K-$20K	$20K-$25K	$25K-$30K	$30K-$35K	$35K-$40K	$40K-$45K	$45K-$50K	$50K-$60K	$60K-$75K	$75K-$100K	$100K-$125K	$125K-$150	$150K-$200K	$200K-$250K	$250K-$500K	$500K UP
Adams	2,394	1,208	1,075	988	930	833	821	546	558	793	872	770	445	155	103	101	141	42
Alcorn	2,332	1,266	1,203	1,046	953	976	904	893	738	1,227	1,372	1,142	551	246	92	71	90	27
Amite	698	390	387	338	322	302	306	251	170	333	377	271	163	51	38	20	16	7
Attala	1,272	715	775	728	609	535	492	405	327	648	605	552	214	156	68	48	42	17
Benton	499	259	254	238	206	181	177	138	156	201	192	144	76	43	7	8	3	-
Bolivar	2,745	1,296	1,135	993	921	834	608	558	641	836	887	852	444	166	126	82	80	20
Calhoun	971	575	571	457	373	356	341	331	280	494	461	341	149	68	55	27	15	4
Carroll	534	261	248	257	221	199	177	153	122	266	232	295	116	46	54	38	31	12
Chickasaw	1,218	719	677	620	548	485	527	482	385	602	601	454	214	70	40	23	35	10
Choctaw	447	255	279	250	158	193	211	199	145	280	263	177	86	52	41	23	14	6
Claiborne	816	356	297	256	237	181	245	185	154	227	217	216	135	81	51	15	16	6
Clarke	1,235	584	529	503	514	410	433	402	320	524	537	542	228	73	61	27	29	8
Clay	1,412	640	598	569	537	520	395	413	359	550	742	619	291	193	94	61	44	14
Coahoma	1,992	917	810	707	602	528	489	405	321	558	720	536	333	190	92	68	65	25
Copiah	1,730	938	977	874	772	743	701	648	541	838	985	983	592	215	157	52	26	14
Covington	1,254	661	655	612	583	564	528	448	346	520	676	529	267	103	59	60	80	29
DeSoto	2,848	1,794	2,153	2,377	2,468	2,885	3,103	3,306	3,387	6,186	7,836	9,873	6,046	2,212	1,376	744	497	191
Forrest	4,439	2,440	2,493	2,227	1,810	1,749	1,616	1,418	1,358	2,019	2,049	1,901	843	413	262	71	84	25
Franklin	578	270	249	257	236	172	172	171	150	206	318	200	95	29	23	17	11	7
George	1,002	493	474	446	519	475	479	562	483	850	1,074	1,047	521	191	149	73	20	8
Greene	534	284	323	270	239	206	218	265	208	332	327	386	143	73	43	19	11	7
Grenada	1,398	736	650	625	673	609	576	479	415	622	721	646	289	135	65	48	32	8
Hancock	1,441	815	884	789	683	814	827	830	875	1,373	1,568	1,285	937	281	236	131	138	57
Harrison	6,392	3,708	4,170	4,080	4,674	4,425	4,390	4,306	4,035	6,673	8,107	7,929	4,534	1,741	1,398	608	572	265
Hinds	11,576	6,065	6,033	5,892	5,786	5,556	5,174	4,745	4,660	7,242	8,517	8,532	4,537	2,042	1,420	981	1,015	481
Holmes	1,757	792	643	466	411	374	361	295	244	455	396	379	173	87	82	57	31	18
Humphreys	809	437	334	274	260	223	165	131	128	157	209	181	71	18	17	20	8	4
Issaquena	100	44	39	43	33	27	21	19	13	18	33	26	17	3	4	7	1	-
Itawamba	1,098	543	562	608	542	532	554	503	487	809	718	658	375	128	93	58	27	9
Jackson	4,010	2,129	2,239	2,351	2,604	2,759	2,831	2,652	2,431	4,377	5,124	5,445	3,031	1,504	853	462	247	105
Jasper	1,209	607	590	569	566	478	418	361	351	582	608	462	200	96	61	32	32	13
Jefferson	660	299	262	259	155	133	128	148	96	198	184	128	81	38	12	14	2	2
Jefferson Davis	900	474	472	427	366	295	245	217	215	358	334	276	158	49	46	30	19	12
Jones	3,046	1,825	1,952	1,791	2,036	1,875	1,574	1,424	1,327	1,970	2,243	2,007	1,074	446	305	200	162	70
Kemper	739	355	323	294	281	246	190	235	195	298	250	195	91	62	29	12	12	4
Lafayette	2,317	1,141	1,119	1,156	998	862	743	709	639	982	1,392	1,699	846	472	375	134	177	82
Lamar	2,106	1,212	1,324	1,436	1,505	1,427	1,361	1,382	1,204	2,103	2,687	2,911	1,651	930	773	375	466	212
Lauderdale	4,971	2,426	2,420	2,109	1,821	1,861	1,988	1,479	1,455	2,447	2,659	2,571	1,257	580	330	217	176	71
Lawrence	919	500	505	466	348	365	314	290	260	493	580	594	347	75	66	27	19	8

	Household Income (Number of Households)																	
County	0-$10K	$10K-$15K	$15K-$20K	$20K-$25K	$25K-$30K	$30K-$35K	$35K-$40K	$40K-$45K	$45K-$50K	$50K-$60K	$60K-$75K	$75K-$100K	$100K-$125K	$125K-$150	$150K-$200K	$200K-$250K	$250K-$500K	$500K UP
Leake	1,441	675	633	631	672	545	495	498	509	760	730	638	351	181	119	33	38	16
Lee	3,363	1,889	1,951	1,909	2,076	2,139	1,947	1,894	1,632	2,814	3,251	3,009	1,530	605	467	258	291	133
Leflore	2,881	1,356	1,173	1,009	894	798	674	541	394	803	765	751	403	207	141	62	91	24
Lincoln	1,608	868	956	916	833	778	723	663	545	960	1,093	1,011	497	327	303	63	32	14
Lowndes	3,320	1,680	1,546	1,344	1,259	1,413	1,464	1,121	1,179	1,970	1,883	2,069	1,165	526	324	206	166	51
Madison	2,455	1,243	1,265	1,264	1,490	1,547	1,496	1,600	1,556	2,702	3,506	4,954	2,951	2,083	2,344	937	813	403
Marion	1,416	741	793	814	573	544	516	449	433	712	702	711	328	131	123	55	39	11
Marshall	2,257	1,133	1,081	978	1,076	987	775	854	781	1,238	1,529	1,204	524	237	171	119	78	29
Monroe	2,437	1,186	1,075	1,025	1,072	1,166	1,056	876	859	1,356	1,545	1,244	494	202	112	74	45	11
Montgomery	720	397	401	333	280	217	272	294	241	389	274	335	124	76	87	21	19	6
Neshoba	1,810	914	903	835	742	741	717	634	568	976	1,106	810	395	208	122	85	64	26
Newton	1,244	726	701	600	605	585	534	462	414	705	890	769	320	106	93	36	39	16
Noxubee	990	468	367	303	292	270	261	235	164	295	265	202	113	74	28	25	30	8
Oktibbeha	3,196	1,581	1,481	1,329	1,132	841	804	750	696	1,260	1,049	1,354	883	552	321	119	117	37
Panola	2,241	1,104	1,039	880	962	790	693	651	700	1,245	1,303	1,012	477	280	181	83	80	33
Pearl River	2,713	1,574	1,707	1,651	1,489	1,527	1,349	1,265	1,181	1,951	2,420	2,061	991	514	301	193	123	46
Perry	602	323	332	295	314	283	279	273	192	373	384	336	136	67	52	12	11	7
Pike	2,711	1,495	1,506	1,301	1,174	1,027	954	780	680	1,212	1,189	1,025	564	263	171	135	115	62
Pontotoc	1,277	607	602	675	766	639	676	522	542	923	1,105	852	416	149	112	67	59	17
Prentiss	1,806	855	993	959	843	798	739	743	568	881	850	686	324	121	45	25	43	10
Quitman	619	302	271	229	193	150	149	138	124	199	207	126	88	24	18	13	9	4
Rankin	3,380	2,134	2,388	2,501	3,070	2,688	3,013	2,958	2,890	5,266	6,838	7,605	4,449	2,310	1,450	670	500	177
Scott	1,461	794	793	740	823	667	607	540	469	844	840	800	323	100	82	76	73	36
Sharkey	333	172	177	147	129	105	82	84	73	127	149	154	64	34	17	14	9	5
Simpson	1,554	880	854	661	666	672	675	598	515	858	919	868	441	144	113	62	47	21
Smith	854	468	457	426	462	408	394	363	307	622	629	444	185	88	57	37	32	10
Stone	797	481	573	558	435	404	345	329	387	575	745	678	348	129	140	67	30	14
Sunflower	1,477	757	789	694	557	486	428	383	351	477	569	488	203	90	73	46	46	8
Tallahatchie	937	443	390	306	344	341	288	219	214	305	384	242	149	49	35	16	16	6
Tate	1,118	643	612	591	695	637	575	574	519	879	1,097	1,141	541	251	135	74	44	14
Tippah	1,450	818	700	735	697	633	606	563	584	719	809	567	218	97	46	28	25	5
Tishomingo	1,103	696	654	566	571	577	581	458	411	550	591	485	226	104	85	45	38	9
Tunica	745	379	372	321	241	250	212	203	186	175	324	300	149	67	20	23	19	12
Union	1,272	692	701	775	738	683	644	502	484	1,068	1,042	735	270	87	47	49	72	14
Walthall	984	511	524	444	374	330	306	267	247	423	425	450	173	51	60	45	27	10
Warren	2,030	1,254	1,294	1,203	1,156	1,040	1,017	1,017	936	1,456	1,761	1,763	1,165	593	341	164	129	39
Washington	3,821	1,849	1,629	1,443	1,314	1,182	1,030	1,027	831	1,394	1,425	1,253	632	290	240	144	131	48
Wayne	1,085	529	520	500	405	403	416	468	274	534	492	408	225	142	100	45	38	20
Webster	565	332	351	298	245	230	285	230	219	332	306	251	130	39	23	14	20	5
Wilkinson	938	411	341	294	228	210	174	154	154	298	244	215	105	42	14	30	33	17
Winston	1,081	539	521	492	546	401	428	409	353	594	621	529	286	114	69	41	33	14
Yalobusha	983	532	562	552	545	470	392	317	319	546	546	429	176	100	49	22	35	7

Household Income (Number of Households)																		
County	0-$10K	$10K-$15K	$15K-$20K	$20K-$25K	$25K-$30K	$30K-$35K	$35K-$40K	$40K-$45K	$45K-$50K	$50K-$60K	$60K-$75K	$75K-$100K	$100K-$125K	$125K-$150	$150K-$200K	$200K-$250K	$250K-$500K	$500K UP
Yazoo	1,543	792	770	659	501	495	457	426	417	595	609	656	489	107	85	54	43	19
Total	**147,016**	**77,652**	**77,431**	**72,834**	**70,979**	**67,285**	**64,331**	**59,716**	**55,277**	**92,008**	**105,084**	**103,374**	**55,642**	**25,474**	**18,072**	**9,448**	**8,228**	**3,374**

Table 11: Uninsured Population Trend (1987 - 2009)

Year	Mississippi Percent Uninsured
1987	17%
1988	19%
1989	17%
1990	20%
1991	19%
1992	19%
1993	18%
1994	18%
1995	20%
1996	19%
1997	20%
1998	20%
1999	15%
2000	13%
2001	16%
2002	16%
2003	18%
2004	17%
2005	17%
2006	21%
2007	19%
2008	18%
2009	18%

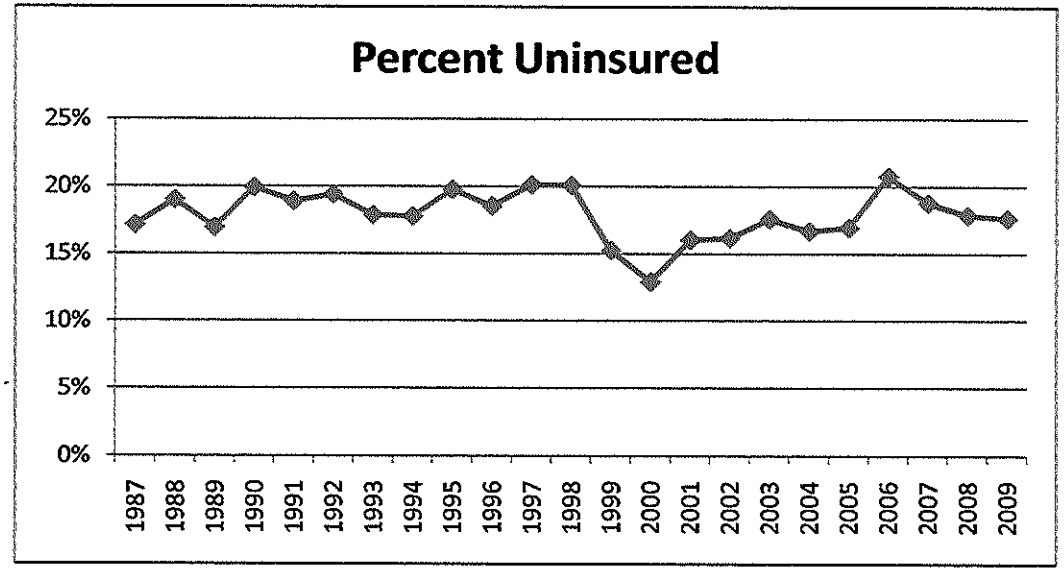


Table 12: Commercial Cost Characteristics (2008)

	2007	2008	% Change
Medical and Rx Per Capita Costs			
Allowed Amount PMPY Med	$3,102	$3,331	7.4%
Allowed Amount PMPY Rx	$810	$892	10.1%
Allowed Amount PMPY Med + Rx	$3,913	$4,223	7.9%
Net Pay PMPY Med	$2,495	$2,691	7.8%
Net Pay PMPY Rx	$559	$635	13.6%
Net Pay PMPY Med + Rx	$3,054	$3,326	8.9%
Inpatient Hospital			
Admits Acute / 1000	76.39	71.62	-6.2%
Average Length of Stay	3.88	4.01	3.4%
Allowed Amount / Admit Acute	$13,346	$14,229	6.6%
Outpatient Hospital			
Allowed Amount PMPY OP Med	$2,051	$2,177	6.1%
Svcs OP Med / 1000	19,147	20,139	5.2%
Allowed Amount / Svc OP Med	$107	$108	0.9%
Outpatient Radiology			
Allowed Amount PMPY OP Rad	$293	$292	-0.3%
Svcs OP Rad / 1000	1,674	1,685	0.6%
Allowed Amount / Svc OP Rad	$175	$173	-0.9%
Outpatient Laboratory			
Allowed Amount PMPY OP Lab	$168	$176	4.8%
Svcs OP Lab / 1000	4,930	5,132	4.1%
Allowed Amount / Svc OP Lab	$34	$34	0.7%
Emergency Department			
Allowed Amount PMPY ER	$109	$128	17.2%
Er Visits/ 1000	237	226	-4.5%
Allowed Amount / ER Visit	$461	$566	22.7%
Rx			
Days Supply PMPY	343	359	4.6%
Scripts PMPY	12.0	12.5	3.6%
Allowed Amount / Day Supply	$2.36	$2.49	5.2%
Generic Dispensing Rate	58%	61%	5.3%
Relative Risk Score	114.63	122.52	6.9%

Table 13: Commercial Population Chronic Conditions Profile (2008)

Episode Summary Group	Allowed Amount Med and Rx	Patients Episodes	Episodes	Admits Episodes	Allowed Amount / Episode	Episodes / 1000	Admits Episodes / 1000
Coronary Artery Disease	$36,491,972	3,912	4,151	699	$8,791	13.9	2.34
Osteoarthritis	$34,334,327	8,733	9,572	488	$3,587	32.1	1.63
Hypertension, Essential	$30,938,181	29,809	29,819	270	$1,038	99.9	0.90
Diabetes	$28,414,764	11,165	11,319	278	$2,510	37.9	0.93
Cancer - Breast	$18,848,297	1,406	1,406	129	$13,406	4.7	0.43
Spinal/Back Disord, Low Back	$17,909,722	13,707	16,911	143	$1,059	56.6	0.48
Cancer - Colon	$11,597,410	387	387	126	$30,006	1.3	0.42
Asthma	$7,173,087	4,146	4,282	164	$1,675	14.3	0.55
Mental Hlth - Depression	$5,973,544	4,577	4,879	281	$1,224	16.3	0.94
Cancer - Lung	$5,511,708	180	180	59	$30,706	0.6	0.20
Cancer - Skin	$3,912,052	3,538	4,044	24	$967	13.5	0.08
Chronic Obstruc Pulm Dis(COPD)	$3,414,705	1,488	1,488	123	$2,295	5.0	0.41
Overweight/Obesity	$2,787,425	533	533	40	$5,235	1.8	0.13
Cancer - Cervical	$2,557,981	1,687	1,687	39	$1,517	5.6	0.13
HIV Infection	$2,271,903	148	148	20	$15,351	0.5	0.07
Congestive Heart Failure	$2,110,161	498	498	66	$4,242	1.7	0.22
Cirrhosis of the Liver	$1,067,350	348	348	22	$3,067	1.2	0.07
Subtotal	$215,314,588	86,258	91,649	2,965	$2,349	306.9	9.93
Commercial Members - 2008	298,622						

Table 14: Projected Population by County (2010 - 2020)

County	Projected MESBP Total Population											
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Growth
Adams County	31,003	30,524	30,069	29,637	29,228	28,840	28,517	28,206	27,905	27,614	27,333	-12%
Alcorn County	35,805	35,813	35,829	35,852	35,884	35,923	35,969	36,018	36,070	36,124	36,181	1%
Amite County	11,049	10,964	10,884	10,810	10,743	10,680	10,630	10,581	10,536	10,492	10,451	-5%
Attala County	20,890	20,830	20,775	20,726	20,683	20,645	20,635	20,628	20,623	20,620	20,620	-1%
Benton County	7,086	7,086	7,088	7,092	7,098	7,106	7,111	7,117	7,124	7,132	7,141	1%
Bolivar County	37,339	36,817	36,333	35,881	35,459	35,075	34,728	34,395	34,077	33,772	33,481	-10%
Calhoun County	14,275	14,170	14,070	13,976	13,887	13,804	13,734	13,665	13,599	13,534	13,471	-6%
Carroll County	8,439	8,391	8,348	8,311	8,277	8,249	8,218	8,189	8,162	8,137	8,113	-4%
Chickasaw County	20,151	20,008	19,873	19,744	19,621	19,505	19,413	19,323	19,237	19,153	19,072	-5%
Choctaw County	7,845	7,759	7,676	7,597	7,521	7,449	7,387	7,328	7,270	7,215	7,161	-9%
Claiborne County	11,104	10,965	10,832	10,707	10,588	10,476	10,381	10,289	10,200	10,113	10,028	-10%
Clarke County	17,356	17,250	17,150	17,057	16,970	16,889	16,822	16,758	16,697	16,638	16,582	-4%
Clay County	20,809	20,610	20,422	20,242	20,073	19,912	19,784	19,660	19,541	19,426	19,315	-7%
Coahoma County	26,715	26,229	25,764	25,320	24,894	24,488	24,167	23,855	23,553	23,260	22,976	-14%
Copiah County	32,381	32,350	32,332	32,326	32,333	32,353	32,370	32,392	32,419	32,452	32,490	0%
Covington County	20,934	20,976	21,023	21,074	21,131	21,192	21,256	21,323	21,392	21,465	21,540	3%
DeSoto County	160,114	164,469	169,006	173,735	178,664	183,803	188,897	194,170	199,631	205,286	211,144	32%
Forrest County	73,211	73,686	74,188	74,717	75,273	75,858	76,436	77,030	77,641	78,268	78,912	8%
Franklin County	8,166	8,124	8,088	8,059	8,036	8,019	7,995	7,973	7,953	7,935	7,920	-3%
George County	25,079	25,387	25,704	26,030	26,365	26,710	27,040	27,377	27,719	28,068	28,424	13%
Greene County	12,925	12,939	12,958	12,983	13,013	13,048	13,076	13,107	13,140	13,176	13,215	2%
Grenada County	22,137	22,038	21,946	21,860	21,781	21,708	21,655	21,605	21,558	21,512	21,470	-3%
Hancock County	33,937	34,009	34,117	34,260	34,439	34,654	34,757	34,882	35,027	35,194	35,383	4%
Harrison County	189,808	191,904	194,117	196,447	198,898	201,476	203,076	204,749	206,496	208,318	210,218	11%
Hinds County	246,769	245,207	243,787	242,502	241,351	240,344	239,657	239,048	238,514	238,057	237,677	-4%
Holmes County	20,838	20,713	20,599	20,496	20,402	20,319	20,245	20,176	20,110	20,049	19,991	-4%
Humphreys County	10,024	9,887	9,760	9,642	9,534	9,434	9,343	9,257	9,174	9,094	9,019	-10%
Issaquena County	1,460	1,426	1,395	1,367	1,341	1,317	1,291	1,267	1,244	1,222	1,201	-18%
Itawamba County	21,297	21,262	21,233	21,211	21,195	21,186	21,182	21,180	21,181	21,184	21,189	-1%
Jackson County	121,156	121,250	121,412	121,642	121,941	122,310	122,514	122,758	123,045	123,373	123,744	2%
Jasper County	18,915	18,862	18,818	18,784	18,759	18,743	18,721	18,702	18,685	18,672	18,662	-1%
Jefferson County	7,971	7,858	7,753	7,655	7,564	7,480	7,407	7,338	7,271	7,208	7,148	-10%
Jefferson Davis County	12,561	12,379	12,203	12,035	11,874	11,719	11,592	11,469	11,349	11,232	11,118	-11%
Jones County	65,744	65,833	65,937	66,054	66,185	66,331	66,473	66,622	66,777	66,939	67,108	2%
Kemper County	10,025	9,923	9,826	9,735	9,649	9,568	9,502	9,438	9,375	9,315	9,256	-8%
Lafayette County	41,826	42,211	42,618	43,047	43,500	43,980	44,439	44,911	45,396	45,895	46,407	11%
Lamar County	65,383	66,491	67,636	68,818	70,038	71,299	72,526	73,784	75,073	76,393	77,747	19%
Lauderdale County	79,321	79,115	78,939	78,791	78,671	78,583	78,530	78,492	78,468	78,457	78,460	-1%
Lawrence County	15,871	15,829	15,794	15,767	15,747	15,734	15,717	15,704	15,693	15,684	15,679	-1%
Leake County	25,545	25,642	25,744	25,853	25,968	26,090	26,237	26,387	26,541	26,697	26,857	5%
Lee County	80,260	80,593	80,951	81,334	81,744	82,179	82,585	83,007	83,445	83,900	84,373	5%
Leflore County	37,133	36,755	36,398	36,059	35,737	35,431	35,185	34,947	34,718	34,498	34,286	-8%
Lincoln County	31,546	31,634	31,728	31,829	31,935	32,047	32,157	32,269	32,384	32,501	32,621	3%
Lowndes County	59,754	59,288	58,854	58,450	58,074	57,730	57,434	57,156	56,894	56,650	56,422	-6%
Madison County	92,502	93,910	95,405	96,993	98,678	100,464	102,158	103,918	105,746	107,646	109,621	19%
Marion County	24,464	24,436	24,416	24,403	24,397	24,399	24,397	24,398	24,402	24,408	24,418	0%
Marshall County	41,600	41,837	42,087	42,349	42,625	42,914	43,193	43,478	43,771	44,071	44,379	7%
Monroe County	39,979	39,838	39,709	39,591	39,484	39,389	39,320	39,256	39,197	39,143	39,093	-2%
Montgomery County	11,363	11,204	11,054	10,911	10,777	10,649	10,552	10,459	10,369	10,281	10,197	-10%
Neshoba County	30,306	30,431	30,560	30,693	30,830	30,971	31,111	31,253	31,398	31,545	31,695	5%
Newton County	22,925	22,912	22,908	22,910	22,921	22,939	22,958	22,979	23,003	23,029	23,058	1%
Noxubee County	11,698	11,580	11,469	11,367	11,273	11,186	11,107	11,030	10,956	10,886	10,818	-8%

County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Growth
Oktibbeha County	44,700	44,696	44,709	44,740	44,789	44,855	44,946	45,046	45,157	45,277	45,407	2%
Panola County	37,073	37,128	37,193	37,267	37,351	37,444	37,536	37,633	37,734	37,841	37,952	2%
Pearl River County	60,480	61,280	62,101	62,945	63,812	64,703	65,582	66,482	67,401	68,342	69,304	15%
Perry County	11,255	11,223	11,197	11,175	11,158	11,147	11,135	11,125	11,116	11,110	11,105	-1%
Pike County	41,913	41,907	41,912	41,927	41,952	41,988	42,032	42,081	42,134	42,192	42,254	1%
Pontotoc County	26,281	26,406	26,538	26,677	26,824	26,978	27,124	27,275	27,429	27,587	27,750	6%
Prentiss County	28,675	28,624	28,577	28,535	28,498	28,466	28,452	28,440	28,430	28,421	28,414	-1%
Quitman County	7,895	7,791	7,699	7,613	7,533	7,460	7,379	7,301	7,226	7,154	7,084	-10%
Rankin County	144,047	146,209	148,453	150,783	153,203	155,716	158,240	160,834	163,501	166,243	169,063	17%
Scott County	27,647	27,598	27,558	27,525	27,501	27,484	27,480	27,480	27,484	27,492	27,503	-1%
Sharkey County	5,392	5,320	5,254	5,195	5,142	5,095	5,036	4,981	4,928	4,877	4,830	-10%
Simpson County	28,208	28,188	28,177	28,176	28,185	28,204	28,221	28,242	28,266	28,295	28,327	0%
Smith County	16,416	16,320	16,229	16,142	16,060	15,982	15,921	15,863	15,807	15,754	15,704	-4%
Stone County	19,777	20,055	20,343	20,642	20,951	21,272	21,573	21,881	22,198	22,523	22,856	16%
Sunflower County	28,581	28,096	27,631	27,183	26,754	26,343	26,012	25,689	25,375	25,070	24,772	-13%
Tallahatchie County	12,794	12,648	12,511	12,383	12,263	12,152	12,033	11,918	11,807	11,701	11,598	-9%
Tate County	27,969	28,092	28,222	28,359	28,504	28,656	28,799	28,947	29,099	29,257	29,420	5%
Tippah County	23,017	22,987	22,963	22,947	22,938	22,936	22,935	22,937	22,942	22,950	22,962	0%
Tishomingo County	18,345	18,260	18,182	18,110	18,046	17,989	17,942	17,898	17,855	17,815	17,777	-3%
Tunica County	10,584	10,635	10,694	10,763	10,842	10,931	11,024	11,122	11,227	11,337	11,454	8%
Union County	25,233	25,328	25,433	25,546	25,669	25,802	25,921	26,044	26,170	26,300	26,434	5%
Walthall County	14,704	14,697	14,694	14,692	14,694	14,698	14,704	14,712	14,722	14,733	14,746	0%
Warren County	47,493	47,063	46,660	46,281	45,926	45,596	45,332	45,081	44,843	44,618	44,406	-6%
Washington County	54,127	53,045	52,020	51,041	50,107	49,215	48,514	47,835	47,177	46,541	45,924	-15%
Wayne County	17,243	17,116	16,995	16,881	16,771	16,668	16,591	16,516	16,443	16,373	16,305	-5%
Webster County	10,059	9,995	9,935	9,880	9,828	9,781	9,736	9,693	9,652	9,613	9,575	-5%
Wilkinson County	10,784	10,728	10,678	10,636	10,600	10,570	10,539	10,511	10,485	10,462	10,442	-3%
Winston County	18,315	18,189	18,068	17,952	17,840	17,733	17,651	17,571	17,492	17,415	17,339	-5%
Yalobusha County	15,939	15,951	15,968	15,992	16,021	16,057	16,090	16,127	16,166	16,208	16,253	2%
Yazoo County	28,199	28,107	28,032	27,965	27,907	27,861	27,844	27,832	27,823	27,819	27,819	-1%
Total	**2,959,939**	**2,965,287**	**2,972,213**	**2,980,685**	**2,990,720**	**3,002,379**	**3,013,914**	**3,026,396**	**3,039,836**	**3,054,252**	**3,069,664**	

Table 15: Projected Medicaid Covered Lives by County (2010-2020)

	Estimated Medicaid Covered Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Adams County	9,151	8,675	8,354	7,915	10,331	10,786	10,727	10,344	10,214	10,062	9,941
Alcorn County	7,347	7,036	6,859	6,553	8,451	8,907	9,253	9,063	9,050	9,036	9,041
Amite County	2,613	2,485	2,403	2,282	2,891	3,019	3,108	3,028	3,007	2,984	2,967
Attala County	5,400	5,187	5,063	4,855	6,091	6,376	6,570	6,451	6,449	6,441	6,448
Benton County	2,038	1,958	1,911	1,834	2,310	2,420	2,472	2,423	2,418	2,411	2,410
Bolivar County	14,018	13,327	12,863	12,238	15,763	16,415	16,132	15,569	15,383	15,151	14,970
Calhoun County	3,640	3,477	3,375	3,219	3,995	4,154	4,266	4,169	4,143	4,116	4,098
Carroll County	1,840	1,747	1,688	1,600	1,996	2,081	2,169	2,120	2,107	2,095	2,086
Chickasaw County	4,804	4,583	4,446	4,231	5,339	5,574	5,738	5,597	5,560	5,522	5,496
Choctaw County	2,109	1,996	1,918	1,811	2,233	2,305	2,353	2,289	2,266	2,241	2,221
Claiborne County	3,624	3,435	3,311	3,141	4,197	4,415	4,390	4,237	4,197	4,142	4,101
Clarke County	3,572	3,400	3,296	3,132	4,179	4,425	4,558	4,429	4,403	4,374	4,355
Clay County	5,676	5,398	5,218	4,958	6,358	6,644	6,724	6,528	6,472	6,406	6,357
Coahoma County	12,083	11,468	11,026	10,465	12,951	13,306	12,991	12,529	12,337	12,108	11,920
Copiah County	8,113	7,797	7,620	7,309	9,222	9,668	9,940	9,760	9,757	9,750	9,765
Covington County	4,786	4,595	4,491	4,306	5,684	6,038	6,243	6,112	6,115	6,112	6,123
DeSoto County	8,729	8,444	8,356	8,037	10,560	11,545	13,983	14,110	14,417	14,780	15,164
Forrest County	14,347	13,802	13,554	13,034	19,183	20,929	21,616	21,117	21,241	21,328	21,477
Franklin County	2,150	2,058	2,003	1,918	2,522	2,665	2,706	2,635	2,624	2,610	2,603
George County	4,405	4,254	4,186	4,026	4,942	5,196	5,565	5,544	5,597	5,660	5,733
Greene County	2,489	2,365	2,291	2,171	2,833	2,994	3,130	3,059	3,051	3,043	3,041
Grenada County	5,071	4,833	4,687	4,458	5,814	6,120	6,276	6,111	6,078	6,040	6,017
Hancock County	5,860	5,582	5,416	5,148	6,588	6,943	7,269	7,125	7,115	7,107	7,116
Harrison County	33,519	32,381	31,850	30,661	37,745	39,693	42,173	41,780	41,974	42,209	42,523
Hinds County	54,389	51,663	49,938	47,393	61,094	64,012	65,497	63,647	63,182	62,625	62,234
Holmes County	9,053	8,703	8,484	8,161	10,600	11,131	10,915	10,600	10,547	10,453	10,395
Humphreys County	4,499	4,298	4,164	3,985	5,136	5,358	5,219	5,038	4,983	4,909	4,853
Issaquena County	541	504	478	446	571	591	583	559	549	538	529
Itawamba County	3,243	3,081	2,983	2,825	3,599	3,793	4,098	4,022	4,012	4,007	4,007
Jackson County	17,570	16,697	16,172	15,314	19,049	19,910	21,212	20,805	20,725	20,667	20,647
Jasper County	4,828	4,626	4,505	4,309	5,437	5,697	5,864	5,743	5,729	5,712	5,707
Jefferson County	2,886	2,734	2,633	2,497	3,357	3,526	3,451	3,314	3,270	3,216	3,173
Jefferson Davis County	4,112	3,896	3,747	3,550	4,508	4,677	4,670	4,516	4,460	4,395	4,343
Jones County	14,047	13,532	13,262	12,743	15,806	16,571	17,408	17,182	17,225	17,272	17,353
Kemper County	2,519	2,386	2,300	2,178	2,930	3,095	3,142	3,042	3,018	2,988	2,966
Lafayette County	4,115	3,920	3,826	3,640	6,538	7,440	8,032	7,809	7,869	7,923	7,994

Lamar County	7,633	7,386	7,292	7,032	9,316	10,069	11,210	11,193	11,372	11,566	11,780
Lauderdale County	17,505	16,734	16,281	15,548	20,507	21,696	22,250	21,689	21,624	21,528	21,487
Lawrence County	3,474	3,326	3,241	3,094	3,962	4,159	4,262	4,163	4,144	4,127	4,119
Leake County	5,563	5,352	5,241	5,032	6,423	6,793	7,133	7,032	7,062	7,090	7,134
Lee County	12,890	12,356	12,074	11,529	14,508	15,279	16,343	16,115	16,142	16,190	16,267
Leflore County	14,190	13,539	13,114	12,522	16,503	17,318	17,008	16,429	16,281	16,071	15,917
Lincoln County	6,493	6,233	6,089	5,831	7,436	7,845	8,236	8,102	8,117	8,130	8,158
Lowndes County	12,872	12,226	11,822	11,214	14,657	15,402	15,720	15,256	15,138	15,003	14,907
Madison County	11,274	10,870	10,686	10,271	12,911	13,707	14,933	14,878	15,050	15,241	15,461
Marion County	6,591	6,347	6,210	5,970	7,491	7,848	8,051	7,904	7,900	7,889	7,896
Marshall County	9,051	8,710	8,531	8,192	10,558	11,180	11,674	11,493	11,534	11,570	11,632
Monroe County	8,171	7,797	7,573	7,210	9,184	9,640	10,046	9,828	9,793	9,757	9,741
Montgomery County	3,297	3,124	3,007	2,845	3,489	3,591	3,623	3,521	3,482	3,442	3,410
Neshoba County	6,529	6,293	6,173	5,940	7,736	8,226	8,648	8,513	8,550	8,578	8,625
Newton County	4,651	4,466	4,366	4,180	5,328	5,610	5,841	5,736	5,735	5,736	5,750
Noxubee County	4,561	4,367	4,243	4,065	5,317	5,575	5,466	5,286	5,239	5,174	5,126
Oktibbeha County	6,933	6,610	6,450	6,154	10,119	11,241	11,628	11,240	11,260	11,254	11,280
Panola County	10,448	10,055	9,831	9,446	11,864	12,433	12,732	12,506	12,509	12,499	12,518
Pearl River County	9,744	9,397	9,240	8,885	11,861	12,745	13,667	13,526	13,659	13,798	13,964
Perry County	2,691	2,560	2,477	2,352	2,943	3,068	3,169	3,096	3,078	3,061	3,049
Pike County	11,980	11,550	11,311	10,892	13,987	14,736	14,983	14,678	14,677	14,652	14,664
Pontotoc County	3,689	3,537	3,459	3,304	4,242	4,509	4,936	4,874	4,892	4,916	4,947
Prentiss County	5,401	5,147	4,996	4,745	6,171	6,511	6,832	6,675	6,648	6,625	6,615
Quitman County	3,567	3,394	3,272	3,114	3,884	4,014	3,926	3,796	3,748	3,690	3,644
Rankin County	13,607	13,091	12,862	12,314	15,377	16,354	18,550	18,549	18,773	19,049	19,352
Scott County	6,771	6,501	6,346	6,080	7,564	7,907	8,206	8,063	8,056	8,047	8,055
Sharkey County	2,690	2,568	2,482	2,369	2,855	2,926	2,862	2,775	2,737	2,693	2,657
Simpson County	6,435	6,153	5,988	5,717	7,340	7,726	7,988	7,818	7,805	7,787	7,786
Smith County	3,349	3,178	3,068	2,904	3,598	3,744	3,933	3,844	3,818	3,794	3,776
Stone County	3,659	3,543	3,495	3,373	4,349	4,630	4,907	4,865	4,910	4,959	5,018
Sunflower County	10,287	9,720	9,329	8,815	11,163	11,553	11,472	11,070	10,918	10,738	10,592
Tallahatchie County	4,872	4,640	4,482	4,271	5,381	5,586	5,521	5,344	5,283	5,208	5,150
Tate County	4,569	4,380	4,279	4,086	5,062	5,316	5,718	5,651	5,665	5,687	5,718
Tippah County	5,349	5,138	5,019	4,809	6,085	6,380	6,587	6,459	6,445	6,433	6,435
Tishomingo County	3,361	3,202	3,107	2,950	3,805	3,997	4,165	4,063	4,039	4,017	4,004
Tunica County	3,207	3,093	3,033	2,928	3,868	4,112	4,168	4,080	4,092	4,093	4,106
Union County	3,865	3,704	3,619	3,457	4,410	4,674	5,075	5,003	5,013	5,030	5,055
Walthall County	4,143	3,971	3,867	3,704	4,845	5,119	5,206	5,084	5,079	5,062	5,059
Warren County	10,580	10,045	9,701	9,186	11,226	11,606	11,996	11,708	11,609	11,513	11,440
Washington County	22,811	21,603	20,735	19,631	24,159	24,754	24,237	23,358	22,962	22,508	22,129

Wayne County	4,331	4,112	3,972	3,768	4,918	5,166	5,270	5,116	5,079	5,034	5,002
Webster County	2,536	2,424	2,354	2,243	2,774	2,879	2,944	2,875	2,854	2,833	2,819
Wilkinson County	3,399	3,258	3,175	3,047	4,181	4,455	4,433	4,300	4,289	4,262	4,250
Winston County	4,536	4,324	4,189	3,986	4,977	5,181	5,321	5,197	5,169	5,136	5,114
Yalobusha County	3,875	3,730	3,650	3,505	4,419	4,637	4,777	4,694	4,693	4,694	4,705
Yazoo County	9,267	8,888	8,656	8,296	10,600	11,111	11,173	10,921	10,901	10,857	10,843
Total	**615,884**	**588,969**	**573,062**	**547,150**	**704,152**	**741,428**	**767,269**	**750,766**	**749,369**	**747,451**	**747,327**

County	Estimated Medicare Covered Lives (As a % of Total Population)										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Adams County	30%	28%	28%	27%	35%	37%	38%	37%	37%	36%	36%
Alcorn County	21%	20%	19%	18%	24%	25%	26%	25%	25%	25%	25%
Amite County	24%	23%	22%	21%	27%	28%	29%	29%	29%	28%	28%
Attala County	26%	25%	24%	23%	29%	31%	32%	31%	31%	31%	31%
Benton County	29%	28%	27%	26%	33%	34%	35%	34%	34%	34%	34%
Bolivar County	38%	36%	35%	34%	44%	47%	46%	45%	45%	45%	45%
Calhoun County	25%	25%	24%	23%	29%	30%	31%	31%	30%	30%	30%
Carroll County	22%	21%	20%	19%	24%	25%	26%	26%	26%	26%	26%
Chickasaw County	24%	23%	22%	21%	27%	29%	30%	29%	29%	29%	29%
Choctaw County	27%	26%	25%	24%	30%	31%	32%	31%	31%	31%	31%
Claiborne County	33%	31%	31%	29%	40%	42%	42%	41%	41%	41%	41%
Clarke County	21%	20%	19%	18%	25%	26%	27%	26%	26%	26%	26%
Clay County	27%	26%	26%	24%	32%	33%	34%	33%	33%	33%	33%
Coahoma County	45%	44%	43%	41%	52%	54%	54%	53%	52%	52%	52%
Copiah County	25%	24%	24%	23%	29%	30%	31%	30%	30%	30%	30%
Covington County	23%	22%	21%	20%	27%	28%	29%	29%	29%	28%	28%
DeSoto County	5%	5%	5%	5%	6%	6%	7%	7%	7%	7%	7%
Forrest County	20%	19%	18%	17%	25%	28%	28%	27%	27%	27%	27%
Franklin County	26%	25%	25%	24%	31%	33%	34%	33%	33%	33%	33%
George County	18%	17%	16%	15%	19%	19%	21%	20%	20%	20%	20%
Greene County	19%	18%	18%	17%	22%	23%	24%	23%	23%	23%	23%
Grenada County	23%	22%	21%	20%	27%	28%	29%	28%	28%	28%	28%
Hancock County	17%	16%	16%	15%	19%	20%	21%	20%	20%	20%	20%
Harrison County	18%	17%	16%	16%	19%	20%	21%	20%	20%	20%	20%
Hinds County	22%	21%	20%	20%	25%	27%	27%	27%	26%	26%	26%
Holmes County	43%	42%	41%	40%	52%	55%	54%	53%	52%	52%	52%
Humphreys County	45%	43%	43%	41%	54%	57%	56%	54%	54%	54%	54%
Issaquena County	37%	35%	34%	33%	43%	45%	45%	44%	44%	44%	44%
Itawamba County	15%	14%	14%	13%	17%	18%	19%	19%	19%	19%	19%
Jackson County	15%	14%	13%	13%	16%	16%	17%	17%	17%	17%	17%
Jasper County	26%	25%	24%	23%	29%	30%	31%	31%	31%	31%	31%
Jefferson County	36%	35%	34%	33%	44%	47%	47%	45%	45%	45%	44%
Jefferson Davis County	33%	31%	31%	29%	38%	40%	40%	39%	39%	39%	39%
Jones County	21%	21%	20%	19%	24%	25%	26%	26%	26%	26%	26%
Kemper County	25%	24%	23%	22%	30%	32%	33%	32%	32%	32%	32%
Lafayette County	10%	9%	9%	8%	15%	17%	18%	17%	17%	17%	17%
Lamar County	12%	11%	11%	10%	13%	14%	15%	15%	15%	15%	15%

Lauderdale County	22%	21%	21%	20%	26%	28%	28%	28%	28%	27%	27%
Lawrence County	22%	21%	21%	20%	25%	26%	27%	27%	26%	26%	26%
Leake County	22%	21%	20%	19%	25%	26%	27%	27%	27%	27%	27%
Lee County	16%	15%	15%	14%	18%	19%	20%	19%	19%	19%	19%
Leflore County	38%	37%	36%	35%	46%	49%	48%	47%	47%	47%	46%
Lincoln County	21%	20%	19%	18%	23%	24%	26%	25%	25%	25%	25%
Lowndes County	22%	21%	20%	19%	25%	27%	27%	27%	27%	26%	26%
Madison County	12%	12%	11%	11%	13%	14%	15%	14%	14%	14%	14%
Marion County	27%	26%	25%	24%	31%	32%	33%	32%	32%	32%	32%
Marshall County	22%	21%	20%	19%	25%	26%	27%	26%	26%	26%	26%
Monroe County	20%	20%	19%	18%	23%	24%	26%	25%	25%	25%	25%
Montgomery County	29%	28%	27%	26%	32%	34%	34%	34%	34%	33%	33%
Neshoba County	22%	21%	20%	19%	25%	27%	28%	27%	27%	27%	27%
Newton County	20%	19%	19%	18%	23%	24%	25%	25%	25%	25%	25%
Noxubee County	39%	38%	37%	36%	47%	50%	49%	48%	48%	48%	47%
Oktibbeha County	16%	15%	14%	14%	23%	25%	26%	25%	25%	25%	25%
Panola County	28%	27%	26%	25%	32%	33%	34%	33%	33%	33%	33%
Pearl River County	16%	15%	15%	14%	19%	20%	21%	20%	20%	20%	20%
Perry County	24%	23%	22%	21%	26%	28%	28%	28%	28%	28%	27%
Pike County	29%	28%	27%	26%	33%	35%	36%	35%	35%	35%	35%
Pontotoc County	14%	13%	13%	12%	16%	17%	18%	18%	18%	18%	18%
Prentiss County	19%	18%	17%	17%	22%	23%	24%	23%	23%	23%	23%
Quitman County	45%	44%	43%	41%	52%	54%	53%	52%	52%	52%	51%
Rankin County	9%	9%	9%	8%	10%	11%	12%	12%	11%	11%	11%
Scott County	24%	24%	23%	22%	28%	29%	30%	29%	29%	29%	29%
Sharkey County	50%	48%	47%	46%	56%	57%	57%	56%	56%	55%	55%
Simpson County	23%	22%	21%	20%	26%	27%	28%	28%	28%	28%	27%
Smith County	20%	19%	19%	18%	22%	23%	25%	24%	24%	24%	24%
Stone County	19%	18%	17%	16%	21%	22%	23%	22%	22%	22%	22%
Sunflower County	36%	35%	34%	32%	42%	44%	44%	43%	43%	43%	43%
Tallahatchie County	38%	37%	36%	34%	44%	46%	46%	45%	45%	45%	44%
Tate County	16%	16%	15%	14%	18%	19%	20%	20%	19%	19%	19%
Tippah County	23%	22%	22%	21%	27%	28%	29%	28%	28%	28%	28%
Tishomingo County	18%	18%	17%	16%	21%	22%	23%	23%	23%	23%	23%
Tunica County	30%	29%	28%	27%	36%	38%	38%	37%	36%	36%	36%
Union County	15%	15%	14%	14%	17%	18%	20%	19%	19%	19%	19%
Walthall County	28%	27%	26%	25%	33%	35%	35%	35%	34%	34%	34%
Warren County	22%	21%	21%	20%	24%	25%	26%	26%	26%	26%	26%
Washington County	42%	41%	40%	38%	48%	50%	50%	49%	49%	48%	48%
Wayne County	25%	24%	23%	22%	29%	31%	32%	31%	31%	31%	31%

Webster County	25%	24%	24%	23%	28%	29%	30%	30%	30%	29%	29%
Wilkinson County	32%	30%	30%	29%	39%	42%	42%	41%	41%	41%	41%
Winston County	25%	24%	23%	22%	28%	29%	30%	30%	30%	29%	29%
Yalobusha County	24%	23%	23%	22%	28%	29%	30%	29%	29%	29%	29%
Yazoo County	33%	32%	31%	30%	38%	40%	40%	39%	39%	39%	39%
Total	21%	20%	19%	18%	24%	25%	25%	25%	25%	24%	24%

Table 16: Projected Uninsured Lives by County (2010-2020)

	Estimated Uninsured Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Adams County	8,558	8,605	8,628	8,664	4,881	3,765	3,260	3,286	3,204	3,132	3,120
Alcorn County	6,971	7,075	7,183	7,276	4,158	3,245	2,741	2,758	2,723	2,687	2,718
Amite County	2,197	2,221	2,244	2,269	1,270	983	834	838	823	807	810
Attala County	4,181	4,263	4,342	4,421	2,472	1,918	1,635	1,654	1,633	1,614	1,631
Benton County	1,515	1,557	1,595	1,634	910	706	606	617	610	604	611
Bolivar County	11,819	11,919	12,016	12,138	6,732	5,146	4,390	4,420	4,312	4,206	4,192
Calhoun County	2,727	2,769	2,806	2,842	1,571	1,211	1,029	1,037	1,019	1,001	1,007
Carroll County	1,393	1,415	1,440	1,466	807	621	519	520	511	501	505
Chickasaw County	4,146	4,198	4,248	4,289	2,427	1,882	1,585	1,588	1,560	1,531	1,540
Choctaw County	1,541	1,564	1,584	1,607	893	692	582	581	569	556	557
Claiborne County	3,525	3,542	3,563	3,598	2,000	1,527	1,312	1,329	1,302	1,276	1,276
Clarke County	3,882	3,913	3,944	3,969	2,281	1,775	1,519	1,530	1,503	1,479	1,486
Clay County	5,050	5,097	5,144	5,199	2,940	2,280	1,940	1,950	1,914	1,877	1,882
Coahoma County	8,211	8,325	8,401	8,506	4,684	3,591	3,105	3,132	3,048	2,971	2,950
Copiah County	6,846	6,962	7,092	7,212	4,098	3,199	2,685	2,694	2,657	2,618	2,645
Covington County	4,849	4,930	5,015	5,099	2,941	2,303	1,965	1,989	1,970	1,951	1,978
DeSoto County	10,611	10,872	11,246	11,598	7,154	5,871	4,766	4,730	4,801	4,817	5,019
Forrest County	20,772	21,025	21,413	21,751	12,519	9,707	8,249	8,400	8,360	8,309	8,472
Franklin County	2,031	2,056	2,080	2,107	1,193	927	802	815	804	794	801
George County	3,624	3,716	3,832	3,937	2,293	1,825	1,484	1,473	1,471	1,458	1,494
Greene County	2,672	2,691	2,736	2,782	1,578	1,213	939	915	905	879	893
Grenada County	4,981	5,042	5,104	5,159	2,945	2,289	1,939	1,949	1,918	1,887	1,901
Hancock County	5,664	5,759	5,857	5,963	3,511	2,801	2,345	2,333	2,305	2,268	2,294
Harrison County	26,520	27,280	28,117	28,942	16,879	13,510	11,144	11,070	10,992	10,853	11,046
Hinds County	50,971	51,326	51,746	52,249	29,727	23,091	19,494	19,521	19,173	18,793	18,870
Holmes County	7,195	7,359	7,513	7,686	4,292	3,310	2,896	2,963	2,917	2,877	2,891
Humphreys County	3,502	3,555	3,595	3,648	2,019	1,548	1,366	1,397	1,368	1,345	1,344
Issaquena County	404	409	413	419	221	165	137	137	133	129	128
Itawamba County	2,936	2,968	3,011	3,053	1,722	1,338	1,109	1,107	1,094	1,076	1,089
Jackson County	16,148	16,320	16,546	16,758	9,789	7,758	6,350	6,249	6,157	6,028	6,085
Jasper County	3,860	3,934	4,006	4,079	2,292	1,781	1,518	1,534	1,514	1,495	1,509
Jefferson County	2,879	2,893	2,909	2,930	1,626	1,235	1,057	1,067	1,043	1,018	1,016
Jefferson Davis County	3,254	3,285	3,307	3,339	1,834	1,401	1,205	1,217	1,188	1,162	1,158
Jones County	11,154	11,369	11,609	11,841	6,731	5,279	4,396	4,400	4,355	4,298	4,358

Kemper County	2,624	2,637	2,652	2,674	1,494	1,142	970	977	958	939	941
Lafayette County	9,999	9,975	10,072	10,163	5,802	4,435	3,707	3,768	3,760	3,736	3,824
Lamar County	8,442	8,616	8,850	9,086	5,400	4,335	3,629	3,653	3,674	3,674	3,783
Lauderdale County	17,969	18,176	18,401	18,630	10,740	8,390	7,129	7,173	7,073	6,963	7,020
Lawrence County	3,239	3,288	3,345	3,386	1,933	1,507	1,263	1,266	1,246	1,226	1,238
Leake County	5,044	5,142	5,259	5,377	3,105	2,440	2,035	2,044	2,032	2,010	2,046
Lee County	12,044	12,247	12,480	12,676	7,389	5,852	4,847	4,825	4,780	4,719	4,795
Leflore County	12,746	12,906	13,055	13,233	7,394	5,670	4,907	4,980	4,881	4,784	4,785
Lincoln County	5,768	5,874	5,987	6,101	3,494	2,743	2,317	2,334	2,314	2,289	2,322
Lowndes County	13,284	13,363	13,449	13,536	7,820	6,111	5,178	5,178	5,081	4,979	4,995
Madison County	10,080	10,322	10,628	10,937	6,486	5,230	4,375	4,394	4,411	4,406	4,530
Marion County	5,297	5,398	5,502	5,605	3,184	2,490	2,109	2,123	2,095	2,066	2,087
Marshall County	8,284	8,453	8,644	8,834	5,060	3,966	3,336	3,364	3,341	3,309	3,366
Monroe County	7,459	7,550	7,644	7,734	4,418	3,450	2,902	2,908	2,866	2,821	2,846
Montgomery County	2,344	2,377	2,403	2,428	1,335	1,025	865	866	846	827	826
Neshoba County	6,284	6,394	6,508	6,634	3,851	3,044	2,614	2,650	2,635	2,617	2,658
Newton County	4,327	4,399	4,483	4,550	2,618	2,052	1,712	1,713	1,691	1,666	1,687
Noxubee County	4,001	4,056	4,103	4,157	2,335	1,799	1,561	1,584	1,552	1,522	1,523
Oktibbeha County	14,253	14,118	14,177	14,232	8,112	6,182	5,141	5,185	5,136	5,063	5,138
Panola County	8,214	8,399	8,587	8,781	4,986	3,906	3,319	3,352	3,317	3,280	3,321
Pearl River County	10,826	11,062	11,338	11,602	6,824	5,416	4,554	4,595	4,594	4,575	4,686
Perry County	2,220	2,255	2,291	2,327	1,318	1,027	858	858	846	832	840
Pike County	10,306	10,523	10,731	10,940	6,251	4,893	4,208	4,266	4,214	4,165	4,206
Pontotoc County	3,622	3,673	3,734	3,790	2,196	1,732	1,449	1,453	1,443	1,430	1,456
Prentiss County	5,285	5,355	5,435	5,495	3,101	2,394	2,000	2,008	1,979	1,948	1,970
Quitman County	2,319	2,382	2,433	2,493	1,359	1,042	898	910	889	869	867
Rankin County	12,700	12,950	13,299	13,627	8,049	6,465	5,254	5,204	5,218	5,186	5,335
Scott County	5,385	5,477	5,571	5,663	3,212	2,511	2,113	2,121	2,093	2,063	2,084
Sharkey County	1,470	1,514	1,549	1,591	863	667	569	571	555	540	536
Simpson County	6,012	6,098	6,192	6,287	3,620	2,839	2,395	2,405	2,376	2,344	2,370
Smith County	2,663	2,696	2,733	2,771	1,552	1,204	1,000	996	980	962	969
Stone County	3,449	3,540	3,647	3,744	2,168	1,713	1,429	1,441	1,439	1,432	1,467
Sunflower County	8,327	8,384	8,443	8,528	4,670	3,539	2,934	2,927	2,855	2,774	2,767
Tallahatchie County	3,550	3,616	3,670	3,737	2,060	1,585	1,360	1,373	1,341	1,312	1,309
Tate County	3,819	3,883	3,969	4,050	2,318	1,823	1,494	1,485	1,472	1,452	1,477
Tippah County	4,603	4,678	4,757	4,819	2,714	2,105	1,764	1,772	1,747	1,723	1,742
Tishomingo County	3,264	3,300	3,336	3,356	1,900	1,471	1,234	1,237	1,215	1,194	1,203

Tunica County	2,995	3,058	3,120	3,189	1,843	1,451	1,275	1,307	1,300	1,294	1,314
Union County	3,619	3,673	3,738	3,796	2,184	1,718	1,438	1,444	1,434	1,420	1,446
Walthall County	3,773	3,844	3,915	3,994	2,272	1,770	1,523	1,547	1,531	1,514	1,530
Warren County	8,390	8,471	8,556	8,642	4,936	3,871	3,226	3,197	3,133	3,062	3,070
Washington County	15,695	15,871	15,972	16,117	8,871	6,801	5,820	5,834	5,665	5,506	5,459
Wayne County	4,249	4,281	4,313	4,351	2,482	1,929	1,641	1,650	1,623	1,595	1,604
Webster County	1,949	1,982	2,014	2,043	1,143	886	739	738	724	710	714
Wilkinson County	3,692	3,725	3,767	3,820	2,165	1,669	1,433	1,453	1,432	1,409	1,418
Winston County	3,633	3,681	3,730	3,784	2,129	1,654	1,389	1,390	1,366	1,340	1,348
Yalobusha County	3,151	3,226	3,301	3,364	1,898	1,479	1,248	1,258	1,242	1,227	1,242
Yazoo County	7,754	7,897	8,060	8,239	4,628	3,575	2,966	2,976	2,940	2,889	2,921
Total	**567,017**	**574,996**	**584,124**	**593,340**	**339,075**	**264,893**	**223,027**	**223,955**	**221,194**	**217,958**	**220,356**

County	Estimated Uninsured Lives (As a % of Total Population)										
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Adams County	28%	28%	29%	29%	17%	13%	11%	12%	11%	11%	11%
Alcorn County	19%	20%	20%	20%	12%	9%	8%	8%	8%	7%	8%
Amite County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Attala County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Benton County	21%	22%	23%	23%	13%	10%	9%	9%	9%	8%	9%
Bolivar County	32%	32%	33%	34%	19%	15%	13%	13%	13%	12%	13%
Calhoun County	19%	20%	20%	20%	11%	9%	7%	8%	7%	7%	7%
Carroll County	17%	17%	17%	18%	10%	8%	6%	6%	6%	6%	6%
Chickasaw County	21%	21%	21%	22%	12%	10%	8%	8%	8%	8%	8%
Choctaw County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Claiborne County	32%	32%	33%	34%	19%	15%	13%	13%	13%	13%	13%
Clarke County	22%	23%	23%	23%	13%	11%	9%	9%	9%	9%	9%
Clay County	24%	25%	25%	26%	15%	11%	10%	10%	10%	10%	10%
Coahoma County	31%	32%	33%	34%	19%	15%	13%	13%	13%	13%	13%
Copiah County	21%	22%	22%	22%	13%	10%	8%	8%	8%	8%	8%
Covington County	23%	24%	24%	24%	14%	11%	9%	9%	9%	9%	9%
DeSoto County	7%	7%	7%	7%	4%	3%	3%	2%	2%	2%	2%
Forrest County	28%	29%	29%	29%	17%	13%	11%	11%	11%	11%	11%
Franklin County	25%	25%	26%	26%	15%	12%	10%	10%	10%	10%	10%
George County	14%	15%	15%	15%	9%	7%	5%	5%	5%	5%	5%
Greene County	21%	21%	21%	21%	12%	9%	7%	7%	7%	7%	7%
Grenada County	23%	23%	23%	24%	14%	11%	9%	9%	9%	9%	9%
Hancock County	17%	17%	17%	17%	10%	8%	7%	7%	7%	6%	6%
Harrison County	14%	14%	14%	15%	8%	7%	5%	5%	5%	5%	5%
Hinds County	21%	21%	21%	22%	12%	10%	8%	8%	8%	8%	8%
Holmes County	35%	36%	36%	38%	21%	16%	14%	15%	15%	14%	14%
Humphreys County	35%	36%	37%	38%	21%	16%	15%	15%	15%	15%	15%
Issaquena County	28%	29%	30%	31%	16%	12%	11%	11%	11%	11%	11%
Itawamba County	14%	14%	14%	14%	8%	6%	5%	5%	5%	5%	5%
Jackson County	13%	13%	14%	14%	8%	6%	5%	5%	5%	5%	5%
Jasper County	20%	21%	21%	22%	12%	10%	8%	8%	8%	8%	8%
Jefferson County	36%	37%	38%	38%	22%	17%	14%	15%	14%	14%	14%
Jefferson Davis County	26%	27%	27%	28%	15%	12%	10%	11%	10%	10%	10%
Jones County	17%	17%	18%	18%	10%	8%	7%	7%	7%	6%	6%
Kemper County	26%	27%	27%	27%	15%	12%	10%	10%	10%	10%	10%

Lafayette County	24%	24%	24%	24%	13%	10%	8%	8%	8%	8%	8%
Lamar County	13%	13%	13%	13%	8%	6%	5%	5%	5%	5%	5%
Lauderdale County	23%	23%	23%	24%	14%	11%	9%	9%	9%	9%	9%
Lawrence County	20%	21%	21%	21%	12%	10%	8%	8%	8%	8%	8%
Leake County	20%	20%	20%	21%	12%	9%	8%	8%	8%	8%	8%
Lee County	15%	15%	15%	16%	9%	7%	6%	6%	6%	6%	6%
Leflore County	34%	35%	36%	37%	21%	16%	14%	14%	14%	14%	14%
Lincoln County	18%	19%	19%	19%	11%	9%	7%	7%	7%	7%	7%
Lowndes County	22%	23%	23%	23%	13%	11%	9%	9%	9%	9%	9%
Madison County	11%	11%	11%	11%	7%	5%	4%	4%	4%	4%	4%
Marion County	22%	22%	23%	23%	13%	10%	9%	9%	9%	8%	9%
Marshall County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Monroe County	19%	19%	19%	20%	11%	9%	7%	7%	7%	7%	7%
Montgomery County	21%	21%	22%	22%	12%	10%	8%	8%	8%	8%	8%
Neshoba County	21%	21%	21%	22%	12%	10%	8%	8%	8%	8%	8%
Newton County	19%	19%	20%	20%	11%	9%	7%	7%	7%	7%	7%
Noxubee County	34%	35%	36%	37%	21%	16%	14%	14%	14%	14%	14%
Oktibbeha County	32%	32%	32%	32%	18%	14%	11%	12%	11%	11%	11%
Panola County	22%	23%	23%	24%	13%	10%	9%	9%	9%	9%	9%
Pearl River County	18%	18%	18%	18%	11%	8%	7%	7%	7%	7%	7%
Perry County	20%	20%	20%	21%	12%	9%	8%	8%	8%	7%	8%
Pike County	25%	25%	26%	26%	15%	12%	10%	10%	10%	10%	10%
Pontotoc County	14%	14%	14%	14%	8%	6%	5%	5%	5%	5%	5%
Prentiss County	18%	19%	19%	19%	11%	8%	7%	7%	7%	7%	7%
Quitman County	29%	31%	32%	33%	18%	14%	12%	12%	12%	12%	12%
Rankin County	9%	9%	9%	9%	5%	4%	3%	3%	3%	3%	3%
Scott County	19%	20%	20%	21%	12%	9%	8%	8%	8%	8%	8%
Sharkey County	27%	28%	29%	31%	17%	13%	11%	11%	11%	11%	11%
Simpson County	21%	22%	22%	22%	13%	10%	8%	9%	8%	8%	8%
Smith County	16%	17%	17%	17%	10%	8%	6%	6%	6%	6%	6%
Stone County	17%	18%	18%	18%	10%	8%	7%	7%	6%	6%	6%
Sunflower County	29%	30%	31%	31%	17%	13%	11%	11%	11%	11%	11%
Tallahatchie County	28%	29%	29%	30%	17%	13%	11%	12%	11%	11%	11%
Tate County	14%	14%	14%	14%	8%	6%	5%	5%	5%	5%	5%
Tippah County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Tishomingo County	18%	18%	18%	19%	11%	8%	7%	7%	7%	7%	7%
Tunica County	28%	29%	29%	30%	17%	13%	12%	12%	12%	11%	11%

Union County	14%	15%	15%	15%	9%	7%	6%	6%	5%	5%	5%
Walthall County	26%	26%	27%	27%	15%	12%	10%	11%	10%	10%	10%
Warren County	18%	18%	18%	19%	11%	8%	7%	7%	7%	7%	7%
Washington County	29%	30%	31%	32%	18%	14%	12%	12%	12%	12%	12%
Wayne County	25%	25%	25%	26%	15%	12%	10%	10%	10%	10%	10%
Webster County	19%	20%	20%	21%	12%	9%	8%	8%	8%	7%	7%
Wilkinson County	34%	35%	35%	36%	20%	16%	14%	14%	14%	13%	14%
Winston County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Yalobusha County	20%	20%	21%	21%	12%	9%	8%	8%	8%	8%	8%
Yazoo County	27%	28%	29%	29%	17%	13%	11%	11%	11%	10%	11%
Total	**19%**	**19%**	**20%**	**20%**	**11%**	**9%**	**7%**	**7%**	**7%**	**7%**	**7%**

Table 17: Projected Payer Composition (2010-2020)

Payer	2010	2015	2020
Medicaid - Capitated	-	-	-
Medicaid - Non-Capitated	615,884	741,428	747,327
Medicare - Capitated	35,899	40,103	44,707
Medicare - Dual	140,480	147,674	154,900
Medicare - Non-Capitated	310,095	342,026	376,163
Private - Direct	168,838	148,989	134,178
Private - Employer Sponsored	1,121,725	1,201,445	1,163,396
Private - Exchange	-	115,821	228,636
Uninsured	567,017	264,893	220,356
Total	**2,959,939**	**3,002,379**	**3,069,664**

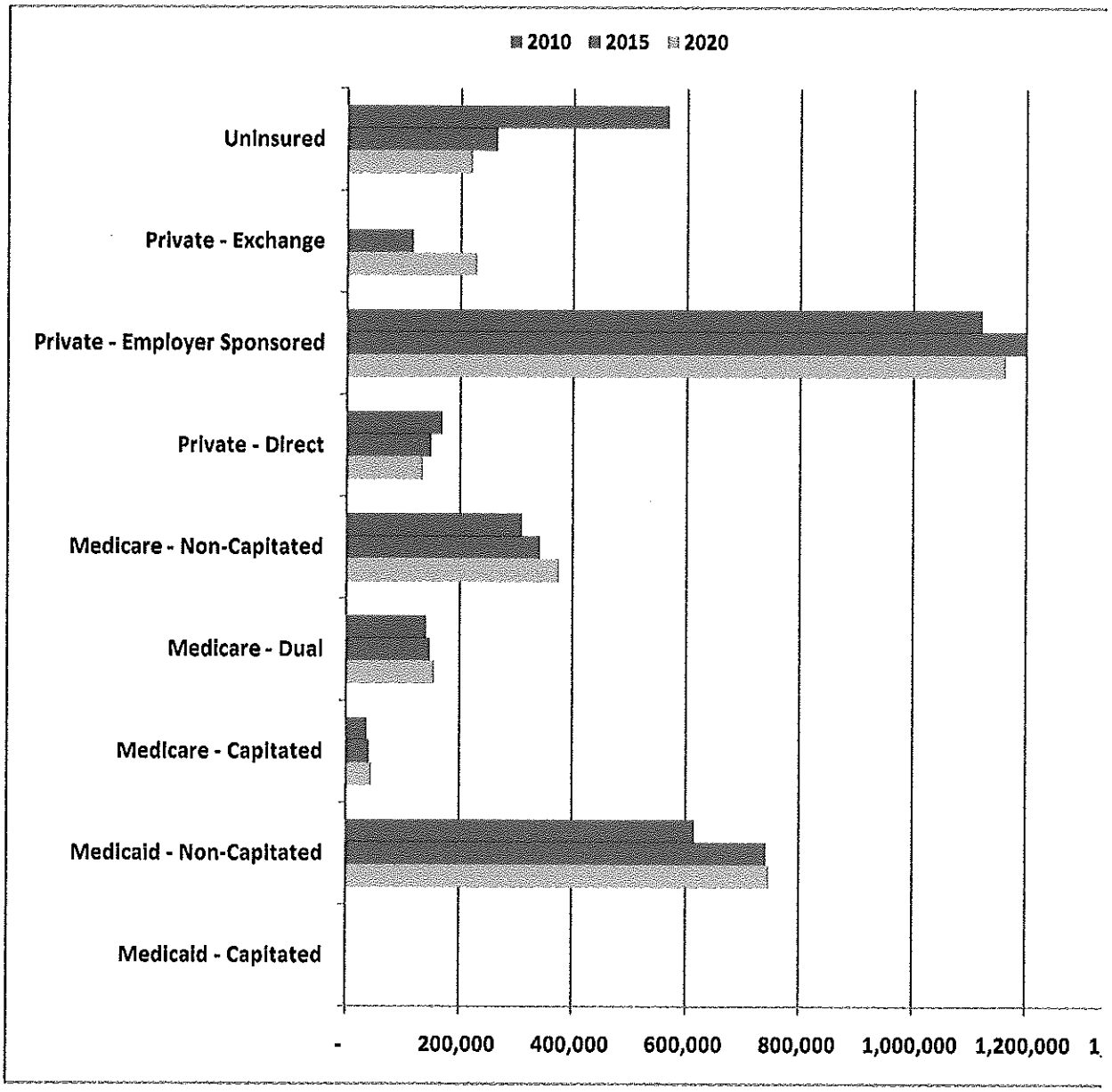


Chart 1: Mississippi Historic Unemployment Rate (Trended)

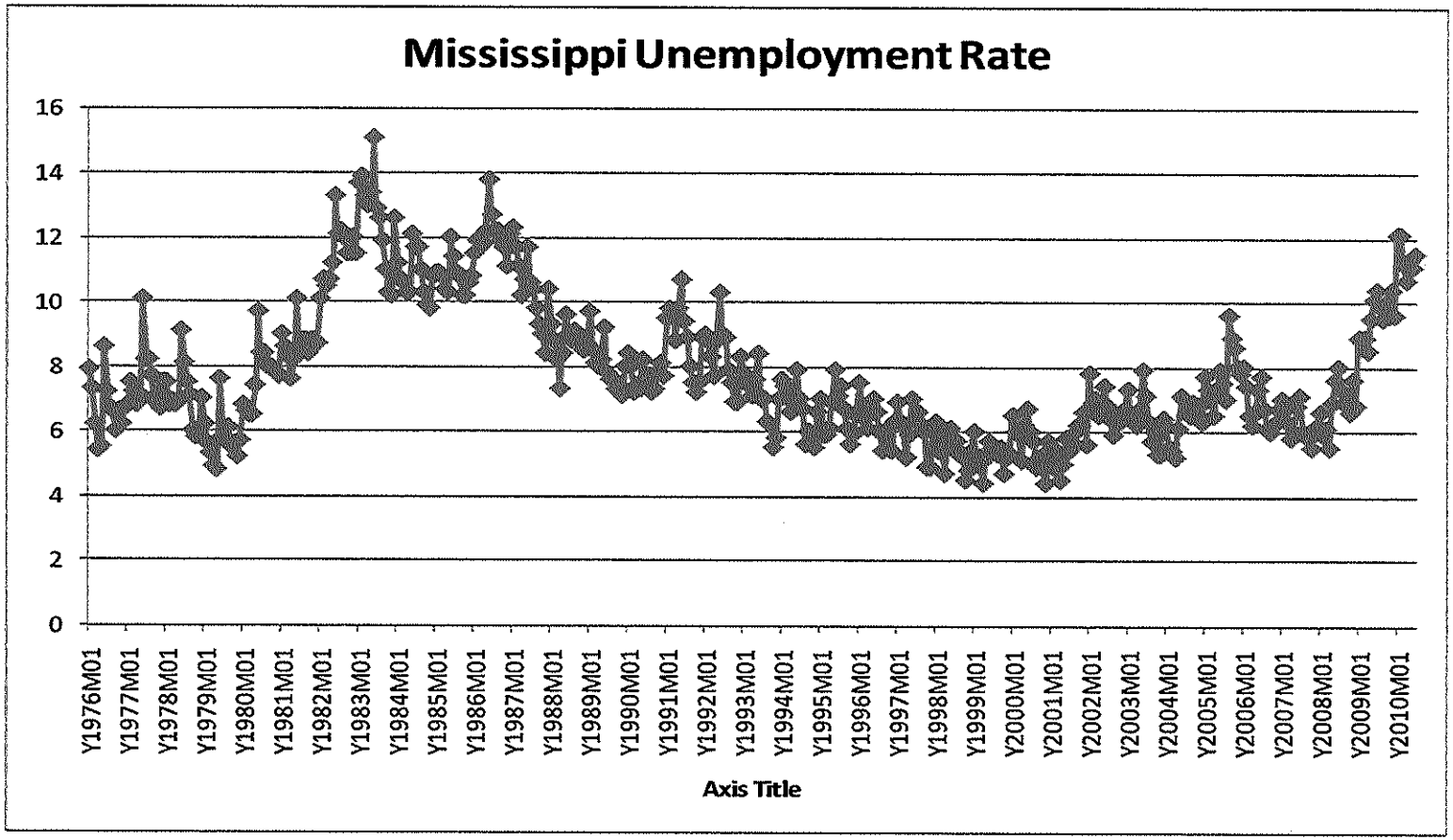


Chart 2: 10 Year Change in Uninsured & Medicaid by Number of Lives (2010-2020)

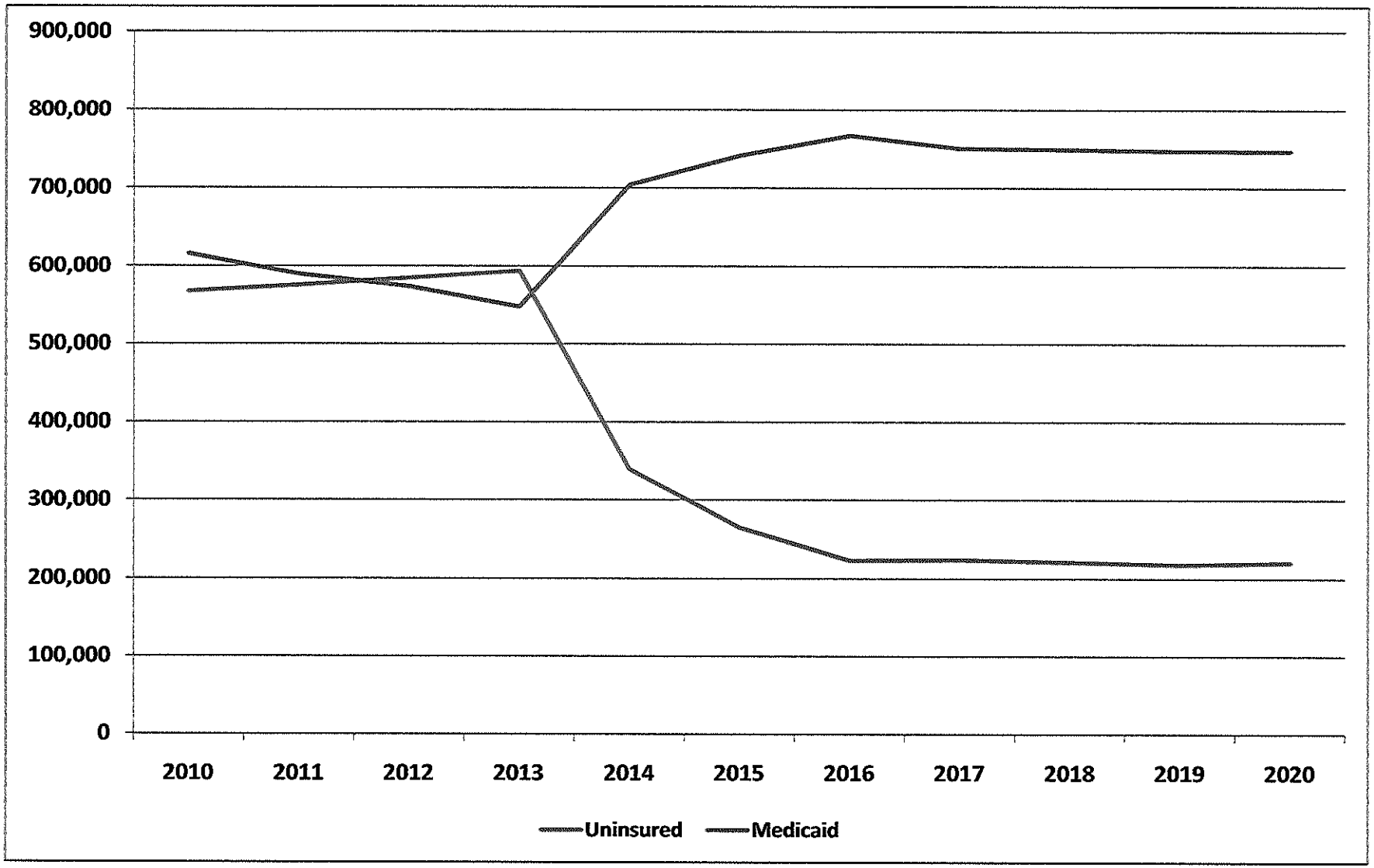
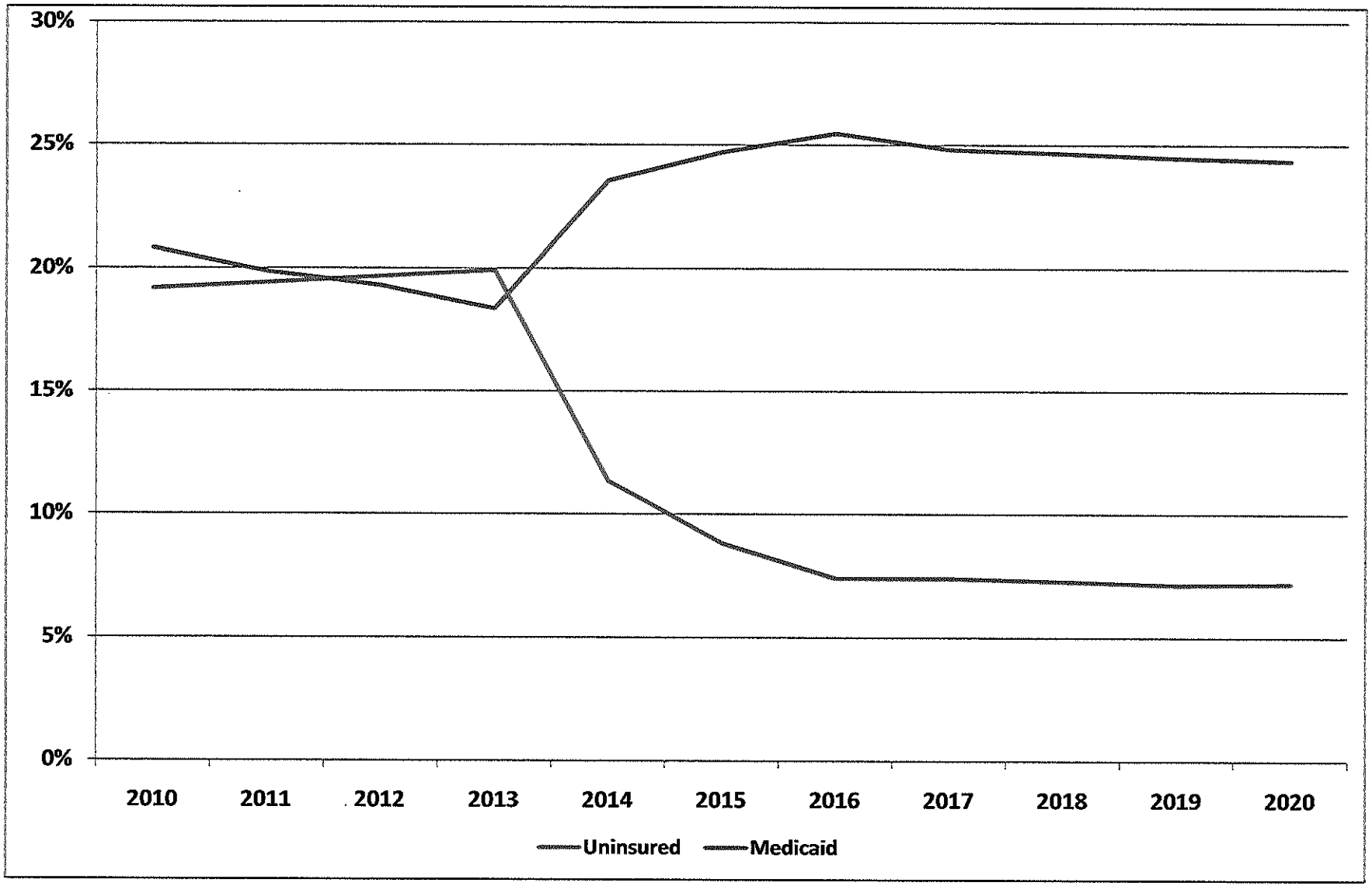


Chart 3: 10 Year Change in Uninsured & Medicaid by Percentage of Population (2010-2020)



ATTACHMENT D

Mississippi Small Group and Individual Exchange
"By Mississippians, For Mississippians"

Phase I
Secondary Research and Data Analysis
Stakeholder Interviews and Mini-Focus Groups

Mississippi Insurance Department
Preliminary Draft

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Section 1: Report Introduction

A key feature of the Patient Protection Affordable Care Act (PPACA) is the mandate to establish a health insurance exchange for each state (or multi-state region) by 2014. States that do not comply with the mandate will be required to participate in a federally-designated exchange. Because of the uniquechallenges and needs associated with each state, many have begun the initial phase of designing their own exchange. This report offers key insights that are critical to designing and implementing a successful exchange in the State of Mississippi.

One goal of an exchange is to increase theoverall accessibility of health insurance for small businesses and individuals. The primary components of past successful exchanges include(1) high levels of participation, (2) transparency, (3) user simplicity, and (4) a choice of health planoptions offered by various carriers. Together, these components promote competition, quality of health care, and better cost management. Exchanges can also serve as a tool for distributing health subsidies to qualified individuals.

An exchange is not a panacea for all health care challenges. In the short-run, health insurance premiumswill not be significantly impacted by an exchange. However, a health insurance exchange is an important step toward making health care coverage options more accessible to small businesses and individuals.

Mississippi has many distinct health and economic needs. As of 2010, 18 percent of Mississippi residents were uninsured. Additionally, the PPACA willincrease Medicaid eligibility in the state from just under 24 percent to approximately 34-38 percent of residents. Moreover,55 percent of the state's residents live in rural areas.[1]Mississippi ranks last [nationally] in the percentage of public high school students who graduate.[2] The state ranks last in the percentage of people who use the Internet inside or outside the home.[3] Furthermore, Mississippi ranks first in adult obesity, first in the number of adults who report no physical activity in the past month, first in heart disease deaths, first in teen birth rates, first in traffic fatalities, and second in infant mortality.[4] These challenges reinforce the need for an exchange built by Mississippians, for Mississippians.

The State of Mississippi has chosen to preempt federal involvement by implementing an exchange that best serves the unique needs of its residents. It is imperative that the exchange becarried out with high efficiency in order to maximize its impact, while preserving taxpayer dollars. To that end, the Mississippi Insurance Department (MID) has hired Leavitt Partners and Cicero Group[5] to assist in designing an effective exchange for the state.

This report includes results from more than sixty in-depth interviews[6] with Mississippi legislators, business associations, economic development leaders, consumer advocates, health care providers, insurance carriers, broker representatives, small businesses, and policy analysts. Also included is an extensive review of secondary research that relates to exchanges nationally. This report provides a

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[1]United States Department of Agriculture. *United States Department of Agriculture.* http://www.ers.usda.gov/statefacts/ms.htm (accessed March 7, 2011).
[2]National Cener for Education Statistics, US. *Trends in High School Dropout and Comlpletion Rates in the United States.* December 2010. http://nces.ed.gov/pubs2011/2011012.pdf (accessed March 7, 2011).
[3]National Telecommunications and Inforamtion Administration, US Department of Commerce. *Current Population Survey, Internet Use 2010.* http://www.ntia.doc.gov/data/CPS2010Tables/Tables_3.xlsx (accessed March 7, 2011).
[4]United States Department of Health and Human Services – Centers for Disease Control and Prevention (CDC). National Center for Health Statistics, Mississiippi Vital Records – Mississippi State Department of Health (MSDS), Behavioral Risk Factor Surveillance Systems – CDC, MSDH STD/HIV Office, National Center for Health Statistics, Henry J. Kaiser Family Foundation – State Health Facts. (accessed April 12, 2011).
[5] Company profiles of Leavitt Partners and Cicero Group are located in the "Methodology" section of this report.
[6] Notes from interviews and small business and broker mini focus groups are an overview of the discussion, not a transcription.

foundation for future qualitative and quantitative research that will be necessary to create the optimal exchange for the State of Mississippi.

Section 2: Executive Summary

1. **Health Insurance and Exchange Confusion:** Among all respondents (including health experts), there was confusion about health insurance and the health insurance exchange. Respondents suggest that part of the confusion about health insurance and exchanges stems from the ambiguity of the Patient Protection and Affordable Care Act (PPACA). For example, very few respondents knew whether insurance would be guarantee issuance within the small business exchange.

2. **Exchange Design:** As an outgrowth of the confusion surrounding health insurance and exchanges, respondents unanimously stressed the importance of simplicity in the exchange. The following represent the most reiterated recommendations from respondents for making the exchange simple:

   - **Marketing and Education**:
     - Mississippi will serve an extremely diverse audience. The needs of Mississippians differ by region, ethnicity, and socioeconomic status. Those implementing the exchange must apply tailored marketing and presentation to appeal to these diverse groups. Outreach must include a variety of channels, including business associations, chambers of commerce, economic development organizations, community health groups, providers (e.g. physicians and nurses), churches, social and community organizations, and traditional media.
     - Outreach initiatives should rely heavily on graphics rather than text in the marketing and educational material.
     - Ensure that the individuals providing education about the exchange, whether in-person or by phone, can present complex concepts of adverse selection, risk pooling, insurance, and the exchange in a simple and easy to understand manner.
   - **Enrollment**:
     - Allow those wishing to enroll in the exchange to do so by web, phone, mail, or in-person.
     - Offer enrollment opportunities immediately after small businesses and individuals receive education about the exchange.
     - Design anonline interface that is simple enough for individuals with limited education and Internet knowledge to navigate.

   - **Product Offerings**:
     - Additionally, consider offering a basic plan with the option of add-ons(e.g. maternity, vision, dental, mental, pharmacy, first-dollar emergency room, etc).
     - Create a solution like the Medicare supplement model, where individuals can compare similar plans across carriers. Carriers then compete on price, service, or network.
   - Insurance Market Structure:
     - A simple defined contribution plan will allow employers to shift the burden of selecting the "right" plan for all workers, to the individual employees themselves. Such a solution must be simple enough for any employee to select a plan they understand and that fits their needs.
     - Carriers and brokers were concerned that a defined contribution model would create significant administrative challenges. It was believed that the model would increase the number of support calls they [carriers and brokers] receive and be particularly burdensome during enrollment periods.
   - **Administration**:

- Ensure that the exchange integrates simply with the day-to-day operations of businesses (e.g. easy to add full-time and part-time employees, pay bills, and review health plan statuses of employees).
- Provide a simple online and offline process where individuals can easily access and review their current policy, and evaluate various options within a framework that constrains excessive plan switching or cancellation.
- Create a separate administrative process for serving the 133-200 percent federal poverty level population. This group will churn in-and-out of Medicaid eligibility, which if not kept separate will increase the administrative burden for the exchange.

3. **Rural, Technological, and Educational Challenges**: Respondents identified Mississippi's rural population, low rates of education attainment, and relative lack of computer literacy as some of the largest challenges for the exchange. Other respondents shared the desire for properly setting expectations that the exchange will not immediately lower insurance costs,broadening stakeholder involvement, and developing a more manageable governing and regulatory body.

4. **A State-Sponsored Tool for Economic Development**:The consensus among respondents was that the exchange should not be viewed as an extension of "ObamaCare," but rather a resource built by Mississippians, for Mississippians. Small business and economic development leaders explained that the exchange should be viewedas a resource for attracting and retaining employees, rather than a tool for reducing insurance costs. For example, the exchange should include case studies showing why offering insurance can improve profits for small businesses (e.g. benefits of healthy workers, increased employee retention rates, attracting productive employees). Some worried that participation in the exchange could suffer if itis linked too closely with entitlement programs.

   Regulation, Rules, and Adverse Selection: Brokers and small business respondents expect the exchange to be regulated by the Mississippi Insurance Department, with the Governing Board of Directors consisting of businesses, consumer advocates, health providers (e.g. nurses and physicians), and insurance representatives. Respondents (excluding legislators) believed an exchange housed within a state agency would be too slow and bureaucratic. However, legislators expressed a strong desire that the exchange be subject to legislative oversight. While only explicitly identified by state leaders, carriers, brokers, and policy analysts, adverse risk is the greatest threat to Mississippi's exchange. High participation rates will reduce the likelihood of adverse selection. The exchange must also limit behaviors that negatively impact risk pools including only purchasing insurance when individuals are ill or hurt. Regulation must be balanced by the flexibility small businesses need to grow.

5. **Funding**: Most respondents could not identify an effective solution for funding the exchange. Brokers and various state leaders suggested funding the health exchange through a mechanism similar to that of the Mississippi Comprehensive Health Insurance Risk Pool Association. Specifically, these respondents recommended that carriers be charged an exchange assessment fee.

6. **Navigators**: Consumer advocates, policy analysts, small businesses, brokers, and some state leaders communicated that navigators must have the ability to educate and enroll participants in the exchange. Furthermore, these same respondents believe commission/compensation should be a flat monthly rate, per-person-enrolled, regardless of the plan or carrier. Furthermore, these individuals must be registered and licensed by the state. Consumer advocates, community health leaders, and economic development leaders all expressed interest in serving as navigators.

7. **Brokers**: All respondents voiced the critical role that brokers will play in the exchange. Yet, most (excluding brokers) spoke of the increasingly consultative role brokers will need to assume.

Respondents acknowledged that broker involvement must be driven by an economic incentive. Yet, such compensation should be given on a flat monthly fee, per-person-enrolled basis, to avoid bias toward one option over another.Furthermore, compensation should be consistent across all plans and carriers. Most respondents believe brokers can as assume the role of a navigator if they are licensed through an exchange certification process. When asked about the benefits of the exchange, brokers spoke of the opportunity to cross sell and offer products to individuals who were previously unqualified for insurance.

8. **Increasing Participation**: There is confusion among respondents about whether the exchange will immediately lead to lower insurance costs. Carriers, state leaders, and policy analysis stressed the importance of explaining that the allure of the exchange should not be cost savings. Rates inside the exchange will be the same as those in the outside market;therefore,the state should disassociate the exchange from the belief that it will result in decreased premium costs. Small business owners, who understood that the exchange would not lead to lower premiums, spoke of the exchange's ability to help them attract and retain employees. While there was no uniform consensus, respondents suggested promoting the following aspects of the exchange:

    - A defined contribution model, which would help employers realize predictable health care costs.
    - Increased health plan empowerment and choice for employees.
    - Simple plan administration that integrates into the daily operations of businesses (e.g. intuitive, automated bill pay, and payment facilitator).
    - The ability for part-time employees to aggregate benefits from multiple employers.
    - Portability of insurance for employees.
    - A mechanism for distributing subsidies, making health care affordable for employees who qualify.

9. **Exchange Rollout Tests**: Policy analysts, community health providers, and various state leaders suggested the exchange be rolled outto a small group first, perhaps a government agency or small city. Depending on the outcome of the pilot test, the exchange will have the ability to make changes before presented to the public. Some of these respondents further recommended that the state consider enrolling its local state employees in the exchange to reach critical mass more quickly.

10. **Outreach**: All respondents spoke about the challenge of educating the public and small business community about the exchange. Yet, these same respondents spoke about Mississippi's strong, existing networks for outreach and education. Outreach channels include brokers, chambers of commerce, planning and development districts, economic development groups, industry and business associations, state health departments, community health centers (FQHCs), health care providers (e.g. nurse practitioners and physicians), churches, schools, and community/advocacy groups. Respondents recommended that the exchange leverage these existing networks to facilitate an in-person outreach and enrollment campaign.

11. **Marketing**: Community health leaders, brokers, state leaders, small businesses, and policy analysts think the marketing campaign should combine in-person and organizational outreach with traditional media (e.g. television, magazines, mailers, newspapers, and online). Additionally, many respondents suggested that the name "exchange" is difficult to understand, and may conjure perceptions not representative of the role of the health exchange. When asked for alternative names for the exchange, suggestions included Magnolia Health (already taken and therefore used in this report simply as an illustration), Small Business Health Marketplace, or The Mississippi Health Outlet.

Section 3: Detailed Overview from Phase I Qualitative Research

Exchange Challenges

Federally-established exchange versus State-established exchange:
Mississippians unanimously agreed thatMississippi must control its own future with regard to the exchange. As stated by the majority of respondents, "[the exchange]must be built by Mississippians, for Mississippians."

What are the primary challenges to creating a successful exchange in the State of Mississippi?
When asked about the primary challenges to creating a successful exchange, respondents focused on the need for education both about the exchange and about insurance, as well as the challenges of accessing the exchange by computerin rural areasand among the state's diverse socioeconomic groups. The list below is an amalgamation of the primary challenges and solutions, as presented by respondents:

- Simplicity is the solution:
  - For most problems, the consensus among respondents was that simplicity is the solution. Respondents listed various aspects including marketing material, outreach, education, enrollment, plan design, navigation (whether by Internet, phone, or in-person), and administration, all of which must be extremely simple for all groups involved (e.g. consumers, businesses, brokers, carriers, and exchange administrators).

- The exchange is complicated and education outreach will be critical:
  - Navigators, brokers, legislators, industry groups, chambers of commerce, economic development organizations, health care providers (e.g. physicians and nurses), employers, and employees will all need education not only to participate in the exchange, but also to assist other participates in the exchange.
  - Outreach must be frequent and broad. Respondents identified several channels for education and outreach including business associations, churches, community health organizations, traditional media, and town hall style meetings in various cities throughout Mississippi.

> *"Even highly educated people do not understand insurance." - Health Policy Expert*

- Insurance is complicated and educational outreach will be necessary:
  - Health insurance is complicated for everyone, including insurance experts. A defined contribution model requires exchange participants (e.g. employees) to understand their plan options. If employees cannot understand their options, they will turn to their employers for assistance, increasing the administrative burden on the employer and resulting in lower participation rates in the exchange.

- The exchange must meet the needs of diverse socioeconomic and geographic groups within Mississippi:
  - The needs and challenges of the Delta region are different from those of the Gulf Coast, which are different from those of Central Mississippi, which are different from those of Northern Mississippi. For example, while online and telephone access to the exchange may be sufficient points of access for Central Mississippi, the Delta region will primarily require a face-to-face approach. Similarly, where business associations may be an effective outreach for one group, churches will be most effective for other groups. Needs and challenges also differ by ethnicity and socioeconomic status. Those designing the exchange must tailor the exchange to the needs of Mississippi's entire population.

- Access to the exchange:
  - Closely related to the challenges of serving a diverse population, is the problem with accessing the exchange. Respondents explained thata single point of access to the exchange (i.e. web portal) is not a viable option in Mississippi. Many rural, low-income, uneducated, or technologically limited Mississippians need in-person support and enrollment. Almost all stakeholders agree that a successful exchange implementation will require significant in-person communication. Fortunately, Mississippi has an existing infrastructure on which to rely to facilitate enrollment and access to the exchange.
  - Policy analysts, consumer advocates, and small businesses suggested the state equip navigators with electronic devices that have wireless Internet to allow for electronic enrollment, coupled with in-person assistance.Enrollment teams could also travel throughout rural Mississippi signing-up the uninsured.

- Administrative burden:
  - All respondents acknowledged that health insurance creates a significant administrative burden on small businesses. Running a small business is demanding and many employersdo not have the time to explain insurance to their employees. The exchange must be simple enough that it integrates into the day-to-day operations of the small business.Small businesses explained that if they have to spend a significant portion of their time responding to health inquiries, they would likely not participate in the exchange.
  - Carriers and brokers also view the exchange as a possible administrative burden. Both groups are concerned that a define contribution model, where employees choose their health plan, would increase the number of support calls they receive. The enrollment phase would be most intense during open enrollment periods. Additionally, brokers believe they would have to make more frequent in-person visits to support the socioeconomic, educationally, and technologically diverse clientele served by the exchange.

- Government intrusion and fear of the Patient Protection and Affordable Care Act (PPACA), a.k.a. "ObamaCare":
  - Individuals participating in the research shared a general distrust of the federal government and some distrust of state government. It was recommended that the state sell the small group exchange ascreated "by Mississippi small businesses, for Mississippi small businesses." Furthermore, focusing on offering a resource to businesses to attract and retain employees may brand the exchange as an economic development tool, rather than a government program. As a related point, many believe the exchange should avoid being associated with Medicaid or any entitlement program.

- Increasing small group participation, quickly:
  - Premium rates for identical plan should be the same inside and outside the exchange. Those selling the exchange must avoid suggesting that the exchange will directly lower health care costs. Small businesses participating in the exchange may benefit from the costs predictability of adefined contribution model, the ability to offer benefits to part-time employees, and a digitallysimple administrative process. However, these are somewhat complex reasons to join. The value proposition for small businesses to join the exchange must be presented in a clear and economically stimulating manner. Some suggested offering case studies that illustrate the economics of the exchange.

- Economic development vs. entitlement:
  - Small businesses, business associations, and economic development leaders believe the exchange will be most successful if branded as an economic development tool. Generally, the majority of negative comments about the exchange came from those who believed the exchange to be synonymous with "ObamaCare," Medicaid, government programs, and federal intrusion. Respondents believe the exchange should be a resource to attract and retain employees while realizing more predictable and controllable health costs.

- Perception of the exchange, lowering health costs:
  - Carriers, brokers, various state leaders, and policy analysts emphasized that while there may be long-run decreases in insurance costs, businesses and individuals should not perceive the exchange as a panacea for reducing health costs. These individuals explained that during the exchange's public outreach campaign – exchange educators, navigators, and brokers must avoid any indication that the exchange will directly reduce costs. Outreach efforts must focus on other positive aspects of the exchange (e.g. defined contribution and predictable costs, increased plan competition, subsidies for those who qualify, and better long-term control of expenses).

- Regulation and adverse risk:
  - State legislators, consumer advocates, carriers, and brokers were all concerned with who will ultimately regulate and oversee the exchange. Most groups did not believe the state should create an agency to support the exchange. Instead, respondents suggested that the exchange should be regulated by an existing agency, the Mississippi Insurance Department, with a governing board consisting of representatives from the insurance industry (e.g. primarily actuaries), small businesses, providers (e.g. physicians or nurses), and consumer advocates.
  - Several groups, including brokers, nurses, consumer advocates, and community health organizations expressed interest in serving as navigators. All groups believed navigators could assist groups and individuals in navigating the exchange and that navigators should be compensated for their efforts. However, all groups acknowledged the importance of some type of registration or certification process necessary to limit fraud and abuse.
  - While only explicitly identified by state leaders, carriers, and brokers – adverse risk is the greatest threat to a successful exchange. Brokers explained that groups often requested the ability to pool risk, believing they would experience lower premiums for everyone. However, once risk is pooled, groups are trapped in a "death spiral" where healthier individuals slowly leave the pool to find cheaper premiums until the pool eventually collapses. Therefore, pooling risk was not advised. However, many small businesses spoke of pooling risk as one of the benefits of the exchange. The risk-pooling disconnect between carriers and small businesses must be addressed. Carriers also believe the exchange should impose rules with which prevent individuals from purchasing insurance only when sick or hurt. Otherwise, carriers will have little incentive for participating in the exchange.

- Stakeholder involvement:
  - Many groups expressed interest in being more involved in the exchange debate. They offered various services to researchers to facilitate further research. Consumer advocacy groups, nursing associations, industry groups, and small businesses have not felt included in the process.All respondents supported solutions to make health care more manageable for small businesses and groups, as long as they are administratively simple and easy to implement.

> *"It should be a small governing board with broad representation. Insurance people, small businesses, brokers... the people who are using this every day." - Small Business Owner*

Creating the Exchange

How should the health exchange be regulated?
Various state leaders and brokers explained that the exchange should likely follow the state's high-risk pool model. In the case of the Mississippi exchange, the majority of those interviewed suggested that the Mississippi Insurance Department be given regulatory oversight. Moreover, consumer advocates, insurance providers, small businesses, and brokers suggested that the Governing Board of Directors for the exchange should appoint members from small businesses, consumers groups, nurses, insurance carriers, brokers, and business organizations. These same respondents suggested the board should be limited to eight members. The allocation of board membership should be of but representing different stakeholders, including varied ethnic and socioeconomic groups.

> *"You've got to convince me that this is worth my time. I'm doing plenty of things that help other people that don't make me money. I don't need something else."* - *Small Business Owner*

Legislators expressed concern regarding the oversight and control of the exchange. Interestingly, individual and group participants emphasized the importance of constructing the right exchange (simple and accessible), while legislators generally focused on oversight of the exchange.

Who should manage the exchange? (State agency or not-for-profit entity)
Brokers, some state leaders, and insurance industry representatives think Mississippi should/could/ will use the current staff of the state high-risk pool to manage the exchange. The Mississippi high-risk pool is one of the few solvent state risk pools in the country. Almost all respondents, excluding most legislators, believe a state agency would not be nimble enough to properly administer the exchange.

However, using the staff and funding mechanisms of the high-risk pool could potentially associate the exchange with that program, instead of reasserting itself as a separate entity. This could decrease small group participation if they perceive it as an individual entitlement program.

Should small group risk be pooled?
Actuarial analysis must be performed to answer fully the question of pooling risk. However, brokers, insurance carriers, and policy analysts suggest that pooling the risk of small groups will lead to adverse selection, resulting in higher insurance rates in the exchange.

Small businesses and consumer advocacy groups believe the risk should be pooled to increase the likelihood of groups qualifying for insurance, perceiving that premiums would decrease as a result.

> *"Groups are always coming to me wanting to pool risk. But every time we try it we end up with the death spiral where healthy people leave to get cheaper insurance outside the group. Eventually the whole thing collapses."* - *Broker*

How will the exchange be funded?
Few groups were able to offer solutions for funding the exchange. Brokers and some state leaders believe the exchange should be funded by using current revenues flowing to the state high-risk pool or by a similar assessment mechanism.

How many carriers should be available?

> *"If you don't have competition, you end up with all kinds of chicanery." - Broker*

Respondents believe the exchange should include as many carriers as possible. However, all carrier-participants should be required to have sufficiently large networks. Brokers and small businesses believe network accessibility is the primary reason BlueCross BlueShield holds the dominant market share in Mississippi. Policy analysts and various state leaders hypothesized that carriers who have not previously had a sufficiently large presence in Mississippi will participate in the exchange in order to gain market share in the state. These same stakeholders forecast that BlueCross BlueShield will participate in order to protect its market position.

How many products should be available in the exchange?

> *"Don't offer more than three or four plans per carrier. Otherwise, it's too confusing." - Small Business Owner*

This question might have stimulated the greatest amount of thought from those interviewed. While some believed that providing the maximum number of options would ensure better customization (e.g. "No pair of sandals fit two people the same") the majority of those interviewed felt that simplicity was fundamentally the most critical feature required to ensure the success of the exchange. Therefore, it was most frequently recommended that a standardized set of plans be established (three to four) for which every carrier could compete. Subsequently, in order to make the options more customized, participants could then choose add-on services like maternity, dental, psychiatric, etc. One example, provided frequently by those interviewed, was to consider the Medicare supplement program where plans are the same and carriers compete on price, service, and network.

Poor understanding of insurance plans will lead to an excessive use of 1-800 numbers and in-person communication for program and plan clarification. If this occurs, many employees will turn to employers for clarification. If employers receive too many employee questions, they will not participate in the exchange.

What types of products should be available?

Almost all participants are excited by the idea of a defined contribution model. Respondents explained that a defined contribution would help employers budget for costs. Carriers and brokers were least enthusiastic about the defined contribution model. Generally, these carriers and brokers believe the model would result in a significant administrative burden. Regardless of the model chosen, the exchange must offer products that are simple and do not add administrative burdens for employers. When asked to give specific plan options, small businesses and brokers suggested the following:

- **Option 1:**
  - Have a basic, high-deductible health plan that is the same for all carriers. Then offer add-ons like a lower degree of deductible, maternity, prescriptions, first dollar emergency room, dental, visions, psychiatric, etc.
    - "Make it like build-a-bear."

- **Option 2: Each plan standardized**
  - Level 1 – High deductible, low premium coupled with a health saving account
    - Deductable:
      - $2,500 per individual
      - $5,000 per family

- Level 2 – Medium deductible, medium premium coupled with a health savings account and moderate co-payment
  - Deductable:
    - $1,000 per individual
    - $2,500 per family
  - Co-pay:
    - $25 - $50
- Level 3 – Low deductable, high premium and low co-payment
  - Deductable:
    - $250 per individual
    - $500 per family
  - Co-pay:
    - $10 - $15

What forms of contact should be available in the exchange?
The question of "contact within the exchange" elicited strong responses about Mississippi's low education and computer literacy rates. Mississippi has a diverse population with various needs. Rural Mississippians may not have access to computers. Therefore, an online exchange may only serve a particular geographic and even socioeconomic group. Respondents suggested the Mississippi exchange offer email, online chat, toll-free telephone, and in-person communication access. Furthermore, given the rural nature of the state, policy analysts recommended that the exchange engage in an outreach method using various mobile eligibility vehicles that educate and enroll qualified individuals in health plans.

What is the role of a navigator?
The PPACA has given little clarification regarding the role of navigators. However, small businesses, brokers, community health representatives, consumer advocates, and policy analysts believe navigators in Mississippi must educate and enroll individuals. Small businesses and brokers think that education alone is not enough. They believe potential exchange participants will request help enrolling in the exchange immediately after education. If navigators are unable to enroll, the state willlikely waste resources.

Who should be considered for the role of a navigator?
All respondents were concerned with the likelihood of fraud among navigators if the certification requirements are too low. Brokers, community health representatives, and consumer advocates suggested a rigorous registration and certification process. Furthermore, community health representatives, consumer advocates, planning and development district representatives, and others expressed interest in acting as navigators.

How should brokers/enrollers be compensated for their role in the small business exchange?
Various groups, including brokers, community health representatives, health providers (e.g. nurses), and consumer advocates, expressed interest in being able to enroll individuals in the exchange. These groups believe they should be compensated for enrolling individuals in the exchange.

> *"You should never have a financial incentive for steering a customer into a plan. If there's an incentive for one plan over another, there is larceny of the heart." - Broker*

Brokers specifically suggested those who enroll individuals in the exchange should be paid monthly per-individual-enrolled, based on the average rate in the market. When asked to specify a fair compensation for enrollment, brokers suggested $20 to $25 per individual enrolled. They also suggested that larger groups might garner a smaller per person fee (around $15 per person).

Almost all respondents believe compensation should be consistent for all carriers and plans. If compensation is not consistent for all plans and carriers, respondents believe carriers and brokers will have an incentive to be biased toward higher premium plans.

What should be the name of the exchange?
Respondents had a difficult time defining a health exchange without aid from researchers. The name "exchange" was particularly confusing to many respondents. Some believed the name connoted exchanging plans, or bartering services/products for health care, or something related to the stock exchange. When asked to suggest alternatives, respondents proposed the following names:

- Magnolia Plan (already branded by a company, but used here as an illustration since it was a suggestion that resonated with several individuals during a group discussion)
- Magnolia Marketplace
- Mississippi Small Group Health Marketplace
- Health Outlet

What groups could cause administrative issues for the exchange?
Respondents generally identified Mississippians located in rural areas, low income, poorly educated, and technologically challenged as the most challenging to serve. For example, it will be difficult to manage the administration and in-person representation needed to enroll rural Mississippians annually in the exchange during an open enrollment period. Policy analysts both inside and outside Mississippi also identified Mississippi's large population of individuals with income between 133-200 percent the federal poverty level. These individuals have frequent income fluctuations that churn them in-and-out of Medicaid, monthly. Such churning will make this group an administrative challenge; analysts have suggested that Mississippi considers different rules and mechanisms for serving this segment of the population.

How should Mississippi rollout the exchange?
Some small businesses and policy analysts were particularly concerned with how the state implements the exchange. These groups believed that the state should implement a pilot project before the exchange is fully implemented in Mississippi. The state could begin with a small group first, perhaps a small government agency or even a small city. Depending on the outcome, the exchange will have the ability to make changes before it is presented to the public. Furthermore, respondents recommended the state consider enrolling its local state employees into the exchange program to attain critical mass more quickly.

Study the failures of TennCare and other failed state-sponsored programs that were poorly publicized or executed. Suggested TennCare failures of the program include:
Those interviewed were asked how the state could most effectively implement the exchange; several respondents suggested learning from the state's, as well as surrounding states, failed programs. One such example was Tennessee's TennCare. Reportedly, the extent of available options within the program was too great, resulting in confusion among those participating. Moreover, policies within TennCare were too volatile due to frequent alterations by state leaders. It is believed that the program did not have enough time to function and be evaluated before changes were made. Lastly, TennCare was said to have had limited stakeholder buy-in, which resulted in poor promotion of the program itself.

Increasing Participation in the Exchange

What channels does Mississippi currently have for educating the public about the exchange?
The majority of respondents acknowledged Mississippi's strong connection between business and community/professional groups. Researchers were able to experience, firsthand, the state's ability to effectively network. Four of five focus group participants canceled on the day of the focus group. With little notice, the small businesses community, in association with the chamber of commerce, was able to identify and recruit four new participants. It is recommended that Mississippi leverage these existing networks rather than allocate resources toward the creation of a new network. Respondents recommended the following groups as potential networks.

- Recommended channels for educational outreach (small groups)
  - Brokers
  - Chambers of commerce
  - Economic development groups
  - Industry and business associations (MMA, ABC, MRHA, etc)
  - Planning and development districts
  - Public service announcements

- Recommended channels for educational outreach(individuals)
  - State health departments
  - Community health centers
  - Providers (nurses, physicians, hospitals)
  - State, county, and local officials
  - Churches
  - Schools
  - Advocacy groups
  - Planning and development districts
  - Public service announcements

> *"Health care is an extremely important issue for businesses. If you have something that will help, they will participate. The Chamber is happy to set up meetings or do whatever is needed to assist." - Chamber of Commerce participant*

How do we increase participation in the exchange among small businesses?
Small business respondents explained that health benefits are a tool for them [the business] to attract and retain quality employees. The quality of an employee can fluctuate in relation to the caliber of the benefits. Small businesses citedthe cost-predictability associated with a defined contribution model, part-time employee benefits, and requiring carriers participating in the exchange to have large networks as methods of increasing the value of plans offered.

Small businesses recommended various methods to reducing possible administrative burdens that would be heightened by the exchange's implementation. First, all respondents mentioned the need for a simple enrollment medium, (e.g. the Internet, phone, or in-person). Second, the exchange should be extremely easy to navigate and understand. Respondents were clear that they do not have a significant amount of time to spend dealing with insurance related matters. Therefore, from a potential consumer perspective, the exchange should integrate effortlessly into their day-to-day operations. If the employees of a small business continually resorted to an employer for health related answers, the business would likely remove itself from the exchange in favor of a less complicated plan.

Several small business respondents recommended the Medicare supplement program as a model for how to present the exchange. This model offers standardized products so that individuals can easily compare plans across an array of insurance providers. Small businesses believe this will compel carriers to compete on customer service, price, and network.

A popular suggestion among small business respondents was to supplynavigators [an individual who provides information about the exchange] with the ability to enroll individuals inthe exchange on location. If individuals are not enrolled soon after education, exchange participation will suffer significantly. Small business respondents stated that they do not have the time to enroll their employees and suggested that enrollment be offered by the exchange as a service.

The Greater Jackson Chamber of Commerce illustrated that a small group discount may be helpful in increasing small business participation. Currently the Greater Jackson Chamber of Commerce offers a discounted benefits plan (Chamber Plus). The insurance premium is discounted three percent for two years. According to the Chamber, this program has significantly increased their membership enrollment.

Why would brokers participate in the exchange?
The possibility of an exchange commission was the primary motivator among brokers. When asked about other motivators, brokers cited the opportunity to cross sell, better serve clients who would not otherwise qualify for insurance, and guaranteed insurance issuance as additional reasons to participate.

Section 4: Stakeholder In-Depth Interviews

Stakeholder In-depth Interviews Introduction and Methodology: A successful health exchange requires the perspectives of many stakeholders. Legislators, consumer advocates, business organizations, insurance carriers, and policy analysis – all contributing key insights that assist in creating the exchange. However, the best-designed exchange is only effective if businesses and individuals use it. Accordingly, Leavitt Partners and Cicero Group have designed a research methodology that is heavily weighted toward those who will actually use the exchange. Phase I of the research plan was originally designed to focus on outside stakeholders, rather than potential exchange users. Phases II and III of the research will focus primarily on seeking input from potential exchange users, including small businesses, brokers and individuals.

Stakeholder in-depth interviews allowed researchers to dig deeply into Mississippi's unique needs and challenges. In-depth interviews were primarily conducted in-person and lasted approximately 60 minutes per interview. The Mississippi Insurance Department provided an extensive list of exchange stakeholders. Leavitt Partners and Cicero Group sent email invitations and invitation reminders to all participants on the list. Repeated follow-up calls were also made to those who did not respond by email. Overall response rates were approximately 50 percent. Researchers conducted over 45 in-depth interviews (with an additional 18 interviews conducted with brokers and small business owners in smaller group settings).

Interviews were conducted with the following stakeholders:
- Consumer advocates
- Business organizations an advocates
- State legislators
- Health policy analysts
- Community health organizations
- Health insurance carriers
- Health providers (e.g. physicians and nurses)
- Health insurance brokers
- Human resource directors

While the data from these reports is qualitative in nature, the themes were very consistent. Accordingly, it is believedthat the data gathered from this stage of the research will become the building blocks for future Mississippi exchange research.

Community Health Leader 1
3.29.2011 4:30 pm CST

Interview Summary

- Education and enrollment will need to be face-to-face to cater to rural areas in the state. The technological solutions, which prior states have adopted, would not be as effective in Mississippi because 35 percent of the Delta region is below a Level 1 literacy standing.

- The exchange will need to be simplified and offer four to five health plans at most. The exchange should require a competitive bidding and procurement process to allow a plan entry to the exchange, similar to that of the Massachusetts Connector.

- Show businesses why health care is important. One approach would be to present an employer with the health exchange's value proposition; the focus would on the lost economic revenue when an employee becomes sick, and lacks sufficient health care.

- The exchange should leverage the Mississippi Insurance Department and local organizations. The idea is to use the existing infrastructure to mitigate resource allocation. Using community health organizations as an existing infrastructure should be avoided, as they have the potential of bias toward whichever insurance company is paying them the most money.

- There will need to be strong educational outreach to the public and government about why the exchange is important. The educational outreach will include general information as well as details about available health plans and how to select and purchase said plans.

- Conducting pilot programs will be very valuable in helping to determine the appropriate approach to increasing participation (small cost, small risk). All programs need to have sufficient time to run to evaluate accurately their effectiveness.

- According to the respondent, the biggest problems with TennCare was that there were too many plan options, biased education process, and the fact that it was forced upon the legislature and public rather than allowing them to buy into it.

Key Verbatim Comments

- *"The problem with the Medicaid population is just like the working uninsured – they don't understand the differences between health plans – they don't know what to pick."*
- *"TennCare started out with ten different plans and it was a nightmare. I mean if you try to do more than four or five, you're nuts."*
- *"You need a few solid health plans, and that's it."*

Notes

What would be the best methods for getting small businesses enrolled in the health exchange?
The most effective action would be to show small business owners that providing health care coverage to employees would ultimately be cost effective. The exchange has the potential to save them money in the end because their employees will seek preventive health care, resulting in fewer sick days, which will grow long-term productivity and reduce the amount of money spent toward substitute workers (i.e. temporary workers).

A pilot project, like a convenience store, could be used to show small business owners that providing health care to their employees will save them money over time. The pilot project will also show that by

providing health care to their employees, small businesses can attract applicants with more valuable skill-sets and have fewer turnovers, which will ultimately lead to increased productivity. Actual evidence, like a pilot program, is the most effective way to illustrate these points to small business owners.

How important is face-to-face communication in the health exchange, versus a website?
Some targeted areas will have low-literacy rates and high unemployment rates; these individuals will not be reachable via web portal. Therefore, face-to-face communication will be a necessity for these regions.

What is the most cost effective way to provide face-to-face communication within the health exchange?
Utilize organizations that are already present in the community, such as the Department of Health, chambers of commerce, and agricultural extension agencies. Since these organizations are already available, they represent the most efficient use of resources to inform people of the exchange. Although additional funding will be required, building on an existing structure would be a more effective use of resources, rather than creating a new infrastructure. Community health organizations bill insurance companies directly and may have too much conflict of interest to inform objectively people of the exchange. Despite already having the incentive to enroll individuals in a new health care program, their conflict of interest would make the incidence of fraud too likely.

Why are many small businesses not currently offering health insurance to their employees?
They see no economic advantage in providing health coverage to their employees – either because it is not worth the cost or because they have not been shown a cost benefit analysis that illustrates how it can be more profitable.

What would be some potential obstacles if the health exchange were to cooperate with Medicaid?
The issue with enrolling people in Medicaid is the same as enrolling the working uninsured. They understand little about health insurance and are very difficult to educate. The system of educating the public is the most important factor in dealing with this issue.

How do we educate people about the health exchange program without bias?
Insurance companies should not be allowed to advertise because the company with the most advertising will get the most enrollments. The education process needs to show accurately the advantages and disadvantages of all the programs.

How many plans should be offered by the health exchange program and how should they be chosen?
The program should only offer four to five plans. There is only so much information people can ingest, regardless of their education level. The insurance companies should be informed that they should draft plans and send them to the exchange program to be reviewed and chosen. An unbiased committee needs to objectively evaluate and choose the best four or five plans.

What were the mistakes and successes of the TennCareprogram?
Though there was sufficient evidence and data to prove how successful the TennCare program would be, there was not enough of an effort to illustrate this evidence to the population – so the state felt they were being forced into it. In addition, there were too many plans being offered, which was very confusing to the uninsured population. Furthermore, the insurance providers were allowed to advertise for the plans that were chosen, which corrupted the program. In addition, the TennCare program was changing too frequently. Each new state administration altered the program before it could produce any long-term benefits.

Mississippi Health Policy Analyst 1
3.29.2011 9:00 am CST

Interview Summary

- Income churning is going to be a large problem in the State of Mississippi. The group that falls in the 133 – 200 percent FPL income bracket does not view themselves as poor. We may need to call the program something else so these people will not view this as a government subsidy.

- Because of income churning, we need to make sure the plans featured in the health exchange are also available in Medicaid. Having this in place will mitigate transitory complications, making the exchange simpler.

- The health exchange can encourage competition among plans and providers through limiting the amount of health plan "slots," similar to the Massachusetts Connector. This will enable a strong, objective procurement process to ensure that only the best plans are available in the health exchange.

- The major issues for the health exchange, as discussed, were:
  - Administrative burden
  - Education of participants
  - Data collection (how do we measure change over time?)

- There will likely be pent-up demand for the first year the exchange goes online. The exchange needs to plan on this because demand will moderate over time.

Key Verbatim Comments

- *"I envision the exchange doing work in improving the current market of health plans – we haven't had a lot of diversity in our markets."*
- *"By opening the market up to so many more people being covered, it could encourage more competition among the plans."*
- *"I would like to see the state think about it strategically – how can we improve the market place, not just for the exchange but for the entire population."*
- *"You can encourage competition, but at the same time simplify it to the employee by moving the competition up to the exchange level."*
- *"The state should leverage the exchange program to make larger improvements in the overall insurance market."*

Notes

What do you believe are the greatest challenges to implementing a health exchange in Mississippi?
The major obstacle is caused by a change in an individual's income (i.e. churning). Keeping track of the individuals as they transfer coverage from CHIP or Medicaid to the exchange will be the real challenge. Most people are used to being covered by a general BlueCross BlueShield plan, and if they are required to transfer to a more individualized plan, they are not going to be educated about the specifics of their new plan.

Educating people who have never been insured on these types of specifics will be even more difficult. Providing plans that are common to CHIP, Medicaid, and the health exchange would help provide transparency for new consumers.

The exchange should work toward providing an increase in diversity or selection of Preferred Provider Organizations in the insurance market. Competition within the market will only cause improvement. The state should use the health exchange to make larger improvements in the overall insurance market.

Additionally, when I look at the quality rankings that were stipulated in the PPACA – Mississippi has not done any of that. We are going from having no system in place to having to create one – and we are unsure on how to rank the quality.

I would like to see common health plans among participants in Medicaid, CHIP, and the individual exchange, which would cater to those who were on the cusp of receiving subsidies. I believe this would mitigate the churning effect that we are likely to see.

What will be the potential challenges for getting small businesses involved in the health exchange?
Well, the majority of businesses in Mississippi are small (less than 50 employees). The last time we looked, roughly 38 percent offered health insurance to their employees. Previous research has looked at why employers opt to forego health benefits to their employees – the main deterrent was cost. When asked, how much you would be willing to pay, the answer was $50-75 per employee.

What these businesses and individuals consider a reasonable cost of insurance coverage would necessitate subsidies. These companies are interested in providing coverage to their employees; however, they are not willing to pay the standard price of conventional coverage. With its subsidies, the health exchange should be able to satisfy the needs of potential enrollees.

Generally, what are the most effective methods for gaining participation in the health exchange?
Medicaid has seen major success in working through a coalition of community-based organizations, as well as compensating people for each individual application. They paid schools to enroll children and worked with the insurance providers who already had an interest in gaining new applicants for their coverage.

Generally, what additional obstacles do you foresee with the health exchange?
A large portion of the uninsured are young and healthy, but there will be a substantial amount of people who will enroll in the program and immediately file Medicaid claims, which is what happened with CHIP. After the initial year, in reference to CHIP, the funding and volume of claims balanced out.

Why is a personable approach recommended as a way of gaining participation in the health exchange, rather than a more generalized, technological approach – like a website?
A website would be effective for gaining the participation of small businesses and younger individuals. The rest of the uninsured population in Mississippi will require a more personalized approach because they are not as familiar with technology.

What are some facilities you would like to see created alongside the health exchange?
Some type of data collection system needs to be created, not only to measure the success of the exchange program but also to measure the overall quality of medical care in Mississippi. This would allow for quality measurements of health plans and inform us as to whether the health care coverage is being used.

Why has Mississippi seen less success than Louisiana in facilitating enrollment in Medicaid, considering their incentive programs are very similar?
Louisiana and Mississippi have differing attitudes toward enrollment and eligibility. Mississippi does not spend resources on seeking people's enrollment. They wait until someone has a need for medical care, then check to see if that person qualifies for Medicaid.

Louisiana has a goal of enrolling every eligible person in Medicaid, whether or not they seek health care. If health care reform continues in its current direction, Mississippi will most likely change its approach and be more proactive in facilitating Medicaid enrollment – as well as helping individuals find other forms of health care coverage.

Who will play the role of educating people and directing individuals toward the health exchange?
Brokers and agents will be essential in educating these individuals. Because Mississippi has no system designed to determine quality ratings, implementing a program for that function – as well as providing that information to consumers, will be a major challenge. Community-based organizations should be used to educate individuals who are not in contact with agents or brokers – whereas the agents and brokers will focus on educating small businesses.

Local planning and development districts could be utilized to inform the elderly; however, the local planning and development districts would need additional resources to accomplish this task. Community Health Centers may be the most appropriate type of organization to educate individuals about the health exchanges because they are already interested in insuring people.

Is the business community of Mississippi capable of successfully advocating for the health exchange?
The business community has enough political influence to be successful in advocating a program, but they are not unified. The large and small businesses have different attitudes, and the small businesses may not know enough about the health exchange to know that they should advocate for it. The small businesses may be uninformed or misinformed by political leaders to believe that the health exchange is associated with President Obama and therefore should not be given support.

What role would brokers and agents play in the health exchange?
Their role would remain the same, whereas their incentive rate would potentially have to change from a percentage of the premium to a per individual basis – their compensation would have to be adjusted in some way.

What would be the advantages and disadvantages of a system where employers agree to pay a percentage of their employees' health care coverage and allow the employees to choose their own plan?
In regard to budgeting, that would be a very attractive approach for employers; however, it would most likely put more pressure on the employee. The employees may choose plans with higher deductibles, so that they are able to have a plan with premiums they can afford. It is a matter of who will assume the risk potential increases in the cost of the insurance.

Community Health Leader 2
3.30.2011 9:00 am CST

Interview Summary

- The cost and effort to educate the public about the health exchange and the various options available are going to be significant.

- To communicate effectively with the public – traditional media, local residents, employer groups, churches, and neighborhood organizations must be utilized.

- The employer's role is imperative in helping to facilitate proper health education to its employees. They will assist not only in educating, but also in guiding them into a proper health plan. However, this option may prove to be too difficult for employers and employees. If this becomes the case, navigators will step in to help alleviate burdens and complexities.

- Federally Qualified Health Centers (FQHC) will play an important role in supplying navigators. In many regards, the FQHC already has the infrastructure, experience, and knowledge on how to deal with individuals in need of health care.

- Compensation to Community Health Center (CHC) navigators should be equivalent to that of brokers. If there is a deviation in the pay structure, brokers may take a more active role. It is important to keep in mind that if a commission package is not effectively engineered, brokers may guide individuals to the plan that offers the greatest commission.

Key Verbatim Comments

- *"The changes (in reference to CHC) mean that the Medicaid Program and the health exchange are really going to have to work together to sort out these (funding) issues."*
- *"We should try to send the message that any (federal budget) cuts would result in care being denied to people in Mississippi through the CHC."*
- *"We need local people who know one another to assume the task of educating the public. This will be much more effective."*
- *"Online communication is important and should be a part of the overall approach, but local people are still needed because a strong online campaign is not going to be realistic for rural areas. Therefore, any online efforts should be coupled with print ads and other forms of written communication."*
- *"Mississippi has a tremendous opportunity with PPACA to get coverage to the population who need it most."*

Notes

What is the biggest challenge to implementing the exchange Mississippi?
A major priority is to develop the Health Information Technology (HIT). Additionally, developing the Medicaid Connection and educating the public are top priorities.

In order to educate the public, I would add that we need aggressive public outreach and enrollment campaigns. Everything needs to be at the level of the public in order to be effective.

Getting plans qualified in the exchange is going to be another challenge. In doing so, we need to set rates that ensure the rural areas are not shortchanged due to the small groups that exist in outlying areas. We have to be sure not to price the market so that participants in rural areas cannot come in and compete.

At the same time, Mississippi needs laws to protect CHCs and safety net providers, so they can contract with plans. All CHCs should pay no more than Medicaid qualified rates. Therefore, we want to contract with plans so they can continue serving the population. We also need to make sure that this structure is carried forward in any statutes and regulations.

How should Mississippi approach education campaign?
We need local people who know one another to assume that task of educating the public. This will be much more effective. This means that local people can work through the churches, neighborhoods, libraries, CHCs, and employer groups to inform the public. These people could also use electronic and video capabilities to reach out to the public. Online communication is important and should be a part of the overall approach but local people are still needed, because a strong online campaign is not going to be realistic for rural areas. Therefore, any online efforts should be coupled with print ads and other forms of written communication.

How should the CHIPRA information be communicated?
We need people on the ground, who are actively enrolling individuals in the CHC. These individuals should actively go out into the community to recruit participants. These recruiters need to be full-time employees that are staffed and supported by the CHCs. These recruiters need to be certified and knowledgeable about programs. This assumes that these people are also adequately trained and certified.

One drawback today is that this type of enrollment is done on paper. Electronic enrollment is coming but there is still a ways to go. We do have some numbers about the effectiveness of these modes of enrollment by full-time staff but again, we still have a ways to go.

How does the CHC utilize the Department of Health?
We see the Department of Health as having a critical role. It is natural that they have a role in the process. The CHC and Department of Health should work together to serve people.

What are your thoughts about participation of small business in the health exchange?
Nationally 80-85 percent of the uninsured are employed by small businesses. We believe it is better for the employee go through the employer-offered plan. As long as the plans in the exchange are required to contract with CHC and safety net providers, there will be good integration of small business into the exchange.

Do you believe the exchange should put the choice of the plan on the individual? Can individuals make those choices?
Some individuals are capable of making those choices. Nevertheless, we believe that it would be better for employers to work with employees to make those decisions. Employers can have a great role to play. We should not just open up the decision-making process totally to individuals. The more we include employers in the process, the better.

Health Consumer Advocate 1 and 2
3.28.2011 11:00 am CST

Interview Summary

- The health exchange needs broad stakeholder involvement. The State of Mississippi has failed to involve enough groups in the implementation process to have a significant impact.
- The allocation of representation on the exchange governing board should be advocacy groups and provider groups. Moreover, membership should be reserved for those skilled in actuarial science, health care economics, etc.
- Proper oversight is a major concern. If the state pursues a not-for-profit entity, for managing the exchange, there must be legislative oversight.
- Currently, the majority of the uninsured in Mississippi are working. So allocating resources toward small business enrollment is a great way to reduce the uninsured rate.
- Medicaid enrollment is abysmal in Mississippi. Despite having one of the highest payouts for doing so, there is a limited incentive to enroll in the current Medicaid program – third-party groups may be the solution for solving this problem.

Key Verbatim Comments

- *"It seems there's an effort to implement an exchange with absolutely no oversight, per the conferees."*
- *"The problem with previous small group exchange designs was that it allowed for too much cherry picking by insurance carriers."*
- *"The current number of members on the health exchange's Board of Directors (16) is too large."*
- *"The Mississippi Health Benefit Exchange Committee is largely defunct now."*

Notes

What should the structure and governance of the health exchange be?
I would like to see a state agency or quasi-state agency with legislative oversight. If the health exchange strays away from a not-for-profit entity, there must be protections in place to prevent any conflicts of interest. In addition, there needs to be real stakeholder involvement in the design, implementation, and governance of the exchange.

The current number of members on the health exchange's Board of Directors (16) is too large. The allocation of representation should be that of insurance (carriers and brokers), advocacy groups, and provider groups. Additionally, with respect to experience, some membership should be reserved for those skilled in actuarial science, health care economics, etc.

Why did small group health exchanges fail in the past?
The problem with previous small group exchange designs was that it allowed for too much "cherry picking" by insurance carriers. Although the small group insurance was based on guarantee issue, insurers were permitted to increase premiums to the point that only high-risk groups stayed in an exchange.

Do you believe there will be legislative involvement in the Mississippi health exchange once created?
Many are wary of the idea. The stakes are too high and several legislators are concerned about potential missteps becoming their legacy.

Can you tell us about the Mississippi Health Benefit Exchange Study Committee?
The study committee has only met once or twice, and was not compliant with open and public meeting laws. The committee is largely defunct now, which implies little to no progress from the group in the future. I believe stakeholders should be much more broad and involved in the implementation process.

Health Consumer Advocate 3
3.28.2011 9:00 am CST

Interview Summary

- The most important aspect in determining an exchange's success is ensuring that it is physically and intellectually accessible. That includes the promise that all information about the exchange is coming from a trusted source.

- Mississippi ran a Medicaid enrollment and screening campaign wherein 44 full-time employees (making approximately $17k + benefits = $25k) signed up 23,121 persons. This was viewed as an effective program.

- The role of a navigator, within an exchange, needs to be clarified. The State of Mississippi could leverage federally qualified health centers, community health centers, and county health departments to serve the role of the navigator. Doing so would help solve the state's problem of reaching rural areas.

- An additional approach to signing up participants would be to send a mobile eligibility vehicle to rural areas. The vehicle would assist in public outreach and enrollment.

- Although a website will be necessary, perhaps the key portal to the exchange, it cannot be the basis for enrollment. The implementation of a 1-800 number will help ease any complexity in the process but the state must have facilities that cater to those who desire "face-to-face" enrollment.

Key Verbatim Comments

- *"We have people without cars, without telephones, and certainly without computers. We need a delivery system for this portion of the population."*
- *"The state needs a streamlined system, one that utilizes a digital framework to mitigate any barriers or inconveniences."*

Notes

Do you have any preferences regarding the exchange?
I am in support of a bill that has the most openness (i.e. accountability). Openness is achieved through transparent policies, such as open meetings and open records. A system designed in this manner enables records to be viewed by the public, thus creating a system of checks and accountability.

I also believe the exchange should have legislative oversight. The difference between the House and Senate bill is that the Senate proposed a not-for-profit organization to administer the exchange, while the House has structured the exchange in a way to be more governmentally orchestrated. However, the House bill has better language on the screener and enrollment aspect. I believe this has great importance for the operational success of the exchange.

Why is the language on the screener and enrollment such an important aspect?
I strongly oppose the state's previous requirement, "face-to-face" enrollment for Medicaid. The locations were too hard to find and were not convenient for those wanting to enroll in Medicaid or to renew coverage. I would hate to see Mississippi take a step backward after the progress it has made in abolishing the "face-to-face" mandate. The state needs a streamlined system, one that utilizes a digital framework to mitigate any barriers or inconveniences.

Since the Medicaid provisions do not kick in until 2014, how important is it to you that the House bill language is passed this year?
Health care should be passed right the first time and doing it in a manner that benefits the residents of Mississippi – I always say, measure twice and cut once. Health and Human Services has to approve the bill's language by 2013. Passing the legislation this year would give the State of Mississippi enough time to make any provisions and amendments deemed necessary by the 2014 deadline.

What should the role of a navigator be?
As depicted in the Patient Protection and Affordable Care Act, the role of a navigator is still unclear. I am concerned with who these navigators are going to be, what their role will be, and how involved they will be in the process. I strongly oppose the idea of an insurance agent serving as a navigator. An insurance agent is in business to make money because their companies are in business to make a profit. This creates a conflict of interest because insurance agents do not necessarily have the interests of the consumer in mind as they conduct business.

I would like to see a full-time navigator being placed at each community health center and county health department (5-6 times per week). This would help increase participation rates in the rural areas of the state (e.g. Delta region etc), where enrollees currently have limited access to the Internet.

What do you see as the primary barrier for the uninsured, who qualify for Medicaid, in becoming enrolled?
The reason individuals opt out of participating is that they do not think about health care until they are sick. There needs to be a significant outreach program to inform this segment of the population. Recent advertising campaigns via radio, TV, and print have proven to be very successful mediums of outreach.

How do we reach the rural population?
The two mediums for communication with enrollees in rural areas, as stated in both the House and Senate bill, are a 1-800 number and Web portal. The state will need to do more in order to reach the rural regions of Mississippi. I support the idea of a van that travels to rural communities to inform individuals (e.g. subsidy eligibility, health exchanges, types of health cover, etc) and enrolls potential customers.

State of Mississippi Medicaid Representatives 1-4
3.31.2011 9:00 am CST

Interview Summary

- It is important that the Mississippi Division of Medicaid (MDM) retain its responsibility for making Medicaid decisions. Currently, MDM is working on an MIS [operating] system, which may include a new eligibility system.

- The Division of Medicaid has no interest in administering or regulating the health exchange. The division has sufficient demands for which it is currently focused. In preference, support has been given to the Mississippi Insurance Department (MID) for administering the exchange.

- MDM will need to work closely with MID in developing the exchange, because Medicaid will play a substantial role in the exchange. The process of sharing information between the two systems will be critical.

- Due to the stipulations and mandates contained within the Patient Protection and Affordable Care Act, Medicaid recipients will grow significantly. Currently, approximately 25 percent of Mississippians are enrolled in Medicaid, roughly 633,000 recipients. By 2014, it is projected that 36 percent of the population will be enrolled/qualify for Medicaid.

- There will need to be an effective outreach program to ensure the success of the health exchange. Qualified enrollees can utilize one of the 30 different Medicaid offices, with locations at approximately 100 sites. There, a caseworker can assist individuals with paperwork to become enrolled. Additionally, since Mississippi is a media-driven state, public outreach will be best accomplished through mass media efforts.

Key Verbatim Comments

- *"The exchange will need to set-up offices regionally; it is not just about having access to a computer, they need to know how to access it."*
- *"The largest challenge will be getting people to join, specifically having the uninsured comply with the new requirement."*
- *"Come 2014, participation will grow to 36 percent [referring to Medicaid]."*
- *"We have to develop a phased approach where we build on to and add new departments in a systematic manner."*

Notes

If the four of you were to design the health exchange, what would be the objectives and what would it look like?
We would direct all Medicaid questions and decisions to the Mississippi Department of Medicaid. There will be various splits in households, where some members are on Medicaid and CHIP, while others are on the exchange. With this being the case, specific things need to be put in place.

We cannot wait for other agencies to determine what their goals are. We have to develop a phased approach where we build on to and add new departments in a systematic manner. All we do is Medicaid; WIC and CHIP are in Health and Human Services, so our focus will be in streamlining the Medicaid process.

We will allow the application processes to be electronic and seamless. A common application will be designed for Medicaid, the health exchange, and CHIP, which will allow us to easily share information.

How would you approach the public outreach campaign?
We have 30 different Medicaid offices, at roughly 100 different locations. We would place personnel at each of these locations to help facilitate the enrollment into Medicaid. Therefore, we will go where the people get their services – hospitals, doctors' offices, clinics, etc. A person can go to any one of those locations; they know where the Medicaid offices are and a caseworker is there to help them enroll. We still have some paper applications; however, through a caseworker they will enroll electronically

The state is very media-driven. I would capitalize by advertising through TV, radio, and print.

What are the Medicaid demographics in Mississippi?
Twenty-five percent of Mississippi is on Medicaid. Come 2014, participation will grow to 36 percent. Medicaid will easily be the largest component of the health exchange.

There are currently 633,000 Medicaid recipients. In Mississippi, there are 119,000 uninsured individuals, of which 51,000 are children.

What do you foresee to be the largest challenges in creating the health exchange?
The largest challenge will be getting people to join, specifically having the uninsured comply with the new requirement. Enrollment poses a complication; the exchange will not be able to establish a website and expect it to be finished.

The exchange will need to set-up offices regionally; it is not just about having access to a computer, they [residents] need to know how to access it. The federal requirement is that you have to interface the exchange with Medicaid. It is why Health and Human Services is throwing so much money to states to develop the ideal exchange

Should the state allocate resources toward the exchange to help increase participation (e.g. coordinating with Medicaid to facilitate enrollment of now ineligible Medicaid recipients)?
Yes.

What will the role, if any, be of insurance brokers in the health exchange?
The good ones [brokers] certainly know Medicaid, and they use Medicaid just like their own product. Therefore, we certainly rely on them, but they do not get a commission for Medicaid. There are some good brokers out there.

State of Mississippi Insurance Expert Representative 1
4.14.2011 9:00 am CST

Interview Summary

- The key barriers to a successful Mississippi exchange include:
  - Many residents are already equating the health exchange with "ObamaCare." The state must disassociate the exchange from the federal health reform.
  - There is a general lack of understanding in regards to what an exchange actually is and does. A critical component of the implementation process will be educating small businesses and individuals about the exchange.
  - High-riskmust be mitigated; the best way to alleviate this issue will be to sign-up healthy individuals in the exchange.
  - It will be challenging to sell the exchange to small businesses. Focus on the exchange's ability to help small businesses attract and retain quality employees.

- The best channels for the exchange's outreach campaign among socioeconomic groups and rural regions will be through churches.

- The exchange should consider the regulatory model of the state risk pool, where the pool has a governing board and is regulated by the Mississippi Insurance Department. Additionally, the state should look to the risk pool's funding solution as one of the many possible models for funding the exchange. The state risk pool is funded by assessments charged to insurance carriers.

- Putting state employees in the exchange would benefit both the exchange and the state health plan. However, this approach may be too politically challenging.

- Different regions in Mississippi have different cultures, which may require different approaches for outreach:
  - Delta region – tradition, rural, and farming communities. The information flows through a limited number of highly connected people.
  - Gulf coast – more transient, new population, casinos, and more technologically connected.
  - Northern Mississippi – timber industry and one of the more rural areas of the state (except for the Southaven area).

- The business community has the potential to influence the legislature and push for the exchange, but they must be more of a unified voice than a spectator.

Key Verbatim Comments

- *"There is the issue of selling the exchange, which has become synonymous with "ObamaCare."*
- *"Most importantly [referring to the success of the exchange], it is providing the right product and experience to employers that will entice them to participate in the exchange."*
- *"You should consider reaching out through churches. Doing so would allow you to reach a large group of individuals throughout the state."*
- *"There are a lot of cultural differences among the states diverse ethnicities. Each group has separate needs and wants, which will need to be catered to."*

Notes

From your perspective, what are the largest barriers to the success of the health exchange?
There are many barriers. First, there is the politics of the exchange. Second, there is the issue of selling the exchange, which has become synonymous with "ObamaCare." Third, it is registering those individuals who are above the federal poverty level and healthy.

If you are asking for answers on how to solve these issues, at this point I do not have any. For the exchange to be successful, you need to have adequate risk to avoid another high-risk pool and thus out of control premiums.

On the small business side, the largest barrier is providing a sufficient amount of education to the employer. Most importantly, it is providing the right product and experience to employers that will entice them to participate in the exchange.

What has the state done, when implementing new programs, to address the cultural differences that reside in the state?
I do not know if there has really been any substantial effort in the past that I am aware of. Keep in mind that I am new to this; I have only been doing this for four years. With that being, I cannot recall any state program reaching out to this issue.

Generally, are there any programs that you think the state has failed at?
I do not think so. Generally, the state has not been that involved in the health insurance debate, other than implementing some federal programs, (e.g. Medicaid). There might have been some tax incentive programs, but nothing that I am aware of, granted my historical perspective is limited.

When you think about the networks in Mississippi, (e.g. chambers, economic development associations, etc), we are concerned we might be focusing on a particular type of small business owner. How do we attract business owners that are not members of those associations?
It is important that the state not be involved in this process, that it be a non-profit. You should consider reaching out through churches. Doing so would allow you to reach a large group of individuals throughout the state.

If you approach these churches as a non-profit, will they be more keen to listen?
It depends on the individual church; they would have to make the decisions on that. I do not know how the logistics of it would work; all I know is that it would be a prime medium for channeling information to individuals who are not members of state business associations.

How is the high-risk pool regulated?
The high-risk pool is a not-for-profit entity that is run by a governing board. The legislature has put the Mississippi Insurance Department (MID) in charge of regulating the program. The relationship between the high-risk pool and MID has been very "laissez faire."

MID focuses its attention on making sure the program has filed their documents in compliance with state law, which is about it. Although MID has the authority to strongly regulate, historically MID has allowed the governing board to run the program, which has turned out great.

How is the state risk pool funded?
The risk pool charges an assessment (premium tax) to insurers in the state. It is also funded through the premiums that are charged.

Is the risk pool a sustainable model for the health exchange itself?
Possibly, it is a model that should be looked at. It is a situation where further legislation might be needed.

An idea that has been talked about is setting up an exchange that is assessable to all state employees, is this a viable option?
This is such a political issues that it would generate legislation action. However, this would be great for the exchange and for the state health plan.

Do the challenges differ among socioeconomic groups?
There are a lot of cultural differences among the states diverse ethnicities. Each group has separate needs and wants, which will need to be catered to. However, I cannot speak specifically on each need and want.

When you get into the more rural areas of the state, do you find that the towns and cities have the same networking abilities as the urban areas?
Some town and cities have the same networking abilities. However, there are some cities and towns where the business community is greatly segregated.

Are there other areas in Mississippi that you would want us to focus on?
The Delta region, the gulf cost, and northern Mississippi.

Do you think the business community can come together and help push the legislature to creating a health exchange bill?
Yes. I think their presence can be a great help. If they come together and voice their concerns, needs, and wants rather than playing the role of a spectator, I believe they can make a difference.

Do you believe there are specific mediums or channels that work best for separate ethnicities?
Yes. I believe there are some socioeconomic groups that will respond best when the message or information is presented through their church. There are a lot of individuals in the state who respect their church and the ideas and information that flows through it. If the exchange can convince the heads of the different churches that the exchange is a great idea, then there is a change you could reach a large group of people.

State of Mississippi Insurance Expert Representative 2
3.29.2011 11:00 am CST

Interview Summary

- Education is going to be a large problem. There will need to be an educator to explain the various health plan coverage and options to individuals, perhaps agents or maybe someone else. However, if individuals are choosing the plans, education on insurance will be a high priority.

- The risk pool program does not aggressively seek out individuals in Mississippi. Many individuals will disregard the pool until they need it.

- Current penalties, concerning health laws, are not strong enough to persuade individuals to participate.

Key Verbatim Comments

- *"The only reason you're not getting an uptake is lack of affordability and lack of desire to access insurance."*
- *"Because of this misunderstanding of what health insurance costs, many folks believe that any premium is unreasonably high."*
- *"Health care reform hinges on the academic concept of people acting responsibly...the problem is people do not act in that manner, some game the system."*
- *"Sometimes, marketing efforts don't have an impact if a person doesn't have a need ...you just can't make people do what's right."*
- *"There's got to be some aspect of the exchange where people can get help figuring out what's best for them, risk pools can help in the effort."*

Notes

What are the largest challenges for health insurance programs in Mississippi?
I have no preconceived notions as to what the State of Mississippi is doing regarding the health exchange.

That said, there is no issue with availability of health insurance in Mississippi. Anybody who wants health insurance, and can afford insurance, can receive coverage – which is the case nationally. The central issue is affordability. There is a demographic of people who want health insurance but cannot afford it.

There are also people who can afford health insurance but choose not to seek coverage. Usually these people lack a desire for health insurance coverage because they have not yet encountered a need for it.

What concerns do you think Mississippians have with the current risk pool?
The main challenge is affordability for people who desire coverage. Another obstacle is the inability to file an immediate claim for those who seek coverage directly after receiving a diagnosis.

How can the benefits of the health exchange be conveyed to small businesses?
I deal primarily with individuals, so I am not the best to answer on behalf of small groups. I know anecdotally that small groups have trouble with the affordability of health care. More small groups will dissipate as their employees continue to find coverage elsewhere.

A major issue is that people do not understand their health insurance as comprehensively as they understand other types of insurance (e.g. car, home, etc). There is a physiological disconnect, people seem to gladly pay for other types of insurance without receiving anything in return. Whereas they seem

to expect something in return when paying for their health insurance.

One reason for this view is that many people have had their health insurance costs fully covered by their employer, so they know little about the quantity/quality of plans and the associated costs. When people are no longer covered by their employer and seek to pay for their own coverage, they often view any premium to be unaffordable – they are unacquainted with the details of the plans, and often overlook their actual benefits.

Will churn be a problem for the health exchange?
The obstacles are similar to those within the conventional insurance industry. Individuals frequently use a risk pool as a bridge between coverage by other providers. This is common when people face early retirement and transitions between jobs or education programs. Though this type of lapse in a risk pool has different practical causes than the conventional insurance industry, it is not a major problem.

Another type of lapse, which the risk pool has in common with traditional providers, is caused by people who acquire insurance and then neglect to pay the premiums. The major obstacle in a communal health care program is the notion that people will act responsibly in the interest of a shared benefit. Some individuals will take advantage in any way they can to benefit themselves in the moment.

What are some current methods of informing people about your program?
When a provider denies an individual coverage, they are required by regulations to send that individual a letter informing them about social programs, such as ours. Support groups also help to educate people about the programs. Pamphlets about the programs are sent to clinics and doctors' offices to be displayed in their waiting areas. These methods are solely aimed to inform those who are seeking coverage but have been unable to acquire it. Marketing efforts do not seem effective if aimed at people who do not desire coverage.

What would be some ways to avoid risks in mitigating the health exchange?
Penalizing people for not participating does not work. Regulating participation requires doctors' offices to automate their records, which often times is more costly to the doctors than paying the fines for not participating. Communal programs that work in other countries will not work in the United States because the people in the U.S. are different.

What are some effective methods for educating people about these types of programs?
Information can be provided both online and in print. There needs to be a part of the exchange program that is devoted to helping people understand the coverage. Agents or brokers could do this.

Agents can have an incentive for informing clients about these programs. If a conventional provider denies one member of a family coverage, and the rest of the family is offered that conventional coverage, the agent can enroll the rest of the family under the conventional provider and the one denied member in the exchange program. Agents can also be given a small, one-time finder's fee for a referral.

Insurance Carrier Representative 1 and 2

3.28.2011 10:00 am CST

Interview Summary

- A simplistic design that leverages an easy-to-use platform would be the optimal design for the health exchange. One suggestion has been to allow individuals to apply custom benefits to a base plan.
- Our organization supports the health exchange primarily for the reason that it increases the company's market share.
- Our organization favors the idea that if a health plan meets the minimum standard, as dictated by the exchange, then it should be allowed in the exchange.
- The make-up of the health exchange's Board of Directors should be comprised of employers, providers, and individuals.
- Insurance brokers will play a key role in the exchange. Their current relationship with small groups will be a key asset in helping to facilitate their enrollment.

Key Verbatim Comments

- *"The health exchange should leverage the concept of simplicity, providing easy to understand information with the option to customize a health plan via option benefits."*
- *"The exchange will allow us to access a greater portion of the insurance market share, which is currently controlled by another health insurance company."*
- *"The underlying goal of the exchange must be to advance consumer choice and innovation."*
- *"I believe their (brokers) compensation should be that of a consistent, flat rate. This would prevent possible tendencies to enroll participants in higher priced plans."*

Notes

What should be the key features of a health exchange?
The health exchange should leverage the concept of simplicity, providing easy to understand information with the option to customize a health plan via option benefits.

Who is the target audience of the health exchange?
One aspect to keep in mind when designing the health exchange is that many of the enrollees will be first time health insurance participants. The large majority will have limited access to a computer and or the Internet.

Does your organization support the health exchange?
We strongly support the exchange. The exchange will allow us to access a greater portion of the insurance market share, which is currently controlled by another organization. Furthermore, the exchange will be a valuable mechanism toward providing access to less expensive health care through competition and choice.

The underlying goal of the exchange must be to advance consumer choice and innovation. They should build on the foundation of current small business and individual plans, not forcing current participants to replace their plans with a new one.

What health plans should the health exchange adopt?

Any carrier who produces a health plan that meets the minimum exchange qualifications should be allowed to participate. Such a stipulation would drive consumer choice and thus efficiencies.

Who should have oversight of the health exchange?
The governance of the health exchange should be through a transparent, non-politicized board, made-up of the following segments: employers, providers, and individuals.

The exchange will need to avoid duplication of the regulatory body. The Department of Insurance is already equipped to handle the responsibility, and should be the regulatory body of the exchange. Furthermore, any rules and or provisions must be applied consistently, fairly, and predictably.

How important are brokers to the success of the health exchange?
Brokers will be a critical component in the success of the exchange. Brokers have embedded themselves into the community – they have strong relationships with small businesses.

I believe their compensation should be that of a consistent, flat rate. This would prevent possible tendencies to enroll participants in higher priced plans.

What is your opinion toward defined contribution plans?
The exchange should allow employers to have the option to enroll its employees in one. However, employees should only be able to choose from plans within the same metallic band (referencing the different tiers of health plans stipulated in the PPACA) selected by the employer.

If you were building the health exchange, what components would you include?
I would emphasize value within the exchange; accentuating the notion that the exchange is a mechanism toward providing access to inexpensive health care through competition and choice. I would develop its structure around the idea of advancing consumer choice and innovation.

What should the online experience be for the health exchange?
The website should encourage flexibility in plan designs rather than being overly prescriptive. There ought to be an open forum for side-by-side comparison, which will stimulate competition among plans.

Should the small business and individual exchange merge?
The two exchanges should remain separate; individuals are more expensive than small groups. Merging the two exchanges would drive premiums prices higher for the small group segment, which would cause them to participate outside of the exchange.

What are your recommendations for launching the small business exchange?
The health exchange should collaborate with qualified health plans. A recent study by the Kaiser Foundation revealed that 50 percent of enrollees will have never had health insurance before. Furthermore, 75 percent are going to have, at most, a high school education. This information is increasingly looking like a Medicaid population, which will drive how we do our outreach.

The exchange must pay attention to this data, understanding its target audience will be crucial for obtaining high participation rates. I believe the exchange should focus more on competition, rather than the types of benefits that will be offered.

Moreover, employee satisfaction will be critical, customer service and quality will be enormously important when dealing with this segment of the population. The health exchange must keep this in mind when launching its small business exchange.

What words should be avoided, and which should be leveraged when marketing the health exchange? First, do not call the exchange "ObamaCare." The exchange needs tobe branded as the Mississippi health exchange. Second, the state should focus how the exchange will benefit its residents; emphasizing the fact, that it offers easy side-by-side comparison and valuable search tools.

The key idea is to brand the exchange as "Mississippi's exchange." Emphasize the notion that there is "no wrong door," accessing the website will either open a door to affordable health care or subsidy programs.

Insurance Carrier Representative 3 and 4

3.28.2011 10:00 am CST

Interview Summary

- The health exchange should attempt to reduce complexity, not to increase it. The exchange is not a replacement for insurance laws, regulation, or other forms of health care mandates.

- The health exchange should not negatively affect those who are involved. Insurance brokers, as well as small businesses, should not have to shoulder additional burdens because the exchange is put in place. Furthermore, insurance carriers should not be forced to participate in the exchange nor should they be forced to funnel all participants through the exchange program.

- The health exchange is not an insurance program but rather a facilitating organization that makes the available programs and their alternatives more transparent. The exchange should facilitate referrals and assistance to available social programs and assistance where appropriate and help people understand what public health plans are currently available.

- Costs will not necessarily decline just because the exchange is put in place; rather, costs will decrease through increased participation and possibly through government absorption of some additional costs associated to administration of the exchange and related programs.

- Insurance brokers will most likely adopt a more "consultative" role over time in that they will help businesses better understand their options available within the exchange and can recommend ways to reduce costs for available plans.

- The health exchange will not create a new reality for individuals. They will not automatically get new or better coverage options at a lower cost. The goal would be for individuals to receive planned coverage through their employer. The business, as an employer, would still need to educate individual employees about their available options and the realities of what each option costs.

- The health exchange may not necessarily add a lot of value for businesses with more than 50 employees.

- The key to the success of the health exchange will be high participation. Issues surrounding why businesses and individuals drop coverage need to be addressed, so that increased participation will reduce costs for everyone.

Key Verbatim Comments

- *"An exchange should not be a step backward for providers who are making steps forward in terms of administration costs, etc."*
- *"The exchange is not an insurance program."*
- *"Ideally, brokers will move more toward a smaller agent force, capitalizing on their role as a consultant for small or large companies seeking to participate in the exchange."*
- *"We are worried about who is going to pay for the exchange. Insurance companies will need to determine how cost increases will be passed on to its customers."*
- *"Everything must be as direct as possible – [insurance companies like ours] should not have to funnel everything through an exchange medium."*
- *"People are too sheltered; they don't understand that insurance costs reflect ones health and wellness."*

Notes

What do you envision the ideal health exchange looking like?
The intent of an exchange should be to create a market place whereby individuals and small businesses can purchase health insurance plans that would be accommodating to their individual or small group needs. Additionally, the exchange should offer the availability of different types of plans with essential benefits, which are yet to be determined.

An exchange should facilitate the purchase of health insurance and be a conduit for social programs, but social services should not reside in the exchange. The main intent should be making it (the exchange) accessible to the public for purchasing health plans. The exchange's function, in regards to social programs, should be to facilitate the enrollment in social programs by redirecting enrollees to programs for which they qualify. It will be educational in nature, with a seamless and transparent transfer to those types of programs, when and if the scenarios fit.

What potential problems do you foresee?
Small employers will need to know what plans employees want. There will be too much bookkeeping for the employer if all employees go to a different plan, which is the intent of a defined contribution plan. The exchange needs to make sure employees have options within employer capabilities.

What will make the health exchange successful in Mississippi?
The exchange will need to be educational in nature. The infrastructure will need to allow for seamless transfers to social programs, mitigating all disruptive barriers to ensure simplicity. In addition, it will be critical to have employer choice, meaning the employer chooses the health plan. If an employer has a different health plan for each employee, the consequences would be excessive administrative duties, which would be a disruption to the majority of employers.

An exchange should not be a step backward for providers who are making steps forward in terms of administration costs, etc and should not add undue burdens to the carriers. Additionally, the exchange should leverage qualification and enrollment through electronic means.

What are the transparency issues within the health exchange?
There is going to be a significant increase in Medicaid participation; the exchange will need to keep social services separate – the exchange is not an insurance program. Complexity is going to be a primary opponent for those engineering its structure. When entering the exchange via a primary portal, an individual should be able to direct themselves to the proper health programs with little to no difficulty.

To mitigate complexity, the exchange should not duplicate current state law. Insurance commissioners should have the same regulatory function as they do now; their role should not be to determine who meets regulatory standards in the exchange. All policies must meet insurance department rules and regulations.

What role should a broker play within a health exchange?
The brokers' role should be that of a fee-based operation, an advisor, or as an individual receiving a commission. Ideally, brokers will move more toward a smaller agent force, capitalizing on their role as a consultant for small or large companies seeking to participate in the exchange. Thus, the volume of brokers will decrease, but their contribution on a consultative basis will increase. A broker should embrace a more holistic role. However, their objective should be to remain knowledgeable in state and federal rules, so that they are able to add further value in the area of strategic planning.

To clarify, consulting is more than informing a client of a cheaper deductible. Consultation is an analysis of the small business tax credit and long-term health planning. The role of the broker will change rapidly as the exchange progresses, and they look to providers for guidance. Their role in the community should not be under-emphasized, for they are an integrated and integral part that will help businesses leverage all

available resources.

What is the ideal size of a small business?
A small business should be 1-50 employees. When expanding beyond this number, it stands to be disruptive. If each employee has a different health plan, the administrative impact can be too great for the majority of employers.

In which ways might the health exchange positively affect the Insurance companies?
Our organization wants the exchange to succeed because it will benefit from the long-term success of the exchange. The increased enrollment will directly benefit everyone, including insurance companies. If done right and the Mississippi Department of Insurance enables a fair playing field, everyone, including insurance companies, will benefit.

What are the potential negative consequences upon the Insurance companies by the health exchange?
There are not a lot of reforms that address the cost issues – only reforms that address accessibility. Adverse selection is a primary issue that concerns us. We are worried about who is going to pay for the exchange. Insurance companies will need to determine how cost increases will be passed onto its customers as insurance companies in Mississippi do not work on high margins. One way to mitigate the portion of costs passed to consumers would be to receive assistance from state agencies that are receiving additional enrollees.

In addition, the general unknowns of the exchange pose a real problem. Our organization is planning but is finding the task difficult without adequate direction. For example, what is the essential benefits package? Little clarity has been presented concerning this area.

What compromises need to be made for the health exchange to be successful?
We are not planning to change our business plan; the company is already transparent. Our organization opposes anything that would compromise our commitment toward making Mississippi a healthier state. There should be no disincentive for people to become healthier. Anything that deters enrollees away from their strategic plan will hurt the company. Everything must be as direct as possible – insurance companies should not have to funnel everything through an exchange medium.

The key to a successful health exchange is high participation rates. What methods should an exchange take to facilitate high participation rates?
An exchange needs to be available in a way that will encourage carriers to participate. Enrollees need to understand which mediums to take when attempting to access the exchange (e.g. website and broker/agent). Moreover, there needs to be strong education and outreach amongst the population.

Where feasible, the exchange needs to be made simple, alleviating hoops and multiple iterations. Having the PPACA discard all rating requirements will make the process easier. Additionally, the exchange should allow for flexibility among carriers - meaning, allowing for competitive advantages such as incentives though wellness programs.

What mandate should be in place?
First, mandates should only be in place to facilitate enrollment amongst the uninsured. Other mandates may need to occur down the line, but there is not a lot of need for change with Mississippi's social programs. Currently, Mississippi has an excellent matching rate on Medicaid. However, this may create problems with provider shortages later on.

Why are small businesses dropping insurance?
Currently, not many small businesses are leaving at renewal rates, only small percentages are (15-17

percent). The primary reason is most likely due to an employer going out of business or having financial difficulty at the high-premium rate.

Why are individuals dropping insurance?
People are too sheltered; they do not understand that insurance costs reflect one's health and wellness. In addition, they have "sticker shock" when seeing the price of health care for the first time after an employer cancels their health plan.

What should be added / taken into account when creating the health exchange?
One small caveat – we are committed to promoting wellness, within and without the exchange. The thing that would be the most disruptive is if the decision process went from the navigator (the employer) to the employee – this would be a real administrative problem. If we had to discuss deductions, cafeteria plans, open enrollments, and different plans on the individual level the administrative cost would be unyielding (i.e. unmanageable).

We should not require a carrier to participate in the health exchange. There should be a good market inside and a good market outside of the exchange. We are going to push both health and wellness inside and out. Finally, accountability is not a bad thing. We need to change that culture.

Insurance Carrier Representative 5
3.29.2011 9:00 am CST

Interview Summary

- The health exchange must leverage the concept of simplicity where possible, though the magnitude of complexity that resides in an exchange is vast.
- Comparison, at a basic level (apples-to-apples), must be implemented. The exchange will attract first-time health insurance participants who will have a limited understanding of the health market.
- The health exchange must have high participation rates to promote credibility and economies of scale. There must be broad educational outreach, specifically for small employers (3-10 employees) since the majority of the working uninsured fall into this segment.
- Past exchanges have utilized various technological platforms to enable strong participation. Technology comprehension in Mississippi is limited; the exchange must depend on alternative forms of enrollment and education.
- Broker/agent participation will be critical to the enrollment process.
- The worst-case scenario would be to allow the federal government to create Mississippi's health exchange.

Key Verbatim Comments

- *"Brokers are integrated into the community in such a way that they have become a critical asset for state residents."*
- *"The key to a successful health exchange will be simplicity."*
- *"A broad educational outreach program will be an important factor in determining the exchange's success."*
- *"Employers will need to start communicating with their employees about available health options before the 2013 year."*
- *"We do not want a federal exchange, whatever that animal may be."*

Notes

What does the ideal health exchange look like?
The key to a successful health exchange will be simplicity. I am concerned about the general complexity of it – the sheer aspect of presentation of products and comparability of products – and then adding tax considerations and subsidies, this is going to be very multifaceted.

The complexity of the health exchange is a combination of things – multiple insurance companies offering different health plans, new people on health insurance, trying to effectively guide people to a suitable insurance plan or subsidized program, etc. That being said, we must take a special effort to simplify the presentation of information as much as possible. Our State is not front-and-center in the use of the Internet, and there are a disproportionate number of citizens in Mississippi that are technologically limited. I highly recommend apples-to-apples comparison. Insurance is complicated enough, and we will be introducing a lot of first time insured.

What are the pros and cons of a health exchange?
The pros of a health exchange are that it has the potential to expand our membership. An exchange creates a common vehicle for potential enrollees. I foresee insurance companies participating in and out

of the exchange. Our organization prefers to call itself a health and wellness company rather than an insurance company. I am concerned that our title/brand will be lost when participating in the exchange due to health insurance becoming commoditized. Additionally, our organization is nervous that the exchange will prevent an investment on proactive and preventive health-and-wellness education.

How do we achieve high participation rates within the health exchange?
High participation rates will be a necessity in order to generate credibility and economies of scale within the exchange – otherwise the exchange poses a risk for high premiums and adverse selection. I believe a broad educational outreach program will be an important factor in determining the success of the exchange – employees cannot depend on employers for education.

The majority of small businesses are 3-10 employees; additional support needs to be allocated to this group. Moreover, the exchange needs to be proactive in communicating with the public, specifically small businesses, before 2013. Some support needs to be given to facilitate participation. Perhaps additional subsidies would be a viable option. Broker/agent and navigator education will help recruiting abilities. In addition, there needs to be clarification on what a navigator is.

Mandates might be another viable option for increasing participation rates. Such mandates might be the passing of a Guest Worker Permit or having state employees and Medicaid/CHIP recipients receive health care via the health exchange.

There will need to be compromises from each stakeholder to ensure success. What compromises do you believe need to be made?
I am sure there are various compromises, but I am not sure what they would be. There have been advocacy groups that deal with issues surrounding investigative procedures within the health exchange. These groups have been very vocal surrounding the make-up of the Board of Directors. However, to the specifics of their message, I am not familiar.

What role will brokers play in the health exchange?
We have invested tremendously in our broker relationships. They are integrated into the community in such a way that they have become a critical asset for state residents. Our organization is not structured in such a way that if all of its customers started calling us directly, we would be effective in navigating their calls. I am not even sure exactly, under an exchange, what we would be able to communicate.

Why are small businesses dropping health care?
They are dropping health care because of the cost, fear of the unknown, and a belief that their employees will get it free somehow.

Why are individuals not obtaining health care?
Various reasons, similar to why companies are not providing it. Additionally, the younger population believes they are immune to health problems and forego health insurance.

What else should be added / taken into account when creating the health exchange?
What we are doing is critical to achieving structure within the health care market, although I remain fearful of what the political climate has done to the state, putting us in a bit of a quandary. What I do know, is we do not want a federal exchange, whatever that animal may be, and I sure hope rational minds prevail in other states\

Insurance Carrier Representative 6
Director, Corporate Development

Interview Summary

- The success of a small business exchange will rely heavily on the participation rates of brokers. However, there needs to be a clear incentive for brokers (commissions). To facilitate payments to brokers within an exchange there should be a format that resembles "promotional codes."An individual/employer would enter the code linked to that broker; the exchange would then pay out the necessary commissions. The main reason for the failure of Massachusetts was that they underestimated the role of brokers in spurring business participation.

- Small businesses are driven to the exchange by reduced and more predictable costs.

- The administrative burden of enrolling / managing exchange participants is a huge problem. Eligibility / terminates once per year / single point eligibility will make the exchange a more tolerable process.

- The optimal solution for small groups would be to put choice in the hands of employees. The employer would essentially open the door to the exchange but it would be the employee that walked through and purchased the plan.

- Having a defined contribution, cafeteria plan, and Health Saving Account (HSA) is a good idea, but all money should go through a cafeteria plan so they can participate in the individual market.

- To reduce possible disruptions within the individual exchange, those between 133-200 percent of the federal poverty level should be place in a separate exchange(e.g. Massachusetts' Mass Health Program, or sub-exchange). Income volatility causes this group to fall in and out of Medicaid eligibility.

- Anything associated with "Obama care" will be viewed unfavorably in conservative states.

Verbatim Comments

- *"I don't think any exchange could have success without brokers."*
- *"Having eligibility and determination once a year will make the exchange a more tolerable process."*
- *"As you get down on the income pool, income becomes very volatile...under 200% FLP people move in and out of Medicaid, on average, 2-4 times every three years."*
- *"The online applications in Utah do not take you all the way thought the process; they rely on a broker to take the employer all the way through."*
- *"Although additional and supplemental products do play a role, 60-80% of participation rates are based on costs."*

Notes

We have spoken with a lot of theorist and your work seems to be more practical, can you explain more about your work with small businesses?
I think if I tell you where I and others have failed it will more beneficial. First, Massachusetts definitely failed to realize the true role of brokers for small businesses. Many small businesses rely on local brokers and that will be key for increasing participation rates.

When we were helping Texas design their health exchange we tried to mitigate the costs of brokers by designing an online portal to promote and direct enrollment with small employers. However brokers are still seen as the primary driver of small business registration. Employers prefer to delegate the tasks of insurance to someone else; they dislike the obligation of gathering an employee's family income. Many employers don't realize the costs of a broker so we tried to incentivize an employer to self register through a 5% discount via online enrollment.

It is important to note that a majority of small business owners have limited knowledge insurance registration. The majority who enroll have done so with the use of a broker.What is interesting about the Utah enrollment system is that is does not take the employer through the entire process, they rely on a broker to facilitate the final enrollment.

How do we get the small businesses to participate in the exchange, how do we get them excited about participating?
What we know, and everyone else will agree, is that costs are the biggest driver for participation. Although additional and supplemental products do play a role, 60-80% is based on costs. I would recommend focusing on options that can weigh down costs.

The only viable solution, one that is not a nightmare for everyone, is to send people into the exchange with a "cafeteria plan". Participants would be assigned to a broker and enter as an individual, the exchange would act as a consolidator.

However, there is no getting around the complexity for brokers unless the exchange actively removes some of their administrative burdens.

The question becomes, what is the solution? Can we consolidate the administrative burdens? How do we rid the issues?
An exchange will need to find a way to leverage the brokers to help in the consolidation process. The employers and brokers will enter with small groups and the exchange will break people into individuals. Taking on a administrative responsibility, the exchange will act as a biller.

Perhaps individuals would use a "promotional code," like a website, and the exchange could pay the broker a commission in that manner. It is crucial that eligibility and determination be once a year, it will make the exchange a more tolerable process.

How have small businesses in Missouri reacted to the exchange, any pushback?
I think anything associated with "ObamaCare" will not be viewed favorably. The exchange content itself is very bipartisan; being tied to the health care reforms has overall been very negative.

Will broker commissions inside the exchange need to be comparable to those outside?
It will need to be a requirement. I don't think any exchange could have success without brokers.

What else is a necessity?
Honestly, it's all about the money.

From a practical standpoint, is there something big, besides brokers, which is necessary to make an exchange succeed?
As you serve people with lower incomes, you find that income becomes very volatile. People who are under 200 percent poverty move in and out of Medicaid 2 to 4 times every 3 years. Mississippi should consider creating a separate exchange for those who receive any subsidies, like Massachusetts.

Employers don't want to pay for their employees when they qualify for Medicaid. This is one area that we are really trying to focus on.I would suggest, in general, making sure that whatever you determine Mississippi's goals and objectives to are, I think that it should be equally thought of on behalf of the consumers and agents. States forget that one party's best interest is not always the best case for their voters. Forgetting this can distort the successes of state exchanges.

Planning and Development Districts Representatives 1-3
3.30.2011 1:30 pm CST

Interview Summary

- The Public Planning & Development Districts would be an excellent, effective organization for administering the educational segment of the exchange. The only concern is that the districts are currently dealing with a program that is easy to sell; the exchange will be much more difficult.

- A major concern is that bureaucracy will create a bottleneck for program implementation. The state needs to be prepared to manage additional paperwork, or contract the job to PPD because they are better able to prepare.

- The Public Planning & Development Districts would be an efficient third party contractor because they have a history of administering large programs for the State of Mississippi.

- Mississippi should create a pilot program that enrolls state and local employees into the exchange. The program would be used as a testing platform to see what issues arise before going live with small businesses.

Key Verbatim Comments

- *"Getting clients hasn't been an issue."*
- *"The major problem currently being dealt with is a lengthy waiting list, and the processing of numerous applications.*
- *"Between the state law and the complexity of bringing different groups together, it's going to take someone innovative like you and your organization to make the health exchange work."*
- *"Our success is a function of our breadth of experience in the field of administration."*
- *"Many bankruptcies of small businesses are the result of health care costs."*

Notes

What are the administrative challenges you have faced, concerning your Medicaid and aging program.
The Medicaid program is efficient and effectively regulated. The major problem currently being dealt with is a lengthy waiting list, and the processing of numerous applications.

The waiver program has been exceptionally cost effective; the primary challenge with this program is dealing with the administrative demands (i.e. paper work). Losing applicants is a minor issue.
The two ways an approved applicant can be lost is if there are admitted by a nursing home, or if they choose to pass on our services. Our only real obstacle is the abundance of applicants.

What are your methods for educating people about your program?
Our program fulfills a need not otherwise addressed. There is a limit on the amount of service people can receive under Medicaid. When that limit is reached, people are referred to our organization for assistance. The care facilities are legally required to inform people of our services.

Public officials are familiar with their constituents in our rural area, so they inform people personally about the services provided by our organization. One prior obstacle was that doctors were not fairly compensated for certifying patients for our services; so that if doctors did certify a patient, it was out of a personal concern for the patient's well-being. We solved that problem with communication and developing relationships with the administrators of the clinics.

Moreover, people are able to obtain information about our program from their local Medicaid office, or from our office directly.

What are the qualities of your administration that make your program so successful?
We have an exceptional amount of experience handling sizeable programs with great amounts of money, with consistent success. Our success is a function of our breadth of experience in the field of administration. We are efficient in managing costs. Our company is self-insured. We employ an underwriter to inform our employees of our insurance program, which has been a cost effective measure.

What makes your program unique?
Most state governments' policies are typically not conducive to an organization like ours. A group would need a point of contact in government to be permitted to form what we have. They would need extensive education about administering insurance programs to understand how to form and maintain one like ours.

A self-insured pool will be less costly for its members than a pool participating in traditional insurance, regardless of the health of its members. When a group is self-insured, they are the ones that make the profit on providing their own health care coverage.

Concerning health insurance, what challenges are faced by small businesses in your area?
The price of health insurance for a small business is unaffordable. Many bankruptcies of small businesses are the result of health care costs. When they cannot pay for their health care, the insured people ultimately pay the difference. If everyone were insured, the cost of health care for each individual would decrease.

Planning and Development District Representative 4
3.30.2011 1:30 pm CST

Interview Summary

- The state should utilize its existing infrastructure to support the exchange's navigators. Possible navigators could be nurses or social workers working with the state's planning and development districts.

- Because the state government is essentially a contracting entity, the exchange should leverage local governments to facilitate educational outreach.

Key Verbatim Comments

- *"The state government has a poor history of delivering services..."*
- *"The biggest challenge we have right now is for the state to have good, long-range, and consistent funding in their policies."*
- *"It [the health exchange] cannot be a profit generating organization, which is why Health Maintenance Organizations (HMOs) have failed."*

Notes

Do you have programs that assist the elderly with Medicare?
Yes. We are the designated agent, as well as nine other districts, that provide home and community-based care. The program allows nurses and other care practitioners to come to one's home and assist in their affairs (e.g. setting up medical appointments, bill pay, meals, trips, etc).

Essentially, it is a cheaper form of assisting those with health care needs. The program is more cost effective than when someone enters' a health institution.

What are the biggest challenges you have had in trying to administer the Home and Community Based Care Program?
It is very much orchestrated like a business in that we are paid on a unit-cost basis. The biggest challenge we have right now is for the state to have good, long-range, and consistent funding in their policies. It is not a program that you can gear-up and then gear-down.

How do you get people enrolled in the Home and Community Based Care Program?
We have people come to us and we have people on the ground because we keep a waiting list. This is one of those rare programs where you can spend money and save money. The program is about one-third less costly in comparison to nursing home expenditures.

What are the challenges of serving the rural area?
Economic development – there is a loss of population in these areas, as well as fewer jobs. The rural area is difficult to serve because of a lesser population density, which makes it less cost effective.

Do you believe the health exchange will work?
You need to have a resource center – 1-800 numbers connected to a computer database – a case management approach. It cannot be a profit-generating organization, which is why Health Maintenance Organizations (HMO) have failed.

Why do you think Medicare/Medicaid went through you instead of the Department of Health in each

of the counties?
The state government has difficulty delivering services – we are an extension of local government. We are a consolidation of local governments coming together to support and assist those with medical needs – the state government is largely a contracting entity.

Do you think the other planning districts are as well organized as you?
They are organized well enough to represent the constituents whom they serve. An urban area, with a sophisticated population like ours, will be more fine-tuned than the urban areas. The trick is, you have to look at what is the best level of delivering services, and you cannot deliver any form of service from the federal level to the state level.

What is the best solution for channeling information to the public?
It has to be a blend of information. You need to go through groups like us, TV, newspapers, fliers, churches, community organizations, and others – those seeking help will find a way.

3.29.2011 2:00 pm CST

Interview Summary

- The health exchange critically needs an effective outreach program, especially in rural areas. Historically, people in these areas have not had any health insurance and are often not knowledgeable about health insurance in general. Additionally, they lack computer literacy.

- The Health Exchange Outreach Program needs to include local brokers with institutional knowledge who can help small businesses (majority with 1-10 fulltime and part-time employees) stay informed about alternatives available within the exchange. The outreach program also needs to inform and provide incentives to local providers (physician offices) to participate actively in their role to provide health care within exchange programs.

- One alternative is for Mississippi to apply for a UPP-like waiver to allow employers to contribute a portion of the employees' health premium to offset costs, before applying the federal subsidy allocations for that individual to the remaining premium amount.

- Rather than mandating coverage, the structure of the health exchange needs to be set up such that participation is appealing. Measures to accomplish this could include, at a minimum, making sure the service is simple to use and using navigators to explain and to assist people with the enrollment process.

- Doctors should also coordinate with their local navigator, so that there is a pre-defined method for providing health care to an individual who comes into the physician's office, but who has no health care coverage. Perhaps the navigator could be contacted in these situations and could assist the individual in an application-approval process for one of the exchange's plans on the spot so that a coverage plan could be put in place prior to receiving health care at the doctor's office.

- Simplicity will be the key to success for the exchange program.

- The legislature must have oversight of the health exchange. It is important that the exchange report annually to the legislature on program performance, including goals and accomplishments in a given cycle.

- At the same time, the exchange needs to be empowered to make financial decisions and to establish standards without the requirement of legislation at each step. The exchange needs some level of autonomy to execute the mission without micromanagement by the legislature.

Key Verbatim Comments

- *"The bulk of the uninsured will be those who live in areas that have insufficient physicians."*
- *"If the state waits until the regulation is out [PPACA], they will not have enough time to build the exchange."*
- *"Signing up someone for Medicaid in Mississippi is a pain. For this reason enrollment in a health insurance plan needs to be much easier through the exchange."*
- *"We do not want one organization in the state to win the right to coordinate the exchange due to being lowest bidder, and then having that organization half-heartedly reaching out to folks in the urban areas."*
- *"With so much money involved, this system [the exchange] cannot be more than an arm's length away from the state legislature."*

Notes

What are some basic statistics that define the scope of increased health care needs within the state, because of recent health care legislation?
An additional 350,000 people will be introduced to Medicaid programs. There are 150,000 additional individuals that will be introduced to the exchange, who potentially qualify for federal subsidies. Based on how the federal law was written, 72% of the Mississippi public could potentially qualify for some degree of subsidy.

What can you tell us about health care in Mississippi?
Mississippi is a rural state; however, most of the health care providers are found in urban areas, such as Jackson and other large cities. At the same time, there are vast rural areas where there is a critical shortage of health care, such as entire counties without a pediatrician. There is one county in Mississippi that does not have a hospital. Health care is not what it should be in Mississippi. There is a lack of capacity in some areas.

What are some of the problems with the current health care system in Mississippi?
Some health care providers are simply not there to serve the necessary population. At the same time, implementation of new health care legislation is now going to introduce 500,000 additional residents that need to be insured. As policymakers, we have to tackle this problem. The bulk of the uninsured will be those who live in areas that have insufficient physicians. You have a culture in Mississippi that tends to use the emergency room as primary care. Therefore, the challenge of the exchange will be to locate those who never in their life have been in the practice of seeing a doctor. It is complicated because they do not know they need to have a primary physician. Finding people in the under-served areas who do not understand the system is another key issue.

How will those with limited coverage be affected by the new coverage options within the health exchange?
In some cases, there are state employees who make $16,000 a year and the state pays for their personal care, but does not pay for other family members. Under the new legislation, this employee can go into the state exchange and obtain health insurance for their family. If their cost-share for family coverage accounts for more than 8.9 percent after tax, the federal government will help subsidize a portion of their premium.

Are there other public sector employees who have similar challenges?
School bus drivers also would be able to seek coverage through the exchange for family members. Their situation will be similar to the one above that I just outlined.

Are there important factors to consider about the timing of the initiation of the health exchange?
If the state waits until the regulation is out (PPACA), they will not have enough time to build the exchange. No one knows what the basic benefits package will be yet because of the exchange. If the state defines the essential benefits package as a very comprehensive plan, then even with the federal subsidies (which are limited because of a lack of funding) the plans available through the exchange may not be less expensive than other options currently available.

Do businesses face unique challenges in their prospective participation in the health exchange?
The biggest challenge for businesses will be in the small business sector. The small-business segment will be the largest portion of the exchange. The nature of the exchange will create problems for small businesses, because of cost limitations. For example, if an employer were to pay for half of the premiums for their employees, many of those employees would still not sign up for health care because it would be too expensive. Furthermore, some businesses will choose not to provide coverage because the penalty is so low for employers that do not participate.

What communicational challenges exist for the health exchange, in regards to how it will work?
Local brokers have expressed a need for institutional knowledge. Health care providers have expressed a need to have an embedded incentive to provide care to those who do not currently have coverage. A key segment that needs information about the exchange is small businesses. Most businesses in Mississippi have 1-10 employees (many of which are part-time). These businesses and their employees are going to need information about how to participate in the exchange.

What is the responsibility of the navigator in the current legislation?
One key issue is whether Health and Human Services is going to let your regular insurance agent or insurance broker fulfill the role of a navigator. For example, will you allow these agents or brokers to sign up individuals for insurance through the exchange? I would think you would capitalize on the existing knowledge of our agents. If you were to publish information about the exchange, so that the public had access to it, many of those being targeted would not know how to use a computer. We need people such as agents and brokers out there signing people up and explaining the difference between a bronze and a gold plan.

Should one organization be responsible for coordination of the health exchange and reaching out to individuals?
We do not want one organization in the state to secure the right to coordinate the exchange due to being the lowest bidder, and then having that organization half-heartedly reaching out to folks in the urban areas. But the coordinators of the exchange also cannot just be a non-profit group of social workers.

We need to reach out to individuals in person, and ideally, you would work with businesses that have many part-time employees. For example, any business filing a W-2 should need to direct their employees to the exchange. Health care providers should be set up to assist those who are uninsured but who come in for medical services to sign up for coverage through the exchange.

Signing up someone for Medicaid in Mississippi is a difficult process, so enrollment in a health insurance plan needs to be much easier through the exchange. Individuals need to know what level of coverage they have.

What do you anticipate to be the largest challenges in creating a successful health exchange in Mississippi?
One challenge will be a cultural rejection of what some people refer to as "ObamaCare." Mississippi is the poorest state in the Union per capita. Furthermore, Mississippi has the highest obesity rate, continuous health problems and injuries, is the second lowest income per capita (behind West Virginia), and ranks 49th in physicians per capita. Insurance and health care costs money, which means that comprehensive insurance coverage is going to be a problem for Mississippi.

What is the role of the State of Mississippi, if any, in ensuring the success of the health exchange?
If the state engages the health care exchange, 500,000 people are going to be enrolled through the exchange. This potentially represents billions of dollars associated with that exchange. A significant amount of federal dollars will flow through the exchange. There will be many people now qualifying for Medicaid through the exchange. This represents a significant challenge.

With all of this money involved, there needs to be oversight from the state. The exchange potentially touches many sensitive aspects of an individual's life, including issues surrounding taxation, assessments,

etc. With so much money involved, this system cannot be more than an arm's length away from the state legislature. Our leading role is oversight.

What type of oversight could the legislature provide in this scenario?
In the House bill, the exchange was created as an agency but freed from the restrictions of most state agencies. For example, the exchange is not restricted to certain information technologies, and the exchange is freed from procurement regulations. This will create greater flexibility for the exchange itself. Nevertheless, the operation of the exchange must be transparent to the legislature. Exchange managers must come to the legislature and provide regular reporting about what they are doing. If something is outside of state government controls, you can hardly get those folks to call you back. We want the exchange to report to the legislature once a year on what they are doing and where they are headed.

What important aspects should be considered about the health exchange as an organization?
It is difficult to have an opinion of something that does not exist and never has. Many questions arise. For instance, how are people, who do not currently have insurance, are going to be able to purchase insurance if they are still in a lower-income bracket? Take a hospital's care for instance – 18 percent of those are receiving care through Medicaid, and another 15 percent are indigent. In these cases, those hospitals are being reimbursed at or below cost or for free. Then you have Medicare (reimbursed at 40 percent) on top of that.

Therefore, the situation we are faced with now, in the wide-sense, is that we are going to be subsidizing coverage for individuals in either case. Therefore, the exchange needs to be organized in a way that accounts for this.

Do you have any other thoughts about health care reform in general?
One issue has gotten lost in the entire health care reform debate. The issue behind health care reform is to find a way to make health insurance affordable for everyone. Somehow, the debate has become about personalities. When you are approaching the exchange element, the idea is to make health care affordable for those who could not otherwise afford it and then you have to require people to participate in order to avoid adverse selection.

We have a very expensive workforce in the U.S. If they are going to have to work into their seventies and if we do not take good care of them with routine health care, then our workforce is not going to be able to work into their seventies.

Americans have more service jobs than ever before and we need to invest in keeping our workers healthy, so that they can continue to be productive as they get older.

Additionally, rather than having health care mandates, we ought to promote the benefits of the exchange. One benefit is the role of the navigator. If there are some options out here, then there should be a person that says, "I'm your navigator and I'm here to assist you by explaining your options and helping you to become enrolled..." Another example would be that if someone walks into a doctor's office and says I do not have insurance, they could get a person on the phone (navigator) who can assist that individual in signing up.

State of Mississippi House of Representatives 2
3.31.2011 9:00 am CST

Interview Summary

- When building the health exchange, the goal should be affordability and accessibility. Mandates should be enacted with the notion of stimulating competition and spurring innovation.

- Regulation and oversight continues to be a critical component from group to group. A recurring theme among individuals is the belief that the Mississippi Insurance Department will create the standards, and the regulations for the exchange. It is recommended that there be legislative oversight.

- When designing and creating the health exchange, the notion should not be to "reinvent the wheel," but to incorporate broad stakeholder involvement that will insinuate creative ideas.

- The exchange should play a passive role, allowing carriers who meet the terms and requirements, stipulated by the governing board, to participate in the health exchange. The policy must be consistent, well-known, and applied fairly with every carrier and participant

- The health exchange should provide the user with as many options as possible. The situation to avoid is a "one-size-fits-all" environment.

- The rural population will need to be addressed via a different outreach medium. Suggestions are to create satellite locations and or mobile command centers that will facilitate enrollment in the rural regions of the state. Possible locations are public libraries and churches.

- Public outreach must be addressed through all mediums (e.g. TV, print, and radio, to ensure maximum exposure).

Key Verbatim Comments

- *"My number one goal is affordable insurance; the bottom line is how do we make it affordable?"*
- *"We do not need to reinvent the wheel, just what do we have to do to get our people insured?"*
- *"I'm going to put everything I've got into it to make sure this exchange works."*
- *"I'm worried about how people in the Delta will access the computer."*
- *"We have to give accountability to the Board or to the legislature – we don't want all this money going through an organization without oversight."*

Notes

When you think of a health exchange, what do you envision? How does it help small businesses?
The goal needs to be affordable insurance. Moreover, we need to allocate resources so broad stakeholder involvement is present in the creation of the exchange. I continue to hear carriers and agents say, "I want a fair shot at this."

In addition, the exchange must be accessible; the purpose of the program is not to become a money generator. It is to stimulate competition among carriers to bring affordable coverage into the hands of consumers.

What needs to be addressed when creating the health exchange?
Well, we need to create a solid groundwork that stipulates the exchange's standards, regulatory authority, and whether it will be a not-for-profit or for-profit entity.
Moreover, we need to figure out the common denominator among all the states that have successfully

established an exchange, and implement it into ours. The process of creating an exchange should not be us trying to reinvent the wheel, simply answering the question, "What can we do to get our people insured?"

What type of oversight would you like to see?
I want the exchange to have minimal bureaucratic oversight. I will be checking into the exchange's oversight next year to make sure it is governed properly.

What are your views toward the health exchange?
Until someone repeals it [PPACA], I am going forward. I am going to put everything I have into making sure the program works next year, since this year the plan failed. Health care is important to everyone; I want to know what every state is doing and what is working and what is not working

What types of health plans should be offered in the health exchange?
The individual should be able to develop his or her own plan based on their needs. To simplify enrollment, I believe part of the registration process should be to require the enrollee to disclose all of their medicines, medical history, etc, and the exchange would customize a plan specifically for that individual.

Do you feel like the State of Mississippi is behind in implementing a health exchange?
When I called Washington D.C. they told me "we're still writing the regulation;" therefore, I do not think we are that far behind, given the regulation still has not been written completely.

How should the state advertise the health exchange?
We need to advertise it – so people know about it

What are your concerns about the Delta region of Mississippi?
Even when we get them health insurance, how are they going to get to the provider? If you get in an accident in one of our urban areas, you will have medical service in five minutes. However, if you have an accident in the Delta you will be waiting far longer and it could take you over an hour to even get to a doctor.

I am trying to send doctors to the Delta. Currently we have one or two OB/GYN's in the Delta, so let us create an incentive, just as we do for schoolteachers. Such incentives could be to pay more and or pay for their school debt, given they work in the regions for a specified amount of time. As of now, an individual must schedule an appointment four months in advance; we just do not have enough of them.

Moreover, I am concerned that people in Delta region will have limited access a computer. Therefore, the idea is to set-up satellite locations – libraries and churches – with a navigator ready to help, them would be ideal.

State of Mississippi House of Representatives 3
3.30.2011 9:00 am CST

Interview Summary

- Legislative oversight is critical to ensuring that all funds are properly allocated and spent.
- The health exchange should be driven by the motive of creating accessibility to as many people as possible. An adequate approach would be to incorporate a simplistic user experience that is both easy and timely.
- Broker/agents will have an important role in the success of the health exchange. They have built solid relationships with small groups and individuals, which can be leveraged to enroll clients into affordable health plans.
- Effective outreach will best be accomplished by leveraging established organizations already on the ground.
- One approach, which caters to the idea of simplicity, would be to allow the buyer to tailor his or her own health plan. They would choose from three or four offered plans, each would vary based on minimum coverage, and add benefit options that fit their needs and wants.

Verbatim Comments

- *"Historically, with large pools of money channeling into the state, there has been no oversight, and we never know where and how the money was spent."*
- *"A key aspect to the success of the exchange will be to listen to all those involved (stakeholders)."*
- *"Insurance carriers are concerned about receiving policies in a timely fashion."*
- *"If the state were to pool all small businesses, I believe we could offer them a better rate."*
- *"As an insurance agent, I like to present options to my clients. But I do not want too many options that end-up simply confusing people. Preferably three, or four options would be best."*

Notes

How would you create the ideal health exchange?
I would ensure that there was legislative oversight. Historically, with large pools of money channeling into the state, there has been no oversight, and we never know where and how the money was spent.

The exchange would be accessible to the public. It would be sufficiently simple and intuitive. I would leverage existing organizations for outreach (e.g. community action agencies, community colleges, public schools, etc). Moreover, insurance agents should not be "squeezed" out.

Remember, there are two facets in Mississippi that you really need to deal with, race and economics.

I would leverage the Chamber of Commerce, Rotary Club, and the Kiwanis Club to increase participation among the White-American communities. To increase African-American participation I would go to Community Action Agencies, General Baptists Conventions, and churches.

As far as economics go, I would keep in mind, when engineering the exchange, that there is real disparity of economics between people.

Who are the various stakeholders in the health exchange?
The stakeholders are pharmacists, insurance carriers, elected officials, VA clinics, organizational leaders, seniors, and young parents.

A key aspect to the success of the exchange will be to listen to all those involved.

How important will the cost of the health exchange be in facilitating enrollment?
Costs will be the single most important issue.

What compromises need to be made for the health exchange to be successful?
There will need to be a compromise between Democrats and Republicans. Currently, Democrats want large oversight, while Republicans are advocating for it to be at a minimum.

What concerns, if any, will Mississippi encounter from the insurance carriers in the state?
Insurance carriers are concerned about receiving policies in a timely fashion. They are worried about being able to answer and relieve concerns from their consumers.

Possible solutions are additional agents that are competent in what they do; further education will be a necessity in this aspect. There will also need to be local access (e.g. brokers/agents and Public Service Centers).

Why are some small businesses (fewer than 50 employees) deciding not to offer health benefits, and what can the health exchange do to help them?
The primary issue is cost, many small businesses are unable to afford a plan that they can offer to their employees, while maintaining their bottom line.

If the state were to pool all small businesses, I believe we could offer them a better rate.

How would you add simplicity to the health exchange?
As an insurance agent, I like to present options to my clients. But I do not want too many options that end-up simply confusing people. Preferably three, or four options would be best. As a buyer, I would like to fix my own plate. By that, I mean I would like to choose a basic plan and add benefit options as they pertain to my needs and lifestyle. Remember that no pair of sandals fits the same two people the same.

State of Mississippi Senate 1
3.30.2011 8:30 am CST

Interview Summary

- The State of Mississippi is market-driven (i.e. pro-business). The health exchange must alleviate undue burdens that stand to be placed upon the exchange. The state's goal should be to present small businesses with access to affordable health care, which has historically been unattainable.

- The health exchange should weigh on the side of minimal bureaucracy, and avoid policies that might lend additional debt to the state. Leveraging existing business networks (e.g. The Chamber of Commerce, would effectively propel the message of the exchange, while allocating little effort and resources). The state should consider employing a department of 4-5 individuals to manage the exchange – this should not be an overly expensive obligation.

- The most significant impact, which should therefore be the primary goal of the exchange, would be to lower the price of health insurance for small businesses. One step toward achieving such a goal would be through pooling small businesses together, which would result in risk spreading and bargaining power.

- The health exchange should engineer creative mechanisms, rather than stipulating mandates to spur participation. One mechanism would be the creation of a defined contribution plan, for both full and part-time employees.

- The legislature must determine the optimal structure for the health exchange. The Department of Insurance, due to limited resource allocation, should act as the regulatory agent. The legislature would play the role of facilitator. Furthermore, regardless of the outcome of health reform, the state of Mississippi should continue in the direction of creating an exchange.

Key Verbatim Comments

- *"The ultimate product should be an affordable package for the employer and employees of a small business."*
- *"We need to introduce innovative mechanisms to spur growth and competition."*
- *"My preference would be to see more of a Utah version of the exchange, in that the government provides the structure with minimum bureaucracy."*

Notes

When you think of a health exchange, what do you envision? How does it help small businesses?
I envision a platform that facilitates the act of comparing and buying health insurance. The ultimate product should be an affordable package for the employer and employees of a small business.

What are your concerns about the health exchange?
My concern is, given the high percentage of uninsured in Mississippi, this program is going to be cost-prohibitive.

Massachusetts started at $30 million and has now grown to $50 million. Utah utilizes their broker community to provide customer support. Moreover, the State of Utah operates on a budget of $600,000 a year and employs two employees. The Utah model is much more appropriate for the state of Mississippi. We do not need a large, independent and expensive agency administering the exchange.

What challenges do you foresee with the health exchange?
The challenge will be in providing small business with affordable health care. That being said, we need to introduce innovative mechanisms to spur growth and competition.

What would you like to see in the health exchange?
My preference would be to see more of a Utah version of the exchange, in that the government provides the structure with minimum bureaucracy. Candidly, I have spent time with various business leaders in every sector, and while they tell me their profits are up, they are not hiring because of the fear of "ObamaCare."

Business Organization Representative 1
3.30.2011 12:00 pm CST

Interview Summary

- A large percentage of the Mississippi population lives in a rural area. A digital enrollment platform could pose as a problem for rural Mississippians. For this reason, face-to-face enrollment and education might be the best medium for this group.

- Health care is cost prohibitive for many self-employed individuals or those with one or two employees. Health benefits are one of the first things these employers drop when they encounter challenges.

- The idea of a health exchange is complex. Simplicity needs to be woven into the fabric of the exchange, furnishing information in a straightforward and easy to understand manner.

- The exchange should create a value proposition to help rally the business community. The message should be that of increased health benefits and quality retention among employees, thus allowing businesses to increase production over time.

- Post recession, the business community has become more unified in Mississippi.

- This organization is supportive of anything that makes health care more accessible to its 1,100 members.

Key Verbatim Comments

- *"The largest challenges associated with health care are the costs and the inability to predict where costs are going."*
- *"My concern is whom the employees will turn to once questions arise."*
- *"Health exchange's personal (i.e. navigators) are welcome to speak at these events to discuss the benefits of the exchange program."*

Notes

Why are small businesses dropping health insurance?
When the economy is in a recession small businesses begin to mitigate excess costs as much as possible and one of the first things they cut is health care. They feel it is better to cut costs than to lay off employees.

What do you think are the biggest challenges to offering health care?
The largest challenges associated with health care are the prices and the inability to predict where costs are going.

What do you think of the idea of employees shopping for their own insurance via the health exchange?
I don't think it's a good idea to have employees shopping for their own insurance. First, they will not know what to choose, resulting in confusion and mistakes. Second, some people lack education or the ability to access the Internet. How can they pick their own insurance if they can't understand what they are getting or even access the information online?

Who handles the insurance issues for your group?
We have a designated employee to handle our insurance issues. They handle ancillary insurance issues and work with BlueCross BlueShield directly.

What do you think of defined contribution plans?
My concern is to whom employees will turn to once questions arise. There is uncertainty surrounding the customer support aspect of the exchange. Will it be a combination of brokers and employers, or a separate agency that takes responsibility for this matter?

Currently, we have a few contractors that provide defined contribution plans.

What percent of your members offer health insurance?
65-75 percent.

What industries are least likely to offer health insurance?
The least likely industries to offer health insurance are small, specialized contractors.

How can your group inform member of the health exchange?
Our groupis divided into six regions, each region holding a quarterly meeting. Health exchange personal (i.e. navigators) are welcome to speak at these events to discuss the benefits of the exchange program.

What types of members do you currently have?
We have subcontractors, law firms, CPAs, insurance agents, medical groups, and the Mississippi Economic Council.

How do you attract members to your group?
We do a lot of advertising. Additionally, we are able to furnish a quality service at a competitive price. When advertising in the rural parts of the state, we focus on face-to-face contact. Although this approach is more costly, it has a high return on investment.

Does your group lobby?
We mostly advocate against working-related issues (e.g. workers compensation and tax-related issues.)

What are the top challenges faced by small businesses?
The top challenges are the economy, taxes, and lack of qualified workers. Health care is not on the list because it is an ancillary item.

Business Organization Representative 2
3.30.2011 11:00 am CST

Interview Summary

- Small business owners are much more involved in the day-to-day operations; they have little to no time to allocate toward health insurance.
- If Mississippi decides to implement a defined contribution program, it has to be easy and intuitive or small business owners will not participate. Most importantly, not all employee questions can be directed toward the employer.
- If the health exchange listens and reacts to the concerns of our industry, there is the potential to incorporate a significant portion of individuals into the exchange, once online.
- If this industry is unable to consolidate its risk pool, small pools will have serious problems (e.g. high premiums, low quality, few choices).
- A digital framework should be created for the exchange to facilitate the enrollment of small entities, as well as young individuals in the industry.
- Employers view health reform as an imposition rather than an opportunity, steps need to be taken to illustrate how it can be economically beneficial.

Key Verbatim Comments

- *"As you go down the pecking order, health care disappears for hourly and part-time workers."*
- *"Health insurance has the largest impacts on recruitment and retention."*
- *"The majority of individuals that join our industry are young, who often turn down health care when offered."*
- *"We would consider offering insurance through an exchange if we had the authority to group all of our members."*
- *"A poor understanding of health care has resulted in employers opting to forego health insurance in general, deciding it was too much of a burden."*

Notes

What is your current understanding of a health exchange?
A health exchange is a marketplace, whereby employers and employees can shop for and compare health insurance; Mississippi, as well as all states, must implement one by 2014. In addition, the Mississippi health exchange bill recently died in conference. If the state fails to create an exchange by next year the federal government will intervene, and build one on behalf of Mississippi.

How do small businesses in your industry deal with health insurance?
Several insurance companies market an endorsed product (i.e. mini-med). It is typical for small business owners and their managers to have medical care; however, as you go down the pecking order, health care disappears for hourly and part-time workers.

What are the challenges of offering health care to employees?
The challenges are not that great – offering health care has never been an issue that drives the economic decision of employment in our industry. For the reason that, the majority of individuals that join our industry are young, who often turn down health care when offered.

The Chamber of Commerce offers discount insurance, would you consider offering insurance through them?
We looked at "Chamber Plus" and it was not that good of a deal. Alternatively, discounts in Mississippi, in general, are not that appealing. BlueCross BlueShield holds the majority market share (roughly 70 percent) which stimulates the notion that offering incentives are unnecessary because of the limited competition.

We would consider offering insurance through an exchange if we had the authority to group all of our members. As of now, various restaurants fall under different groups, preventing a single pool. The risk pools are too small for small businesses, which results in high insurance costs.

What do you think of defined contribution plans?
I do not think employees would like nor need it. Large majorities are already on Medicaid, so I am not sure of the benefit for these employees, options wise. I also do not believe these employees would want to "jump through hoops" (referencing to the enrollment process) when they currently have insurance.

Is the business community unified on health care issues?
We are unified on certain issues. As far as health care goes – we are opposed to "ObamaCare."

Are insurance subsidies for health exchange participants appealing?
I believe subsidies would be appealing for employers; they want the acquisition of insurance to be an easy process. Moreover, the exchange needs to be a one-stop shop, facilitating side-by-side comparison. Additionally, it needs to be respectful of an individual's time constraints. The information needs to be presented in a simple format that allows enrollees to easily complete the enrollment process – in a timely manner.

How large of a role will health care education play in the health exchange?
Our association sponsored the Governor's health care summit last year. There were around 200-300 persons attending; the majority of questions asked were unable to be answered due to a lack of understanding.

A poor understanding of health care has resulted in employers opting to forego health insurance in general – deciding it was too much of a burden.

What channels work best to increase participation in the health exchange?
There needs to be a coordinated effort from all entities, associations, departments of health, etc. I believe there needs to be a lot of web-based training – applicable to the restaurant industry.

What do you think the largest challenge is for getting members to participate in the health exchange?
The more prominent challenge will be to incorporate the usage of the exchange into their regular operations. Employers will need to be educated about how it works – what economic benefits can be gained for its usage.

If the goal is to have employees do their own shopping then there needs to be sufficient information to guide them through the enrollment process. If an employee gets confused and has to come back to the employer, the structure will quickly fall apart.

In this industry, only a handful of employers are using brokers. Come 2014, the vast majority of owners will be entering the health care environment for the first time; the exchange must cater to this situation.

Business Organization Representatives 3 and 4
3.28.2011 1:30 pm CST

Interview Summary

- The Chamber's involvement will be critical to increasing participation from small businesses in the health exchange.

- The Chamber has contracted a deal with BlueCross BlueShield that allows its members to receive a three percent discount on premiums (valid for two years) through their Chamber Plus Program. This program has doubled enrollment in the Chamber in three years.

- The Chamber strongly relies on brokers and local chambers to send them leads. Members of local chambers throughout Mississippi can sign-up with the Jackson Chamber for only $25 per year.

- Adoption rates for solutions involving technology are going to be particularly challenging in Mississippi. BlueCross BlueShield recently went paperless, now requiring email addresses from its members. This approach significantly increased the administrative burden on brokers.

- The defined contribution plan would likely increase the administrative burden on brokers. Additionally, it could be too complicated for employees. Selecting their health plan will have to be simple, and likely allow the business owner to select a default plan from which the individual employees can change if they so desire.

- Health care is likely the second largest challenge for small businesses. Their issues are total cost, ease of enrolling, and administrative burden.

- From the employer and employee perspective, the processes and plans offered inside the exchange need to be the same as those in the outside market. Otherwise, any burden for participating in the exchange is a disincentive for participants.

Key Verbatim Comments

- *"It's necessary to have marketing or informational materials that apply to different types of areas, such as after-hours meetings, lunch meetings, information packets, flyers that refer to a website, and personal representatives."*
- *"It's important to have a network or partnership between local chamber and agents to reach out to small businesses in all areas of the state."*
- *"In order for the health exchange to be successful, it needs to offer a quality product; it needs to offer the services people want."*
- *The health exchange can leverage local chambers by helping to inform and register its members."*

Notes

What are the challenges of informing small businesses about the health exchange?
The key is the availability of information about the program. Small businesses do not have an HR department aimed at informing its employees about insurance. The small business owners do not have time to learn the details of the insurance plan and inform their employees. The information needs to be understandable and available. I believe agents, consultants, or brokers can fill the HR roll.

The system of providers, brokers, and clients is already in place and functional – and should be utilized. However, brokers would only be useful toward small businesses that are already insured. For the uninsured small businesses, there would need to be a broader form of publicity.

Many of our current members were uninsured before signing up with us. Not only is it important to include the Chamber in the program but also state agencies, because they have the information on all statewide businesses.

What are the challenges in covering businesses and individuals in extremely rural areas?
It is important to have a network or partnership between local chambers and agents to reach out to small businesses in all areas of the state. We have noticed that annual informative events that pertain to health care are an effective method of communicating with those in rural areas. Additionally, participants in the events are more attentive when a reliable and knowledgeable representative gives the information.

Is a website an effective medium for informing small businesses on health care in rural areas?
It is necessary to have marketing or informational materials that apply to different types of areas, such as after-hours meetings, lunch meetings, information packets, flyers that refer to a website, and personal representatives. Agents are perfect for rural areas because they can easily integrate into communities and inform members on all matters, regardless of the mediums in place.

What are the primary health care obstacles a small business faces?
The total, long-term cost is always the major factor. I believe special discounts aimed at small businesses, such as a small business tax-credit or a tobacco-free subsidy, would make a health insurance program more attractive.

What value do small businesses place on health insurance?
Health insurance is tied in with the highest priority of a company. A company's top priority is its product. Quality products are produced through the employment of skilled individuals, and to retain skilled individuals an employer must provide quality benefits (i.e. health care).

What are some effective methods for increasing participation rates within the health exchange?
If insurance agents/brokers are given an incentive, they will be more apt to participate within the exchange. The health exchange can leverage local chambers by helping to inform and register its members – the chamber can present the exchange as a selling point, in addition to what they already offer.

I believe insurance agents/brokers would be more effective than local chambers in helping to increase participation – primarily because they would be more informed about the needs of clients and the different programs within the exchange.

How would employees react to a defined contribution plan?
In order for the health exchange to be successful, it needs to offer a quality product; it needs to offer the services people want. At a minimum, it should cover the basic coverage that employees receive with their current health plan. If people are denied coverage by a provider, and are pushed toward the health exchange, you do not want them to be pushed into buying a bad product. For people with serious ailments, the insurance offered by their employer is more important than their salary. They will not continue to work for a company that forgoes quality health care coverage.

I believe it is essential to require all employees to be part of the same package. If the healthier employees decide not to participate because they do not foresee a need for obtaining coverage, the plan will fall through for everyone, especially those with serious ailments.

How do we emphasize the broker's role in the health exchange?
We need to focus educational resources toward the broker rather than small business. For every 10 businesses there is a brokers. Educating brokers would essentially be a lot cheaper for the state. The

broker should capitalize on the role of educating employers and their employees. The process should be relatively simple since the relationship between small businesses and brokers is already in place.

Are there any special features you would like to see offered by the health exchange?
It is difficult because the insurance companies will raise the premiums on a group if it includes individuals that are shown to be high-risk. The majority of general health care costs are directed toward the chronically ill. Coverage needs to be provided to those with pre-existing conditions, but the situation gets complicated when you expand into groups with a variance in their members' quality of health. There has to be a balance between the people with pre-existing conditions and those who are healthy.

Business Organization Representative 5
3.30.2011 5:00 pm CST

Interview Summary

- The Federal government's Army Corps of Engineers is located near this city and provides such good health insurance that small businesses feel like they need to compete; however, it's hard for these businesses to provide anywhere near that quality of health insurance.

- Health insurance is a high priority for small businesses. With only 30 minutes notice, this individual was able to coordinate three people to attend our focus group meeting on Wednesday, March 30 in this city; thus illustrating the strong and close-knit business network.

- Mississippi has a strong network that can very quickly convey messages throughout the small business community regarding things that are of high importance.

Business Organization Representative 6
3.30.2011 5:00 pm CST

Interview Summary

- Mississippi has a great infrastructure for communicating with small businesses. Business leaders throughout the state are great examples of people who know many other business leaders. In fact, there was a distinct example experienced by one of the researchers in which the Vicksburg Chamber of Commerce scheduled three different business owners to attend a focus group meeting with only 30 minutes notice. They (small businesses) all know one another and can get a compelling message communicated to businesses throughout the state very quickly.

- While this person knows very little about the Mississippi health exchange, this person wants to ensure that whatever is built will be business-friendly and not remove the incentive for businesses to grow, innovate, and employ. We must work toward lowering the overall cost of health insurance.

- Health insurance is a significant burden on small businesses. They encounter high costs, minimum participation rates, and the unpredictability of constant change.

- Private enterprise is effectively tackling the issues that the health exchange is trying to solve for small businesses, such as the Chamber Plus plan implemented by the Jackson Chamber of Commerce.

- Researchers need to come to Wheatley, presenting the idea of the health exchange to a number of small businesses, and then meet with small business owners separately in focus groups that this and other organizations will help coordinate. Multiple business development/chamber leaders around the state would be willing to coordinate similar meetings.

Business Organization Representative 7
3.31.2011 9:00 am CST

Interview Summary

- When engineering the health exchange, the structure must be built from simplicity and flexibility. Employees need to have the ability to utilize health tools, such as a health savings account, to create an insurance plan that meets their needs.

- As an individual begins enrollment, each step taken must be informative and intuitive. Perhaps a fifth grade-level presentation would be the most effective medium to feature the information.

- Simplicity and choice will play a balancing act once the health exchange goes live. Both components must be watched and allocated as the exchange progresses. A high volume of options will result in inexperienced individuals becoming overwhelmed and not know what to select.

- The health exchange should adopt health assessment and financial management tools to mitigate complexity and assist in simplicity.

- Roughly 80% of small businesses have between three and five employees, with the majority being uninsured.

- There are true technology challenges in the State of Mississippi. A large portion of the population has limited access to a computer and or the Internet. Mechanisms need to be put in place to cater to the digitally disabled.

- It will be beneficial to both employers and employees to implement a defined contribution approach, so long as there is sufficient information available to make the process intuitive. Furthermore, empowering part-time employees with the ability to pool health benefits from various jobs would help give them access to affordable health care.

- Small businesses perceive the structure of a health exchange to be complex and unmoving until the concept is depicted in visual form. It is recommended that exchange advocates approach community meetings to present the proposed structure of the exchange, in a visual form, to small businesses.

Key Verbatim Comments

- *"Small businesses are the most uninsured category in Mississippi; roughly, 80% of small businesses have between three and five employees."*
- *"Large shares of Mississippians are not technology savvy; furthermore, many are without a computer and Internet access."*
- *"From an administrative standpoint, the exchange needs to act as a payment facilitator..."*
- *"Those engineering the health exchange must understand that individuals have a limited comprehension of health insurance."*
- *"The notion of an exchange is so abstract until people are able to visualize what it is going to look like."*

Notes

What are the demographics of small businesses in Mississippi?
Small businesses are the most uninsured category in Mississippi; roughly, 80% of small businesses have between three and five employees and definitely less than ten (when including some part-time employees). The majority of these employees are without health insurance, with no intention of obtaining insurance in the near future.

The State of Mississippi has two business audiences – those who do not intend to obtain health insurance, and those who currently offer or want to offer health insurance to their employees.

What are the technological challenges that Mississippi faces?
Large shares of Mississippians are not technology savvy; furthermore, many are without a computer and Internet access. These individuals will rely on a local agent or someone in the community that can assist them. It would also be helpful if the state implemented a mechanism (e.g. local offices or traveling mobiles that can facilitate enrollment and education).

How should the health plans be packaged in the health exchange?
They need to be packaged in terms of affordability. Their presentation should be presented in a side-by-side comparison, allowing me to compare benefits and prices.

What are your opinions toward a defined contribution plan?
I am in favor of the health exchange implementing such a program. Stipulations should be enacted that allow employers to offer separate defined contribution toward full-time and part-time employees.

From an administrative standpoint, the exchange needs to act as a payment facilitator; in the fact that employers pay the exchange a single check for all employees and distributes the funds to the necessary carriers.

Furthermore, I would like to see part-time employees have the ability to pool their benefits from various employers into a single plan, similar to the Utah Aggregation Benefits Program

What must the health exchange have in order to succeed?
First, it would need to be flexible. Employees should be allowed to couple a health saving account with their high deductible health plans to offset future costs.

Second, it will need to be simplistic. Those engineering the health exchange must understand that individuals have a limited comprehension of health insurance. All public information should be presented at a fifth grade level, includes features such as illustrations and applicable examples.

How do we mange choice within the health exchange?
When we manage choice, it must be structured around the concept of simplicity. I suggest offering health assessment tools, financial tools, and illustrations regarding what the options are. The process of deciding should not only be simple, but also informative.

How do we inform the public of the health exchange?
The notion of an exchange is so abstract until people are able to visualize what it is going to look like. It would be helpful to present the structure of the exchange, as is proposed, to the business community. I would capitalize on Chambers of Commerce, contractor associations, NFIB, and Rotary meetings to present the information.

Health Care Provider Representative 1
3.31.2011 9:00 am CST

Interview Summary

- Nurse practitioners have the potential to be a key piece in the state's public outreach program. Nurses will be a great channel for not just the small business exchange, but also the individual exchange.

- The foundation of the health exchange should be simple and user-friendly. When engineering the exchange the notion of simplicity should be reverberated by the use of limited health plans. Too many choices would only increase the complexity and resentment toward the exchange.

- In addition to being user-friendly, other variables may affect the participation rate in the exchange. Such variables are premium costs and the availability of benefits.

- Much of the rural population has a negative connotation toward the health exchange. For that reason, the exchange must be branded in a way that separates it from the state and federal government.

- The exchange should focus its educational outreach program through local chambers, industry groups, and not-for-profit organizations.

Key Verbatim Comments

- *"The population's dislike for a health exchange runs parallel with their limited understanding of what an exchange is."*
- *"The exchange will need to educate the population, not just about what the exchange is, but how it can economically benefit their lives."*
- *"The quantity of health plans should be limited; too many choices would dissuade people from making a choice at all."*

Notes

What do you believe are the largest challenges in creating a successful health exchange?
Thus far, the largest challenge has been the surrounding politics of the exchange (e.g. who will be serving on the Board of Directors). I believe the largest challenge has yet to come, and that is getting individuals used to the idea of obtaining insurance through an exchange.

What challenges do the rural regions of Mississippi present?
For the most part, they lack the expertise to analyze and compare the available health options. Moreover, a vast majority of the population distrusts government, state, and local agencies.

The population's dislike for a health exchange runs parallel with their limited understanding of what an exchange is. To overcome this negative connotation, there must be active outreach programs to education the rural and urban populations.

What mediums will be the most effective for educating the public?
I believe primary care providers and nurse practitioners will be an effective medium to use. If the state allocates resources toward educating nurse practitioners, they will promote it. The state can leverage the Mississippi Nursing Association to help educate nurses about the structure and benefits of the exchange.

What are the potential problems with the health exchange?
Currently, the health exchange is focusing on how it will affect potential enrollees, rather than paying attention to its legislation. The exchange will need to educate the population, not just about what the exchange is, but how it can economically benefit their lives.

What is the Mississippi insurance network like?
There are few insurance carriers in Mississippi. Furthermore, there are several counties that lack a single doctor; and without nurse practitioners, that county would not have any care. Mississippi does not have enough primary care providers to address all of the needs of the state.

Would the Public Development & Planning District be a viable channel for educating nurses?
Yes. The association would be a great channel for educating nurses. Additionally, nurses have always been a great way to disseminate health education to the public.

How can we increase participation in the health exchange?
Participation rates will depend on costs, benefits, and ease of use. The quantity of health plans should be limited; too many choices would dissuade people from making a choice at all.

Is there anything else you would wish to add?
If you want to be successful, you need to have nurses involved in the pre and post implementation process. If the goal is design a system that is user-friendly, then this is the group to do it.

Broker Representative 1
4.7.2011 10:00 am CST

Interview Summary

- Education is the largest barrier to implementing the exchange. New ideas and concepts garner strong resistance. Countering such resistance is possible through progressive educational outreaches.

- The best way to educate the public, in high volumes, is through active state and municipal outreach campaigns. Mississippi conducted the Wind Pool Program through traditional media as well as town hall meetings.

- Employers must see a clear economic reason to join the exchange. The exchange must emphasize its ability to help employers attract and retain employees.

- The most challenging issue will be attaining/maintain high participation rates.

Key Verbatim Comments

- *"We find this, repeatedly, in any new program that getting the knowledge out to be the most difficult."*
- *"From my experience, it is simple to assume that the general population understands something, when in fact they do not."*
- *"If you are reaching out to small employers they will come, but you have to find a way to reach them and explain it to them."*

Notes

What challenges do you think we are going to have for the health exchange?
Education. Typically, with anything that is new you are going to have resistance at different places because people do not understand it. Following this, the exchange is going to have to conduct an active education process. We find this, repeatedly, in any new program that getting the knowledge out to be the most difficult.

One of the concerns with in Mississippi is the rural population. Do you know of some effective solutions that others have employed to get into the rural area?
The simplest solution is meetings, actually going to the region. First, figure out your resources, and then whom you are targeting so you can conduct proper meetings.

From my experience, it is simple to assume that the general population understands something, when in fact they do not. As a precaution, I tend to overeducate those I am trying to inform. In Mississippi, it is largely rural and under educated in many ways.

There are many profitable businesses in Mississippi, but that does not make them sophisticated about health care. For example, I have someone who cuts my trees (he does a great job) but I do not think he is sophisticated about this topic. Largely, these individuals learn via oral and audio mediums, not so much via paperwork. What we did with the Wind Pool Program was schedule meeting that reached our constituencies. We did this by giving out notice and finding out who the drivers were.

How did you target and reach out to the wind pool group?
We were meeting in local county meeting rooms, as well as small municipal meeting rooms – wherever anyone would be. We found our target group via this process. However, we still needed to reach out to contractors and code enforcement personal. We had to retrain our agents about the role they will play.

Additionally, we ran news ads that advertised where and when our meetings would be. If you are reaching out to small employers they will come, but you have to find a way to reach them and explain it to them.

How do we small businesses to offer benefits if the exchange is not driven by costs?
You need to focus on the notion that benefits enable the employer to hire and retain quality employees. The company saves money via two ways. First, quality employees are more productive and thus generate more income. Second, employee retention rates are higher. Employers spend less time training new employees, which is expensive and time consuming.

When you do not have the right set of cards (i.e. subsidies, Medicaid, etc), health coverage is outrageous. However, when you are looking for employees, health benefits are a competitive advantage.

What is the one thing the exchange needs to have or do to be successful?
It seems to me that the exchange has two audiences; (1) a group that does not provide insurance and (2) a group that struggles with insurance, but would do better participating in the exchange. As I see it, this type of program [health exchange] will only succeed through a high volume of participation. That being said, the trouble will be in attaining members.

Broker Representatives 2 and 3
3.30.2011 12:00 pm CST

Interview Summary

- On average, small business employers do not have the time to deal with insurers; therefore, they depend on local brokers to mitigate their responsibility.

- The greatest challenges to increasing participation in the exchange will be controlling price, developing a participation process built on simplicity, and creating a solid customer service foundation.

- A growing concern, built on the notion that employees will choose their own health plan, is that they will gravitate toward the cheapest plan without understanding its benefits. When questions or concerns arise, the concern is that they will go back to the employer and the employer will turn to the broker. Brokers do not have enough resources to help each person individually.

- The health exchange needs to offer a limited number of health plans (four or five). Too many plans will result in confusion; therefore, the Medicare Supplement may be a good model.

- Thus far, the response from brokers toward the exchange is fear. When proven that the exchange will make the brokers lives easier, they will be more accepting of it.

- Mississippi is a rural area in terms of computer literacy and provider networks. The options available to individuals may be limited because of the rural nature of the state.

Key Verbatim Comments

- *"If you take somebody to the exchange, and they find that the coverage is not comparable or the price is more than what they are currently paying - then you're going to have trouble increasing participation."*
- *"There's going to be a litany of questions and uncertainties...because someone has chosen a health plan they knew little about, simply because it costs them less than another option."*
- *"Everybody loves to have choices, but you don't want to have too many choices."*
- *"If the health exchange ends up being a going thing, brokers will settle in pretty quickly."*

Notes

How should brokers be compensated in the health exchange for it to be worth their time?
It depends on how much time consumption the exchange places on brokers. Currently, our brokers are paid on a per-contract-per-month or per-employee-per-month basis, rather than a percentage. The large providers pay brokers on a capitation basis, for continuance of ease, brokers should be paid per-contract as they are now.

What challenges do you foresee in acquiring a sufficient rate of participation in the small group exchange?
The price and quality of health coverage should be comparable to that of conventional health insurance. Individuals who are covered under the exchange must have an understanding of how they are going to pay for coverage.

Several individuals will qualify for subsidies or social programs; a facilitator must be in place to act as a guide. Brokers may have a limited understanding of the exchange's subsidies and programs, so there

would need to be an alternative group to occupy this role. However, if brokers were to provide this education, they need to be compensated for it or they will lack the necessary incentive.

What is your prediction of the successes and failures of a defined contribution plan?
Currently in Mississippi, about 90 percent of employers use a defined contribution approach. They pay a fixed amount or percentage, and the employees primarily cover any premium increases, which has caused a decrease in participation.

In the current situation, the role of the broker is to present the different insurance options. The main fault of allowing people to choose their own health plan is that they choose the plan with the lowest premium, without understanding the details of the plan's coverage. When the employee begins to see that their plan does not cover what they need, they complain to the employer, who then eventually complains to the broker. Increasing the variety of plans offered will increase the frequency of this dissatisfaction.

What should the health exchange do to make participation easier for brokers and the people who want to enroll?
The plan options should be as similar to each other as possible, and there should be a limited number of plans offered. This will make plans easier to understand and easier to compare. Ideally, only four to five plans should be offered, and plans should be as similar as possible, so that it is simple for the consumer to compare prices. The brokers and consumers need to know sufficient details, not just about the price and benefits but also about the network options before they enroll, so that they know which doctors and facilities are available with each option. People often consider the price of the plan to be the primary factor in their choice and benefits secondary, and overlook the network options entirely. Consumers need sufficient guidance so that they do not make this mistake.

How important is face-to-face interaction, compared to providing a user-friendly website in gaining participation in the health exchange?
Mississippi is very rural. A large segment of individuals has limited access to a computer. In this state, face-to-face interaction is an absolute necessity.

How important will the role of the broker be to the health exchange?
Brokers need to have their perspective considered in all major decisions and actions, and they need fair compensation for their efforts.

Small businesses are not required to provide insurance, they are generally less informed about health care, and often have less time to devote to administrative tasks. Brokers are the individuals who assist and facilitate the enrollment of small businesses.

What attitude do you expect brokers to have toward the health exchange?
Brokers will initially feel apprehensive and possibly even obstinate toward the exchange; however, if it benefits them without too much difficulty, they will immediately support it.

What do you believe conventional health care providers expect from brokers in the future?
The health insurance companies seem to have decreased their infrastructure, and now have an increased dependence on brokers to maintain and increase their membership. There seems to be a lot of uncertainty about how there are going to determine "risk" with regard to those who have been previously uninsured.

Broker Representative 4
3.31.2011 2:00 pm CST

Interview Summary

- Small business participation rates will depend on administrative qualities, predictable and moderated prices, subsidies and incentives, and creative enrollment mechanisms like a defined contribution plan.
- Simplicity should be reiterated through limited choice. Allowing few carriers to participate will result in few plans, thus reducing possible complexities in the future.
- Brokersshould be leveraged and not disregarded. Allocate resources toward educating the broker population. These individuals already have a keen understanding and relationship with the business community, which they can draw on to spur participation.
- If brokers are utilized, the State of Mississippi should adopt a compensation package similar to that of Utah.
- Apply caution when associating the exchange with entitlement programs. There is a risk that the population will begin to view the exchange negatively.
- To avoid bureaucratic redundancies and bottlenecked services, the exchange should avoid being run by a government agency and limit legislative involvement.

Key Verbatim Comments

- *"The particulars of a small group exchange, in terms of the quantity and diversity of options offered, will be subjective to what can be realistically administered."*
- *"Brokers are the existent, functioning infrastructure of insurance distribution."*
- *"The concept that the public seems to be most ignorant of is that health care costs money, and that money has to come from somewhere or someone."*
- *"Many people are eager to get health care they can afford; they are just uninformed of the process and the details of qualified plans/programs."*

Notes

What do you think are the primary challenges of instituting a health exchange in Mississippi?
Knowledge; there needs to be sufficient education on all levels, from the public to the legislature. The health exchange initiative makes individuals uncomfortable, for they believe it represents a transition to socialized medicine.

What problems do you foresee in offering health insurance to small businesses via the health exchange?
Administration will be the primary issue. The particulars of a small group exchange, in terms of the quantity and diversity of options offered, will be subjective to what can be realistically administered. Regardless of the quality or affordability of a plan, the administration is the major facet in the success of the program.

Moreover, the exchange will need to be practical and functional for the small businesses to participate, and that functionality will depend on its administration. The exchange will need manage the billing, subsidies, and invoices, which are all administrative tasks. A decision needs to be madeas to whether the exchange itself will administer the task, or whether it will contract to a third party.

Is a defined contribution plan a viable model for the health exchange?
The difficult aspect to this model is that once the employer decides upon the defined amount, the employee is responsible for his or her plan. The concern is that the state will allocate additional resources to educate employees of their options, resulting in further costs.

Another problem with the model is that it requires the employee to contribute a portion of the cost for their coverage, and many individuals are resistant to paying any amount for health insurance. The public has no frame of reference for the cost of health care, so they view relatively small premiums to be unreasonably high.

There needs to be a drastic increase in the transparency of health care, especially about the cost of services. The public seems to be ignorant that health care costs money and that money has to come from somewhere or someone.

How much of a problem are health care costs to small business employers?
They consider it a major problem. Their primary expenditure is their payroll, and health benefits are a large part of that payroll. As a general estimation, health insurance accounts for roughly ten percent of an employer's payroll costs. When the cost of health plans increase, employers compensate by distributing smaller pay raises to their employees.

How will brokers react to the health exchange?
Brokers are unacquainted with the logistics of the exchange (i.e. the role they will play); however, they are essential for its success. Without the cooperation of insurance brokers, the exchange will fail. Brokers are the existent, functioning infrastructure of insurance distribution.

The combination of a website and a call center would not provide sufficient education to the majority of the public. Face-to-face education and guidance is an absolute necessity, which will be the role of a broker.

How can the health exchange benefit small businesses?
The exchange must offer health insurance at a competitive price or people will not enroll. For the exchange to present plans at a low cost, a diverse group of members must be maintained. If the more healthy individuals realize they can attain cheaper insurance outside of their group, they will, and the price of the plans will increase.

What are the most effective channels for educating the public about the health exchange?
Many individuals are eager to obtain health care they can afford; they are just uninformed of the process and the details of qualified plans/programs. I believe, currently, brokers are the only persons prepared to offer this information.

The Chambers of Commerce and other business organizations do not understand the complexities of the system adequately enough to be an effective channel. A significant obstacle in educating the public of these programs is distrust, which is the result of ignorance.

Not only are the brokers informed about the market, but also they are already trusted members of the community. Moreover, brokers currently play the role of an informer and enroller of insurance plans.

What security risks would be involved with the health exchange, and how does the exchange safeguard these issues?
Identity theft is the primary risk. Brokers need to be educated and trained or fraud will occur.

How can the health exchange enroll small groups as quickly as possible?
It is necessary for the price of health plans to be competitive with those offered in the outside market. The administration has to be efficient, in comparison to conventional providers. The defined contribution model would be effective in attracting employers. The problem with this is a matter of who will guide the employees in their chosen health plans.

What will be the primary difficulty with the health exchange?
The inefficiencies inherent in any state administered program. The administration will be less efficient than that of the private health insurance companies. Its administrative procedures will be more complicated and will take more time, so its service will be less competitive with the conventional health insurance market.

Broker Representative 5
3.30.2011 1:00 pm CST

Executive Summary

- The exchange should ensure maximum flexibility for the consumer. The consumer must be able to select the plan that is most appropriate to his or her needs, and not be limited to a metallic band/carrier that is selected by his or her employer. Consumers should have the ability to access the exchange via a broker or the Internet. Furthermore, the consumer should have the option to approach the market in any way he or she prefers, whether through the exchange or the outside market. The exchange should supplement, not replace, the other channels for obtaining health insurance. This will maximize competitiveness and ensure greater innovation in the industry.

- Brokers will be vital to the success of the health exchange. Insurance is hard to understand and the role of a broker will be to simplify it for exchange participants. Moreover, brokers are in every populated county in Mississippi, and therefore will be able to improve the traction of the exchange once online. The vast majority of individuals that enter the health insurance market do so through the help of a broker/agent. The exchange will want to create a conducive environment to get agents anxiously engaged. To increase the success of the exchange, the exchange should provide seminars and continued training for agents that includes at least the following:
    - The pro's and con's of the exchange
    - When to work inside of the exchange and when to work outside of the exchange
    - How to navigate the exchange
    - How they are compensated in the exchange

- There is skepticism surrounding the health exchange, whether the impact and success of the exchange will truly be a "game changer" in improving the manner in which health insurance is delivered. Obtaining health insurance is more about expense than it is about access; small businesses are not offering health insurance because it is prohibitively expensive. Unless the exchange lowers the cost of insurance it will not have the impact needed. The ideal would be lowering the overall cost of health insurance, which will be the greatest help to small businesses (and everyone else in Mississippi).

- Effective outreach will be a critical component of the health exchange's success. It has been suggested that networking efforts are much more effective than mass marketing. A few networks that could be leveraged are:
    - Chamber of Commerce
    - Trade Associations
    - Realtor Associations
    - Economic Development Corp
    - Other trade associations

Key Verbatim Comments

- *"They [small businesses] are dropping insurance because of the expense of health care, not due to lack of access."*
- *"The exchange needs to be a supplement to the current channels for health insurance delivery."*
- *"The health plan options need to be kept to a minimum."*
- *"This [defined contribution plan] would be a very compelling model."*
- *"In general, people need an expert to tell them what they need and do not need."*

Notes

If you were building a health exchange, what components would you include to ensure its success?
I would ensure policies that prevented the exchange from being overly destructive to the private market. The exchange needs to be a supplement to the current channels for health insurance delivery. Furthermore, it should provide maximum flexibility for the consumer, giving him or her the option of registering via the Internet or a broker (comparable to that of automobile insurance).

What are your thoughts on the health exchange?
I am a skeptic surrounding the success of the health exchange. I am unsure whether its implementation will truly be a game changer for the health insurance market. However, if the exchange gives another outlet there is certainly no harm done, so long as it does not crowd out important pre-existing channels.

Why are small businesses not providing health insurance to their employees?
They are dropping insurance because of the expense of health care. Additionally, I would say the general complexity of insurance is another issue.

What would be necessary for employers to offer health insurance to their employees?
We first need to figure out a way to lower the costs of health insurance. There might be some administrative burdens to help alleviate, but I do not really know.

How could the health exchange be made simple?
Health plan options need to be kept to a minimum. If this is not a viable option, a mechanism needs to be created to allow the individual to sort by factors that directly relate to their needs and wants.

What are your thoughts on a defined contribution plan?
This approach actually happens now, and very frequently. This would be a very compelling model.

What role would brokers play?
In Mississippi, we have many worker compensation pools. Many of them began with little to no broker/agent participation. However, as time went on and program complexity became an issue, brokers/agents began to play a larger role. In general, people need an expert to tell them what they need and do not need.

How should the exchange's outreach be applied?
Part of the outreach will certainly be through engaging brokers/agents. The vast majority of people who enter the exchange will do so through the help of a broker/agent. That being said, you will want to have seminars for agents that educate on how to use the exchange and how they are compensated within the exchange. Overall, you would want to create a conducive environment to get agents anxiously engaged.

Furthermore, use associations (e.g. trade associations, restaurant associations, manufacturer associations) as an outreach channel. In my experience, networking efforts are much more effective than mass marketing. I suggest networking through the following channels:

- Chamber of Commerce
- Trade Associations
- Realtor Associations
- Economic Development Corporation

Broker Representative 6
3.31.2011 9:30 am CST

Interview Summary

- If navigators are to facilitate small business enrollment, they should undergo a certification that is equal to that of a broker certification. In addition, existing insurance brokers will need to have additional training on the exchange – how it works, and its benefits.

- Rural areas are going to pose a problem for the state in terms of marketing and enrolling. The rural population has limited access to the Internet. These individuals must be approached personally and the information presented must be as simple as possible.

- Insurance carriers are concerned about the potential adverse risk within the exchange pool. Some believe that without a carrier participation mandate, there will be no incentive to join.

- Broker compensation should be that a flat fee. If compensation is based on a percent of the premium, brokers will have an incentive to enroll individuals into more expensive plans.

Key Verbatim Comments

- *"We need to get the bones of the exchange passed through the legislature as soon as possible."*
- *"The state must allow the health exchange to be fertile enough to maintain and attract new insurance carriers."*
- *"Those who cannot access the information digitally, a palatable medium must be used (i.e. paperwork, to inform and educate)."*
- *"My concern is that they will be giving insurance advice without a license."*

Notes

What is the largest challenge in implementing the health exchange?
The largest challenge is political. We need to have the bones of the exchange passed through the legislature as soon as possible.

What is the largest challenge in the actual implementation of the health exchange?
Mississippi is a rural state; very few carriers offer insurance in these regions. The state must allow the health exchange to be fertile enough to maintain and attract new insurance carriers.

Moreover, the rural population has limited access to the Internet. Therefore, implementing a system designed around a digital framework will not function for everyone. The exchange will need to assist those without computer access, which is a large portion of the Mississippi, by offering "paper" enrollment.

How do we pass information to the rural areas of the state?
Information will need to be presented via face-to-face contact. Those who cannot access the information digitally, a palatable medium must be used (i.e. paperwork, to inform and educate).

How do we encourage participation among insurance agents in the health exchange?
The exchange must establish a competitive remuneration program to incentivize agents. In addition, the exchange must actively educate insurance agents about the exchange, its programs, and benefits for members.

How should we compensate brokers?
First, we should design the compensation so it rewards for increased participation. Second, the majority of insurance carriers have gone with a captivated arrangement, so the framework must mirror this.

What incentives do carriers have to participate in the health exchange?
In Mississippi, the largest carrier is BlueCross BlueShield. Currently, they do not have a basic plan that can go in the exchange. Furthermore, they have no incentive to offer a plan, unless it is mandated.

Additionally, there is too much adverse selection. Carriers are concerned about their reward and the risk that must be taken.

How do we educate the rural population, aside from brokers?
I do not know, perhaps a billboard. I would say churches, town hall meetings, and traditional marketing mediums.

What is your concern about the role of a navigator?
My concern is that they will be giving insurance advice without a license. I believe a navigator should undergo the same licensing as brokers.

Who should regulate the health exchange?
The federal government is putting forth the requirement, but I believe regulation will fall on the Department of Insurance (DOI).

I do not advocate for a separate state agency. Resources should be allocated toward an existing agency, and the DOI already has the means and resources to monitor and regulate the exchange.

What is your opinion of the Risk Pool Program?
I believe it is a great model for the country. It is successful, run conservatively, and works well with the market place.

Why don't more people participate in the Risk Pool Program?
Individuals do not participate because of a lack of access; it is more to do with affordability. Individuals do not want to pay the extra costs associated with obtaining insurance.

Gaming Industry Representative 1
3.30.2011 2:30 pm MST

Interview Summary

- With regard to the gaming industry and levels of health care coverage, this company offers a competitive benefits package (15 percent of the cost is covered by an employee). Those who do not enroll in coverage tend to fall into three categories:
  - Younger employees who tend to not want to pay for something they think they will not use.
  - Transient employees who do not work for the company very long; an employee profile seen more often in the gaming industry.
  - Married employees who are on a spouse's insurance plan.

- In particular, Mississippi employees tend to not sign up for, and to not use primary care physicians at a much higher rate than anywhere else. There is a high volume of emergency room visitation, even for routine medical situations. Even though co-pays are much higher in an ER ($20 normal office visit versus $150 for ER visit), employees in Mississippi still tend to use emergency room services at unusual levels.

- This company has tried to develop agreements with urgent care and quick care clinics, as an alternative to primary care physicians and as a more viable alternative to ER visits. This is a way to encourage employees to get urgent care that is needed but at a lower cost.

- The company is 100 percent self-insured, so cost and utilization ratios are extremely important. The company uses a large provider as an administrator and leverages the large provider network (with negotiated rates) as a cost control measure.

- The company offers one, and only one, bundled coverage plan, which includes health, vision, and dental. No unbundling of coverage is allowed. This has reduced coverage and administrative costs significantly.

- The exchange should offer simple plans that include health, vision, and dental coverage. As a business, the employee is not productive if they are healthy but their teeth hurt. Employees cannot unbundle coverage or individuals will simply go without coverage and pay a penalty when there is a problem.

- Keys to the success of the exchange will be to get the volume up and to make sure that there is as broad a network of providers as possible. Players in the exchange will only be successful if these factors are met, so the cost can be brought down for everyone.

Key Verbatim Comments

- *"In regard to a health care exchange, the average employee is not that sophisticated. They do not know the difference between a PPO, HMO, or something else."*
- *"We only offer one, bundled health care plan. Take it or leave it."*
- *"One reason that there are so many uninsured employees is that younger employees don't want to pay for something that they don't think they need or use."*
- *"We focus on the 'whole self', which is why we offer our bundled coverage with no option to unbundle the health/dental/vision plan."*

- *"The players in the exchange will only succeed if the state can bring the volume up so that the cost can come down for everyone."*

Notes

Why do some people not purchase insurance?
First, we have manyyoungindividuals that work in our casinos. Younger people tend to not want to pay for something (insurance) that they do not think they will need or use.

We also have many unskilled workers who tend to be transient in nature. Transient individuals are not looking too far out into the future and therefore opt to forego participation in our benefits program.

Another big reason people do not participate, and we know this from talking to our employees, is that they often have insurance through a spouse's program at another job. Sometimes a spouse's program offers something we do not. Therefore, the employee signs up with an alternative program.

What are some of the challenges that you have had in the past in providing health insurance in the State of Mississippi, as well as at other properties?
One of the things we see a lot of in Mississippi, and this is rather common within the state, is the tendency for employees to not have a primary care physician. They don't sign up for a primary care physician and will go directly to the Emergency Room when a wife or child gets sick—even with something fairly minor.

What is the cost difference for this type of care?
A standard office visit has a co-pay of $20. A visit to the emergency room has a co-pay of $150. Even though it is more expensive, they still just go to the emergency room. It is has been very surprising to see this in Mississippi. We still do not understand why this is the case.

Have you done anything to address this issue?
Yes. We noticed that in many areas there were urgent care clinics. We made it as easy and as cheap to visit one of these clinics as it was to visit a Primary Care MD. Emergency room visits cost us a lot of money. This will hopefully reduce the use of emergency rooms by our employees when there is not a serious medical ailments involved.

One issue in Vicksburg proper is that there are no urgent care clinics. Therefore, we are still searching for solutions in this region.

What cost issues have you had to deal with in administering your benefits programs in Mississippi?
Our basic measurement is focused on cost versus utilization. For example, you asked me why so many of our employees have not designated a primary care physician. We do not know all of the reasons. Nevertheless, it may be related to that fact that we make our program so simple.

We offer what we call a bundled health care plan. This means we offer one, and only one, health care plan to our employees. Take it or leave it!

Our plan also includes health coverage, dental coverage, and vision coverage. There is no unbundling. There are no other options.

The average person does not know the difference between an HMO, a PPO, or anything else. This means that we have significantly reduced the administrative costs and effort it takes during periods such as Open Enrollment.

What other considerations have you had in administering this health care program?
Another way we look at costs is through the size of the network. Many companies have different plans and options. Since we have opted for only one plan, we have to choose an administrator with a network that is as extensive as possible. This reduces the amount of out-of-network coverage. We need a network that has as many doctors in as many places – and has as many services as we can find. This helps us to keep the cost down.

What issues do you see specifically regarding the implementation of a health exchange in the State of Mississippi?
We only benefit from the health exchange if there is a broad network of physicians. We may or may not be in the exchange. However, any involvement we have as a company or through our employees would rely on as broad a network as possible to bring the costs down for everyone. Players in the exchange will only be successful if the state can get the volume up.

The other thought about the exchange would be about the breadth of coverage. We take a very broad approach with our bundled coverage. Our research suggests that someone can be healthy, but there are unable to perform if his or her teeth hurt. We focus on the "whole self," and this is why we offer our bundled coverage with no option to unbundle the health/dental/vision plan.

In addition, you cannot fragment the care. We found that if you unbundle coverage or fragment what you are doing, the employee would just go without and pay a penalty when they have a health problem. Sometimes this has an impact on the employer.

Beyond that, I do not really have any input. I will be curious to see what results. We intend to continue offering our plan until something concrete results with the exchange.

Gaming Industry Representative 2
4.6.2011 4:00 pm CST

Interview Summary

- When the health exchange begins its public outreach campaign, the negatives of the exchange must be address alongside the positives. The business community in Mississippi does not want to be misled.

- The underlying reason for offering health benefits is to retain and attract quality employees. This should be noted as a selling point when conducting the exchange's public outreach.

- A digital interface (i.e. a website), will not work as the primary enrollment facilitator for two reasons. First, a large percentage of the population is not informed enough to enroll without the assistance of a third party, (i.e. employers and brokers). Second, a significant portion of the public has a limited understanding/access to the Internet.

- Small businesses would be interested in the concept of a defined contribution plan, as long it was intuitive, simplistic, and was able to save the employer money.

Key Verbatim Comments

- *"The main concern with small businesses is cost; the exchange must offer something that will save money."*
- *"The younger typically take the high deductable, while those over the age of 30 take the lower."*
- *"They would not be unreceptive toward it [referring to a defined contribution plan]; they just need to be sold."*

Notes

Based on the benefits you offer, what are the largest challenges with the exchange?
The main concern with small businesses is cost; the exchange must offer something that will save money. This year, our rates went up significantly.

Mississippi is an unhealthy state; there are too many individuals with diabetes. The majority love to eat, which is having a direct effect on the cost of insurance. They exchange needs to help businesses save money, if not through cheaper insurance, than something else that does.

Who participates in your benefits program?
Well, we offer two plans – one high deductable and one low. The younger typically take the high deductable, while those over the age of 30 take the lower.

How much education needs to go in to helping employees pick plans?
During the orientation, we train and educate our employees on their health plan options. They are aware of what the contribution and benefits are going to be. However, many individuals opt to not put their kids on the program because the premium is too high; instead, they go through CHIP or Medicaid.

Should there be an online component?
I love the idea of going digital and think it is a great platform to use; however, I am not sure if it will work in Mississippi. The high school dropout rate in Mississippi is 40 percent. Not too long ago, I tried to obtain all of our employees email addresses to send them information regard their health care; the majority didn't have an email address, only 30 percent were able to give me one. The state is simply technologically challenged.

When you are enrolling employees in health care, do you simply tell them the information and allow them to do the rest?
We have them make the decision immediately. We walk them through the entire process. In six months, if they want to add or drop someone, then it is their responsibility.

Do you think an aggregated benefits approach would be beneficial to your part-employees?
If you are working for our company, you cannot work for another casino. Moreover, we pay very well and many decide to work full-time rather than part-time here and part-time somewhere else.

How do we get the business community involved?
Well, if the exchange will not lower the cost of insurance, it must offer something that will save me money, or I will not participate.

Would employers participate in a defined contribution plan, or would they be concerned about employees coming to them with many questions?
They would not be unreceptive toward it; they just need to be sold. If you tell me it is not going to save me money, it had better help me make everything else easy and accessible. It has to save me money in some way, or I am not going to be interested.

Section 5: Small Business and Broker Quads

Small Business and Broker Quads Introduction and Methodology: A successful health exchange requires the perspectives of many stakeholders. Legislators, consumer advocates, business organizations, insurance carriers, and policy analysis – all contributing key insights that assist in creating the exchange. However, the best-designed exchange is only effective if businesses and individuals use it. Accordingly, Leavitt Partners and Cicero Group have designed a research methodology that is heavily weighted toward those who will actually use the exchange. Phase I of the research plan was originally designed to focus on outside stakeholders, rather than potential exchange users. Phases II and III of the research focus primarily on seeking input from potential exchange users (e.g. including small businesses and brokers). However, researchers were able to conduct four mini-focus groups or "quads" with small business owners and health insurance brokers in Jackson and Vicksburg.

Given the early stage of the research, it was decided that quads with 4 to 5 individuals would allow researchers to dig deeply into the challenges of health insurance in Mississippi. Participants for the Jackson groups were recruited from online lists provided through OneSource while the Vicksburg group was primarily recruited by the Vicksburg-Warren County Chamber of Commerce. Participants were offered free dinner and a $150 honorarium for their participation. Leavitt Partners and Cicero Group asked participants to be cordially open and honest, even if comments reflective negatively on the State of Mississippi.

The following quads were conducted:

March 28th – Jackson – 4 Small business health care decision-makers (owners and business managers)
March 29th – Jackson – 5 Health insurance brokers
March 30th – Vicksburg – 5 Small business health care decision-makers (owners and business managers)
March 31st – Jackson – 4 Health insurance brokers

While the data from these reports is qualitative in nature, the themes were very consistent and aligned with interviews conducted with stakeholders throughout the state. Accordingly, it is believed that these groups and the 45+ stakeholder interviews conducted will become the building blocks for future Mississippi exchange research.

Aggregated Executive Summary

- **Fear and Uncertainty Caused by ObamaCare**: Small business and broker participants expressed great uncertainty and fear regarding federal health insurance reform. Although government intrusion will be looked at skeptically, it will be more accepted when presented from a state or local level.

- **An Exchange Built by Mississippians, for Mississippians**: All small business and broker participants agreed that the exchange should be designed by Mississippians, for Mississippians.

- **Small Business Health Care Challenges**: The major health care challenges for small businesses include costs, administrative burden, poor participation rates, and a feeling that employees do not fully appreciate the benefits employers offer.

- **Simplicity:** Exchanges and insurance are complicated concepts. The simplicity of physically and intellectually accessing the exchange will determine its success. Consider a solution that offers a basic plan and allows individuals to add-on aspects they may need or want (e.g. maternity, dental, vision, psychiatric, prescription, prosthesis, etc). The system will have to serve the needs of rural individuals and those who are not computer literate.

- **Accessing the Exchange**: Small business and broker groups suggested that an online exchange (as the sole access port) is unrealistic. The exchange should be accessible by computer, phone, and in-person.

- **Carrier Participation**: Seek for broad carrier participation, but limit the number of plans they may offer in the exchange. Having too few of carriers in the exchange could lead to "chicanery."

- **Number of Standardized Plans**: Limit the number of plans offered to three to four benefit plans. The benefit plans will range from a high deductable, low premium plan with an HSA to a low deductable, high premium plan. Plans should be the same for all carriers. Therefore, carriers will compete on price, service, and network.

- **Education and Enrollment**: Mississippians will need to be educated about the exchange and insurance. Education will likely need to come from in-person meetings. Additionally, there is strong agreement that education is not enough to increase participation. Mississippians will need assistance enrolling in the program.

- **Outreach and Marketing**: Mississippi has strong, existing networks that can be leveraged to help inform the public and business community of the exchange. In addition to traditional media, the state should use faith-based organizations, business organizations, schools, providers (e.g. nurses and doctors), and brokers as an outreach medium.

- **Broker Participation**: Brokers are critical to the success of the exchange. Broker commissions should be standardized so there is no incentive to enroll participants in specific carriers or plans. "You should never have a financial incentive to steer the client." "If there is an incentive, there is larceny in the heart." Brokers should be trained to navigate the exchange and all navigators must become certified as an agent to participate in selling in the exchange.

- **Branding the Exchange**: The exchange should not be associated with entitlements or Medicaid. The exchange should be viewed as an economic development tool, one that helps businesses attract and retain employees. The ability to offer benefits to part-time employees, portability of plans, and

defined contributions are attractive to employers and employees. Consider calling the exchange the "Magnolia Plan," "Magnolia Solution," "Health Outlet," "Medimall," or "Health marketplace."

- **Employer Exchange Options:** Follow the defined contribution model. Defined contributions offer employers and employees flexibility. Part-time employers should be able to aggregate benefits from multiple jobs. Aggregating part-time benefits also helps employers attract and retain quality part-time employees using the high-risk pool as a model for regulating the exchange. The exchange should be regulated by the Mississippi Insurance Department with oversight from a diverse group of stakeholders.

Broker Groups

Executive Summary – Broker Quads – Jackson – 3.29.2011

- **Exchange design**: This should be an exchange built by Mississippians. A portion of the exchange will be online. Small businesses and employees will need one-on-one assistance navigating the exchange and enrolling in a plan.

- **Plan design:** Limit the number of plans offered to three benefit plans. The benefit plans will range from a high deductable low premium plan with an HSA to a low deductable, high premium plan. Plans should be the same for all carriers. Carriers will compete on price, service, and network.

- **Outreach and marketing**: Use Mississippi's existing networks to spread the word about the exchange. In addition to traditional media, use small business organizations and brokers. Many people will need the face-to-face interaction.

- **Broker participation**: Brokers need financial incentive to participate in the exchange. The lower the commission, the lower the quality of broker advice that will be given. Brokers working in the rural areas will need to be given larger commissions than those in urban areas.

- **Employer participation**: While a defined contribution plan is recommended, brokers agree that this approach could increase the administrative burden on brokers. Encourage small business participation by offering less expensive plans.

Key Verbatim Comments:

- *"Explain what you mean by exchange."* (the concept of an exchange is difficult to understand) – All participants
- *"It has to be easily understandable; the intricate details of health insurance are difficult even for brokers to understand."*– Steve
- *"The exchange could put brokers out of business."*– Kurt
- *"People in rural areas are not going to sign up for the exchange – most people won't even sign up for Medicaid if they don't have a case worker walking them through the process."*– Clarence
- *"The fewer the better – keep it as simple as possible."*– Nita

Notes

How would you build an optimal exchange?

- Explain to me what you mean by exchange – All participants

Explain to me what you think a health insurance exchange means.

- From what I have read from the national news,it is a one-stop shop for health insurance. Consumers choose what they can afford and what they want based on their medical needs. It promotes consumer choice. – Nita
- People will be required to purchase insurance if they currently do not have insurance. States are going to have to comply with the new law by 2014. Brokers should be involved in the process but I am not sure they will be. Moreover, if brokers are involved, how will they be paid? – Kurt
- People will still have access to other insurance outside the exchange. I see the exchange as similar to the Part D Medicare program. The agent will still be very important in getting people enrolled. – Madeline

Where is this exchange?
- Online – Nita and Madeline

What is the objective of the exchange?
- The objective of the exchange is to get the uninsured insured. – Kurt
- If the objective of the exchange is to get the uninsured insured then why is the answer the exchange? Why will people all of sudden get smart and start getting insurance. I do not see it happening. – Clarence
- Consumers do not understand the process of selecting health insurance. – Steve
- If brokers are going to be involved then there has to be broker compensation – how are they going to pay for this system? – Nita
- I do not know that the exchange is going to solve any problems. – Kurt
- Currently 51 percent of the population does not have automobile insurance, and that is mandatory. The fine is $800 and people are willing to risk it. – Steve
- The exchange should be a place where people can choose insurance, but it has to be regulated. – Clarence
- Until you address costs of care, nothing is going to change. – Nita
- You have to stop people from only signing up for insurance when they need it. You cannot pay for a system like that. – Steve

Researcher: What I hear you say is that the exchange needs to compensate brokers, has to prevent people from jumping in, and jumping out of the market, needs to address affordability.
- It has to be easily understandable; the intricate details of health insurance are difficult even for brokers to understand. – Steve
- How can you make the exchange simple? Health care is so difficult to understand. – Madeline
- You have to find a way to get insurance for the uninsured. Some people would buy insurance, but they are unable to do so because of underwriting. – Kurt

Researcher: What I hear you say is that the exchange needs to take something complex and make it simple and user-friendly. It needs to be a mechanism that allows individuals to get insurance who could not otherwise get it.
- The idea of offering something online for consumes to pick without broker expertise is a detriment to the consumer. People will make the wrong choices. – Steve
- The exchange should be a place that employs people who can help walk others through the process of obtaining insurance. Many in Mississippi are not able to navigate online. – Kurt
- The exchange could put brokers out of business. – Kurt
- I am not panicking yet. I do not think brokers will be put out of the health insurance business because people will always have a need for assistance in understanding and selecting products. – Madeline

How do we encourage high participation rates in the exchange?

- Calling it an exchange is going to be a problem. People will think a lot of "exchanging" is going on and will not understand exactly what the service offers. – Nita
- Health marketplace is a better term. – Madeline
- People in rural areas are not going to sign up for the exchange – most people will not even sign up for Medicaid if they do not have a caseworker walking them through the process. – Clarence
- Brokers are essential to the entire process. – Madeline
- Medicaid enrollment is difficult; people do not even finish the application. – Steve

Should caseworkers or brokers be used to enroll people in the exchange?

- Brokers will have to make money. – Steve
- If brokers have to go out and make house calls then the cost is going to be very expensive. It will be so time consuming. – Nita
- If they want people to sign up, they are going to have to hold their hand to sign them up. It will have to be very attractive financially to a broker to help sign them up. – Clarence

What will make it easier for brokers to go out and get people into the exchange?

- It will be more interesting to help individuals because now they can actually get coverage. – Kurt
- Are we going to be paid commission on the subsidies? – Kurt
- Brokers get a flat fee for enrolling people in the high-risk pool. It is not an attractive option because it is a one-time $100 fee. We mostly do this as a favor to clients. – All participants

What will be the role of brokers in a small business exchange?

- Employers will need help comparing plans. – Nita
- People will still want help deciding on plans. Clarence

What if brokers received a fixed fee per month per head (no matter what employee chooses), for each small business enrolled in the exchange?

- The less the broker is paid the less they are going to work and the more risk that will occur due to poor consumer choices. – Nita

Absent the exchange, will anything change in the broker/carrier relationship?

- BlueCross BlueShield has already cut payments to brokers. That may continue. – Madeline
- I think BlueCross BlueShield will follow Alabama BlueCross BlueShield and cut out the broker, and it sounds like the exchange could do the same thing. – Nita

How many plans should be included in the exchange? How you can couple competition and simplicity?

- The fewer the better – keep it as simple as possible. – Nita
- In order for the exchange to have any success, it needs to have few plans. People cannot understand a montage of plans. With multiple plans, the success will be zero. – Clarence
- Three plans: good, better, best.– Steve
- The exchange should have an incentive to get the healthy to join. – Clarence
- Three plans:
  - Silver: HDHP $2500 individual, $5000 family

- Gold: middle of road plan, high deductible – but pays for doctor visits and diagnosis - $1000 individual, $1500 family, co-pays $15/25
- Platinum: $250 for individuals, $500 for families, low co-pay – Madeline

Should the exchange offer multiple plans or offer the same plans and just different networks?

- The exchange really needs simplicity. Anything you add that create more decision making is going to create more problems. – Clarence
- This is like Medicare Supplements: each company can make up any design they wanted. There were many different plans, but they realized there were too many. So plans were standardized and reduced to ten and then to five. – Madeline

Is five plans enough for the population not on Medicare?

- Five is too many for rural areas. – All participants

What do you think of defined contribution plans?

- Yes. Many would do that in a heartbeat. Employers do not want to be the go-to person. – All participants
- There would be problems, but it would take the employer out of the loop. However, defined contribution will create more problems in the long run. – All participants
- How are brokers going to handle the increased workload? – All participants

Executive Summary – Broker Quads – Jackson – 3.31.2011

- **State versus federal design:** The exchange needs to be designed by Mississippians, for Mississippians. The purpose of the exchange should be to help small businesses get access to health care.

- **Broad carrier participation**: Seek for broad carrier participation, but limit the number of plans they can offer in the exchange. Having too few carriers in the exchange could lead to "chicanery."

- **Simplicity**: Every aspect of the exchange must be simple and user-friendly. Consider a solution that offers a basic plan and allows individuals to add-on aspects of insurance they may need (e.g. maternity, dental, vision, psychiatric, prescription, prosthesis, and so on). The system will have to serve the needs of rural individuals and those who are not computer literate. Insurance is complicated. In the words of one broker, "Do you know how many attorneys cannot navigate Medicare?"

- **Broker participation**:Brokers are critical to the success of the exchange. Broker commissions should be standardized so there is no incentive to enroll people in certain carriers or plans. "You should never have a financial incentive to steer the client." "If there is an incentive, there is larceny in the heart." Brokers should be trained to navigate the exchange and all navigators must become certified as an agent to participate in selling in the exchange.

- **Outreach and marketing**: Mississippi should leverage existing networks to market the exchange. These include business organizations, chambers of commerce, churches, and schools. Messaging needs to be catchy. Do not refer to ObamaCare. Consider calling the exchange the "Magnolia Plan," "Magnolia Solution," "Health Outlet," "Medimall," or "Health marketplace." We need to consider how Medicaid is incorporated into the exchange as it could negatively affect exchange acceptance.

- **Regulation**: Use the high-risk pool as a model for regulating the exchange. The exchange should be regulated by the Mississippi Insurance Department with oversight from governor appointed board of diverse industry and small business representatives.

- **Employer participation**: Follow the defined contribution model. Defined contribution offers employers and employees flexibility. Part-time employers should be able to pool benefits from multiple jobs. Pooling part-time benefits also helps employers attract and retain great part-time employees.

Key Verbatim Comments:

- *"We need as many carriers as possible, without competition you have all kinds of chicanery."* – Don
- *"Offering access will be difficult. Many Mississippians cannot go online to shop because they do not own a computer. Employers and agents should be there to assist these people. Additionally, insurance is complicated."* – Susan
- *"The requirements for helping others with insurance in the exchange have to be the same as the training for offering insurance inside the exchange. Those helping others need to be certified brokers."* – Robert
- *"You never want an agent to have a financial incentive to steer the client toward a particular carrier or plan. If there is an incentive there is larceny in the heart"* – Don
- *"Why not set regulation up like the risk pool. The state has oversight, but regulation and governance come from the insurance department."* – Gail

Notes:

What is your understanding of an exchange?

- Very complex, I see it like a mall, shopping for insurance. – Gail
- Complex on the inside, but it really needs to be simple to the consumer. – Susan
- If an exchange is ever going to work, it has to be technologically user-friendly. – Gail
- [An exchange] will likely cause challenges and more work for brokers. People will start seeing all the details of insurance and get confused. – Robert

Assume you are building the Mississippi health exchange. What would you include?

- The exchange has to be simple and user-friendly – Susan and Gail.
- It should have a lot of choices and carrier participants. BlueCross BlueShield will definitely need to be included because they have so much market share in Mississippi. – Susan
- We need to make sure carriers can strike a deal with those designing the exchange. All carriers should have a chance to participate. Definitely include BlueCross BlueShield, United Health Care, and Humana. – Robert
- We need as many carriers as possible, without competition, you have all kinds of chicanery. – Don

Why is BlueCross BlueShield so dominant in Mississippi?

- BlueCross BlueShield has a strong provider network – even in the rural areas. They also have some good products. – Robert
- They have been around for a long time. They have name recognition and a really great network. – Susan
- It is easy to file claims with BlueCross BlueShield and they have a reputation for paying claims. That's not to suggest other companies do not pay, but BlueCross BlueShield has a reputation for paying. – Gail
- They have a really great network and that has made the difference. – Don

BlueCross BlueShield does not currently offer high deductible health plans with HSAs in Mississippi. Why is that?

- The public does not understand the concept of HSAs so there really is no the demand for them. – Don
- Initially, it really did not make sense from a premium standpoint. Nevertheless, things are starting to change where an HSA may make more sense. – Susan

Should we have a state exchange or a federal exchange?

- Without a doubt, the exchange should be local to Mississippians. Our state is simply too different from the rest of the country. – All participants

What should be the purpose of the Mississippi exchange?

- The exchange should help small businesses and individuals gain access to insurance. – All participants
- Some groups in Mississippi need great assistance accessing health insurance. The exchange should serve a diversified group. Minority businesses, for example, need as much help as they can get. Their perspective needs to be included when designing the exchange. – Gail
- Offering access will be difficult. Many Mississippians cannot go online to shop because they do not own a computer. Employers and agents should be there to assist these people. Additionally, insurance is complicated. – Susan

The inability to access a website may be a problem. How do we ensure people can access the health exchange?

- The exchange should encourage people to go an agent. Perhaps even require people to use an agent in order to participate in the exchange. – Robert
- The state risk pool has a great solution. People can go direct or they can use an agent. – Susan

How many plans should be offered on the exchange?

- Two – Gail
- Three – Susan
- Plans need to be the same from carrier to carrier. The only thing that should be different is price, service, or network. – Don
- Follow the Medicare Supplements model. They do a great job of comparing plans and prices. – Susan
- People have different needs. I think you need around six so you can offer benefits to people who are in different stages of life. – Robert

What benefit plans should be offered in the exchange?

- Definitely include a high deductable plan with an HSA. – Susan
- Have a plan that covers the basics. – Gail
- Follow the build-a-bear model. You have a basic option and then people can choose maternity, prescription drugs, first dollar emergency room, and so on. In addition, you would not need to offer many different plans. – Susan and Don
- Employers would really like a defined contribution model. This allows them to say, "Here is what you offer. If you want more, you have to pay for it." – Robert

How do we address the insurance needs of part-time workers?

- This is a good question. Some businesses strategically hire part-time workers so they do not have to pay the benefits. If we create a solution for offering benefits to part-time workers, companies would have to compete for talent. That would be a good thing. – Don

- The money needs to follow the workers. Therefore, you can have multiple employers contributing a little bit and it will add up to pay all of the benefit. – Susan

How should brokers be compensated in the exchange?

- It really depends on how broker compensation counts toward the medical loss ratio. If it counts toward the medical loss ratio, carriers will likely cut fees. – Susan
- Pay a flat fee per head. – Robert
- Whatever you choose for compensation, it should be the same for all plans so there is no incentive for choosing one plan or carrier over the other. You never want an agent to have a financial incentive to steer the client toward a particular carrier or plan. If there is an incentive, there is larceny in the heart. – Don
- Go with the same compensation across the board. – Gail

How do we conduct outreach and marketing for the exchange?

- Train agents about the exchange through agent continuing education courses. – Gail
- The requirements for helping others with insurance in the exchange have to be the same as the training for offering insurance inside the exchange. Those helping others need to be certified brokers. – Robert
- Public service announcements are going to be the linchpin for the exchange – Don
- Schools, churches, and word of mouth.– Gail
- You need to build the exchange into Mississippi's culture. Small businesses and individuals need to just know to go to the exchange. Like selective services, it is automatic. – Don
- This is a cross-sell opportunity for agents. They can offer insurance through the exchange to people that did not used to qualify and then sign them up for other products. – Don

How do we conduct marketing and outreach in Mississippi's rural areas?

- Churches, schools, and community centers.– Susan
- All the rural areas have agents who serve them right now. – Robert
- Television is going to be key. – Gail

What messaging do we use to promote the exchange?

- Do not call it "ObamaCare." That carries a negative connotation with it. – Don
- Mississippi one-call has a great solution where phone carriers donate a bit of money to offer a free service to Mississippians. The exchange should follow a similar model where this is viewed as a public utility or public good. The carrier can donate. – Don

What should we call the exchange?

- Medimall (like Medicare, Medicaid) – Gail
- Every state can use its state flower to the name. Therefore, Mississippi should be the Magnolia Plan. – Robert
- Health Hotline, Health Outlet

How should an exchange be regulated? Should the exchange itself be a regulatory body or should it be outside the exchange?

- The exchange needs to be a separate entity. You have to remove politics from operations. Governance of the exchange can come from a board or something, but actual regulation should come through the insurance commission. – Gail
- I would really like to see a diverse group of people governing the board. It should include brokers, businesses, and carriers. Ultimately, the governor should appoint the board. – Susan

- I think Leavitt Partners and the Cicero Group should govern the exchange. You have talked to a diverse group of people and understand the workings of an exchange. The governing body should be outside of state government. – Don
- Why not set regulation up like the risk pool. The state has oversight, but regulation and governance come from the insurance department. – Gail

What are the perceptions of the state risk pool?

- No one knows about the risk pool because the state has done a poor job of advertising it. The exchange would have to correct this problem. – Don

What are the risks of associating the exchange with Medicaid?

- Medicaid is broken. Do not associate the exchange with Medicaid. – Robert
- I do not see a problem associating the exchange with Medicaid. The exchange can be a filtering process that sends people to Medicaid if they qualify. – Gail
- There is a stigma that goes along with Medicaid. There is a large middle class that would qualify for the exchange that does not want to put themin the same boat as Medicaid. – Don

Small Business Groups

Executive Summary – Small Business Quads – Vicksburg – 3.30.2011

- **Health care uncertainty**: Small businesses are concerned about health care. The idea of something different is frightening ("Southern Baptists don't like change"). The PPACA has created a lot of uncertainty and small businesses fear it the worst ("It is a huge unknown…it is creating fear and anger"). Furthermore, small businesses are also frustrated with entitlements. Associating the exchange as an entitlement program will negatively affect exchange acceptance and participation.

- **Intellectually and physically accessing the exchange**: The exchange concept is difficult to understand. Additionally, computer literacy is going to be an issue ("Many people don't even have email addresses!"). The exchange will need caseworkers or navigators.

- **Outreach and marketing**: The exchange should leverage chambers of commerce, provider networks (e.g. doctors and nurses), clubs, faith-based organizations, and annual business registrations. Additionally, attributing the exchange to Mike Chaney could have a positive impact in the business community (this could be a Vicksburg-specific finding). The exchange should learn from the failures of rolling out other state programs (e.g. CHIP).

- **Exchange design**: Keep it simple. Potential participants should be able to access the exchange online (including chat), in-person, by phone, and through email. Plans should be laid out in a simple and comparable way. The fewer plans the better; however, younger respondents preferred more choices compared to the older respondents.

- **Education and navigation**: The idea of an exchange and insurance are foreign to individuals. Education will likely be the key to the exchange's ultimate success. The exchange must offer in-person education. Brokers will be helpful, but primarily because brokers have gained the trust of the small business community. A navigator should be unbiased when educating the public. There should be no incentives for pushing people toward a particular carrier or plan. Employers may not be the best source for educating employees about the exchange ("Most employers in Vicksburg cannot be trusted to provide employees with insurance.").

- **Branding the exchange:** Do not associate the exchange with entitlements or Medicaid. The exchange should be viewed as an economic development tool, designed to help businesses attract and retain quality employees. The ability to offer benefits to part-time employees, portability of plans, and defined contribution are all attractive to students and employees.

Key Verbatim Comments:

- *"To advertise the exchange, you've got to go through doctors, the chambers of commerce, letters, and other mandatory business functions like registering your business."*– Angie
- *"The education piece of this is going to be slow and difficult."*– Mike
- *"This is going to have to be the most dynamic, user-friendly website ever! From simple overarching answers to really detailed responses."*– Mimi
- *"People are going to want advice, people they don't have the self-confidence to make that decision. Small businesses need more than just education; they need you to help them enroll."*– David
- *"The exchange sounds beautiful until you roll it out. That's when everything goes wrong."* – Mike

Notes:

What are the health care challenges for your businesses?

- The biggest challenge for us is not knowing how [PPACA] it is going to rollout. – Mike
- Many people have learned how to work the system. It is part of the culture to seek for Medicaid. People learn the tricks that allow them to qualify for benefits at an early age. It is not that they are lazy; they just do not know how to do anything else. However, it adds to health costs.

What should the Mississippi health exchange include?

- There should be a base coverage that is equivalent to what is offered through Medicaid. – Angie
- Theoretically, plans should compete. I just do not know how realistic this is though. There will need to be transparency. In addition, competing plans will bring premiums down. – Mimi
- Someone will need to help people through the process. Not everybody has access to a computer or the education to be able to figure out insurance. Insurance agents will be important. – Mimi
- The exchange has to make insurance more affordable. Additionally, you should not be denied for pre-existing conditions. – Kaye
- Portability is an attractive part of the exchange. My husband is leaving one career and going to another. Therefore, portability is something we would love. – Angie
- There is not a lot of transparency in the current market. So having all of your options on the computer would be amazing. – Angie

What are the largest challenges to the exchange?

- The system needs to be very simple. I recently qualified for Medicare. It isreally tough to figure out what the benefits of Medicare are. The exchange sounds beautiful until you roll it out. That is when everything goes wrong. – Mike
- Insurance is confusing to educated people. You will need assistance. – Mimi
- You need unbiased people giving the education. – Kaye
- The education piece of this is going to be slow and difficult. – Mike
- This is going to have to be the most dynamic, user-friendly website ever! From simple overarching answers to really detailed responses – Mimi
- Most people are going to want a real person to talk with. – Kaye

How can we effectively get the message out about the exchange?

- Tell everyone that it is from Mike Chaney. He is very well respected among small businesses.– Mike
- You have to have a continuing education piece throughout the process. – Mimi

- To advertise the exchange, you have to go through doctors, the chambers of commerce, letters, and other mandatory business functions like registering your business. – Angie
- Hold informational course on Saturdays and quarterly. Have businesses fill out the enrollment forms when they come in for the education courses. – David

What would be the ideal process for enrolling?

- You have to enroll people through the employer. Have exchange enrollment be part of new-employee orientation and user brokers when they present to new employees. – Mike
- It would be great if the exchange could hold personal information from previous insurance. That way you do not have to keep justifying the fact that you had insurance. – Mimi
- Perhaps offer an initial gimmick to get people interested and get them into the exchange. – Angie
- Learn from past mistakes. The CHIP program is great, but it was not rolled out very well. We need to learn from past mistakes. – Mimi
- The more you can divorce it from Medicaid, the better. Mississippians are proud people. There is a stigma that goes along with entitlement programs. – Mike

Whom do your employees go to when they have questions about insurance?

- Other companies have agents come in, but my people cannot pay for that kind of things so we need volunteers. It ends up that people have to look for answers themselves. – Kaye
- Sometimes the employees come back to you. It is not a big deal because your employees are like family. However, there is an emotional burden if your employees do not qualify or if they have problems. – David
- I hope that the exchange and plan choices are so easy you do not need any assistance. – David

How many choices in the exchange?

- The fewer plan choices the better. – Mike
- I think three plan choices per carrier is enough.– David
- If you have too many options,you are going to confuse everybody. – Kaye

Does exchange education for small businesses have to come from brokers?

- It is not about the broker, it's Ms. Bell – She is just a trustworthy person. It is about the individual, not the broker. – Mike
- The success of exchange depends on having trusted individuals navigating the system. – David
- People are going to want advice, people do not have the self-confidence to make that decision. Small businesses need more than just education; they need you to help them enroll. – David
- I would not trust a small business employer to give me health insurance advice. They simply do not understand insurance well enough. – David

Executive Summary – Small Business Quads – Jackson – 3.28.2011

- **State versus federal exchange**: The exchange must be built by the state of Mississippi. Small businesses would rather limit government intrusion. However, if intrusion is going to occur, it should be at the state rather than the federal level.

- **Small businesses and health care**: The major health care challenges for small business include costs, administrative burden, minimum participation rates, and ungrateful employees. Small businesses understand health care because they have to deal with it every day. The initial reaction to the exchange is somewhat apathetic. If the program does not significantly lower costs or make things easier for employers, the value proposition is not compelling.

- **Exchange design**: Make the exchange simple. Reduce paperwork, increase transparency, and offer great customer service.

- **Broker**: Small businesses do not have the time to research and understand health care plans. Many small businesses do not understand how much money their broker makes in premiums. However, small businesses feel that brokers justify their pay. The broker serves an important role in researching plans and presenting the small business with options. The exchange will need to utilize brokers.

Key Verbatim Comments:

- *"Younger employees would rather have HSAs. They can escrow thousands of dollars and use that as a catastrophic insurance plan later in life."*– John
- *"I have no reason not to trust the company, I just don't."*– Lance
- *"Insurance companies pay 80 percent of what they think you should have been charged."*– Janice
- *"An exchange would be too administratively top heavy coming from the state."* – John
- *"The biggest issue with a health exchange is educating the public."*– Theresa
- *"The agent is not there on a daily basis – problems will arise when the agent is not around; then the questions fall on the employer."*– Janice

Notes:

What influenced your decision to offer or not offer insurance?

- My employees are generally healthy and those who are older can be covered by private insurance. Therefore, it just works for our company. – John
- My company is too small to offer insurance. Risk sharing is just not an option. – Janice

What are the greatest challenges to offering insurance to employees?

- Cost – we have to re-evaluate and manage our budget every year. – All participants
- We struggle to make payroll. Therefore, the costs of offering health care are prohibitive. – Teresa

Would employees rather have the extra money in salary rather than benefits?

- It is really an age issue. My younger employees would rather have the extra salary. Younger employees would rather have HSAs. They can escrow thousands of dollars and use that as a catastrophic insurance plan later in life. – John

Why do you use brokers?

- We do not really know of any other way. Moreover, we do not have the time to deal with this. I have to go through my broker. – John
- Brokers shop the market and explain the coverage plans. – Janice

Do you understand insurance?

- Yes, because we have to pay for it. – John
- Employees do not understand their total package – they do not know what the benefits add to their total salary – they are generally only concerned about take-home pay. – Group discussion

What are the problems with the current insurance market in Mississippi?

- Cost / predictability
- Employees don't understand the full benefit
- Minimum participation levels (gateway to other hurdles)
- Administrative nightmare

All of you have mentioned BlueCross BlueShield. Tell us about that company.

- BlueCross BlueShield is great as long as you are healthy.
- I have no reason not to trust the company, I just do not. – Lance
- The "usual and customary charges" is where they get you. Insurance companies pay 80 percent of what they *think* you should have been charged. – Janice

Who within your company makes decisions regarding health insurance?

- Managers vs. influencers?
- I am a business manger. Therefore, I bring everything to the table for the owners. In the end, cost is the primary influencer for what we choose. – Janice
- My sister-in-law is my business manager; she presents me with 3-5 plans. I then cut her list down quickly because of costs and then make the final call. – John
- The ultimate say comes from the board. – Theresa
- My broker does the work and brings me solutions. They are not tied to BlueCross BlueShield, so they shop many carriers. – Lance

What can the State of Mississippi do to help solve your health care problems?

- Reduce paperwork – several companies have to hire people just to deal with the paperwork of health insurance.
- Increase access to health care. It should be easier for people to get access to treatment.

What would you think about having employees choose their health plans?

- Getting employees to choose their own plans would not work – they just do not know about all the options that exist in the market. In addition, this approach would put the administrative burden back on employers. – Lance

Do you know what brokers make?

- Three percent of premium is likely the broker fee. – All participants
- I do not care how much my broker earns. He takes care of a lot of work so he earns his money with me. – John

What does Health Exchange mean to you?

- It allows people to personally get insurance and leaves the broker out. – Theresa
- It is a way of getting several businesses together to pool risk and it does not sound good. – Lance
- I do not know. – Janice
- Co-op of businesses working together to get less expensive health care. Unless it can save everyone money and everyone can afford it then what is the point. The program would be too administratively top-heavy coming from the state. – John

Researchers then explain the workings of a health exchange and then ask small employers for comment.

- The current system is confusing enough right now. Employers have a basic understating of options, but employees have no understanding whatsoever. What if they select a plan and are then disappointed? – John
- People do not have the time and energy to sit and go through all of the plans. – John
- An exchange would not work for my employees, because they do not understand the insurance market and plan options enough now. Then the administration of the plan falls back on me. I will have to learn 24 different plans rather than one. – Lance

- It is not because employees are not smart, it is because they do not have the time to research it. – Lance
- Employees will not understand the process, making it a logistical nightmare as they try to purchase their insurance. – Theresa
- I do not know what to say. It sounds better than what we have now. However, I would want to know more about it first. – Janice

To whom are employees going to go if they have questions?

- Employees have a personal relationship with the employer not the agent. They are going to come to me. – John
- Employees are on floor without a phone. Therefore, they are going to come to me. – Lance
- The agent is not there on a daily basis – problems will arise when the agent is not around; then the questions fall on the employer. – Janice

Will your employees go online and enroll?

- Employees do not have access to a computer or will not take the time to fill it out the information needed for the exchange. – Lance
- Computer accessibility is low – many do not have a computer or Internet at home.
- Most employees will likely use my time to figure out their insurance.

Thoughts on federal versus a state health exchange:

- I do not like the federal government telling what me what to do. What is going to stop the state from coming in later to change the rules? I want as little government intrusion as possible. – John
- If reform can make it easy for employees to guarantee good coverage, then do whatever. Nevertheless, if the exchange is too complicated then employees cannot use it. – Lance

Section 6: Secondary Research Literature Review

Intent of this Literature Review: Public health exchanges have only been in existence for a few years, yet their successes and failures are being studied and well documented. This review consolidates and simplifies thousands of pages of policy commentaries, academic and scholarly analysis, news articles, and other secondary sources that discuss exchanges. This review also surfaces the primary themes found throughout the research. The goal of this review is to provide insights that will assist in designing an exchange tailored to the needs of the State of Mississippi.

Literature Review Executive Summary

- A health insurance exchange is an organized marketplace for the purchase of health insurance.
- Many small businesses do not offer health insurance because it is too costly, administratively burdensome, and relatively complex to enroll employees. As a result, public exchanges in Utah and Massachusetts have promoted participation through defined contribution plans (making costs more predictable), tax credits, reduced administrative burdens, and user simplicity.
- Notable exchange failures occurred in California, Colorado, Florida, and North Carolina. Failures occurred primarily because of adverse selection, inadequate broker participation, high costs, lack of public outreach, enrollment complexity, poor participation rates, lack of quality assurance, limited health plans, and exchange administration challenges.
- Eighteen percent of Mississippi's population is uninsured. Forty-nine percent of the uninsured have a household income below 133 percent federal poverty level. The uninsured are over-represented in Mississippi's entertainment, construction, and retail industries.
- As a result of the Patient Protection Affordable Care Act (PPACA), the number of Medicaid-eligible Mississippi residents is projected to grow 50 percent from approximately 25 percent to 34-38 percent of Mississippians by 2015.
- Mississippi will need to address the failures of past exchanges while meeting the needs of the state's rural population. Secondary research encourages implementation of a defined contribution plan, significant exchange and insurance education outreach, heavy reliance on brokers, and aggregation of part-time employee benefits from multiple employers.

What is a Health Exchange?

The Patient Protection Affordable Care Act (PPACA) calls for the establishment of federal and state health insurance exchanges. A health insurance exchange or "exchange" is a term used to describe an organized marketplace for the purchase of health insurance.

In theory, an exchange increases access to health care by making insurance more affordable (primarily through subsidies). Exchanges also manage costs over the long run through increased competition among insurers. Key drivers for exchanges to be successful include (1) high levels of participation, (2) transparency, and (3) an abundance of health plan choices. Holding these assumptions to be true, exchanges facilitate an environment that promotes optimal competition, leading to controllable and predictable costs for consumers.

Increasing Exchange Participation

The majority of the uninsured have full- or part-time jobs. Additionally, most Americans receive insurance through their employer. Therefore, an effective approach for serving the uninsured is to encourage small businesses to participate in the exchange. Small businesses list myriad reasons for not offering health insurance to employees including cost, administrative burden, and enrollment complexity. Small businesses are more likely to participate in an exchange if it offers predictable and lower insurance costs, reduced administrative burdens, and a simple solution for managing insurance for employees.

Current & Past Health Exchanges

Currently two public health exchanges, the Massachusetts Connector and Utah Health Exchange, serve as helpful examples for developing future state exchanges. However, careful analysis is also being conducted on why past public exchanges failed. States with exchanges that failed:

- California
- Colorado
- Florida
- North Carolina
- Texas

Recent findings suggest that exchanges that fail do not properly resolve the following issues:

- Adverse selection
- Broker participation
- Controllable costs
- Education committees
- Enrollment simplicity
- High participation rates
- Ongoing quality assurance
- Quantity of health plans
- Third partly leveraging

Adverse selection: Adverse selection occurs when an exchange is unable to capture and maintain a large enough portion of the healthy population. As a result, healthier individuals inside the exchange leave to find less expensive insurance outside the exchange. Risk ratios in the exchange increase leading to higher premiums. The pattern of healthier individuals leaving the exchange to find less expensive insurance continues until the exchange collapses. The Massachusetts, Texas, and California exchanges all fell victims to adverse selection. The Massachusetts Connector has attempted to alleviate the issue by merging their small business and individual exchanges.

Broker participation: Utah has been more successful than Massachusetts at increasing small business participation. One reason for Utah's success is the state is leveraging of brokers. Utah sought increased broker participation and offered broker education days while Massachusetts limited the number of brokers that participated in the exchange. Eighty-five percent of small businesses enrolled in the Utah exchange entered through a broker.

Controllable costs: With respect to health insurance, small businesses are primarily concerned with controlling and predicting costs. A defined contribution plan is one of the best solutions for assisting small businesses in predicting costs. Additionally, tracking and reacting to adverse selection, increasing participation rates, and encouraging competition among health plans helps control costs.

Education committees: The vast majority of citizens are uneducated about exchanges and insurance. The public's perspective is directly correlated to what they hear and read in the media. Utah and Massachusetts facilitated public outreach programs that not only educated the public but also took the initiative to enroll interested respondents. Both states began an active outreach 12 months prior to the exchange going online.

Enrollment simplicity:Many potential enrollees have been dissuaded from participating in an exchange due to the complexity of enrollment. Poor website design, unclear communication, misdirection, and an overall intimidation of the process all contribute to exchange complexity. Some researchers have

suggested that Massachusetts relies too heavily on paperwork while Utah relies too heavily on their website. Successful exchanges will include myriad online and offline resources for education and enrollment.

High participation rates: A common trait among failed exchanges was their inability to attain large enough pools of participants. Massachusetts implemented low-income subsidy programs to increase participation. Utah developed a defined contribution plan, giving employers the opportunity to allocate more responsibility to employees. Utah's approach was attractive to employers because allowed them to better predict health costs while offering employees the ability to choose their health plans.

Ongoing quality assurance:The long-term success of the exchange lay not in continuing the growth but in sustaining the current exchange population. Successful past and current exchanges have strong customer service divisions capable of reacting quickly to issues.

Quantity of health plans: Exchanges offer the possibility of an array of health plan choices. However, low participation rates may limit the number of plans that can be offered. As an exchange's market share increases, insurance providers can compete and offer new businesses.

Third party leveraging: A theme that many have expressed is the concern that a state run exchange would be too inefficient. Bureaucratic policies and political shaping could undermine the ease and simplicity that many desire. Private firms are often more efficient than government entities. A common mistake of past exchanges was their failure to leverage the capabilities of private companies. Massachusetts has contracted their quality assurance segment to a private firm, which has allowed the exchange to be more responsive

Mississippi's Uninsured

Mississippi's population is just under 3 million, of which eighteen percent are uninsured. The most likely candidate to be uninsured in Mississippi is a male between the ages of 18-44. Business segments with the highest percent of uninsured are the entertainment, construction, and retail industries.

Total Medicaid coverage in Mississippi is projected to increase by 50 percent from 25 percent to 34 - 38 percent 2015. In an effort to reduce criticism, the PPACA has stipulated full federal funding to cover the increased costs of expanding Medicaid up until January 1, 2017. The PPACA does not directly address how Medicaid sustainability will be achieved beyond providing the option of charging insurers a fee for operating within the exchange.

Conclusion & Recommendations

Mississippi's health exchange, if implemented successfully, can significantly decrease the proportion of uninsured individuals in the state. To do so, past exchange failures must be carefully analyzed. The majority of exchange failures can be tied to their inability to quickly attain large participation rates, which eventually led to a collapse of the exchange. The following recommendations apply to help the Mississippi exchange achieve strong participations rates, notably from small business owners.

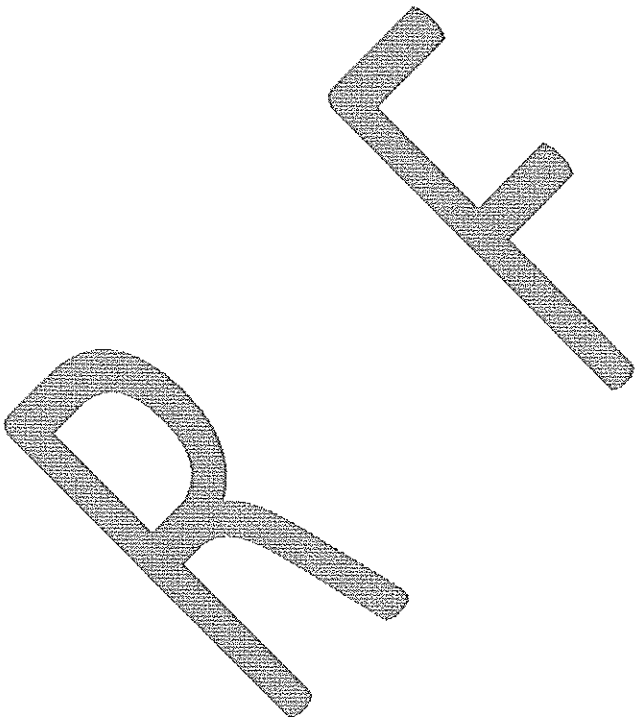
Education and simplicity: Mississippi must focus on exchange and insurance education and simplicity. A large proportion of Mississippi's population is located in rural areas. Additionally, the exchange and insurance generally are difficult for most individuals to understand. The difficulty of understanding the exchange and insurance combined with the challenges of reaching rural Mississippians necessitates an effective education outreach combined with an extremely simple and usable exchange.

Defined contribution plan: Based on secondary research, a defined contribution plan can help employers

achieve predictable health insurance costs. The defined contribution plan will allow employees to contribute to his or her premium, tax-free.

Broker participation: Mississippi must leverage brokers in order to significantly expand exchange participation. Mississippi should pay a competitive commission, one similar to the outside market. Additionally, the exchange should provide broker education days, during which brokers receive education about the types of plans within the exchange as well as the enrollment process.

Premium aggregation benefits: The Mississippi exchange should focus their efforts toward small business recruitment as well as recruiting in the individual market. One way to increase individual participation is through the aggregation of part-time employee benefits. This approach also allows employers to attract and retain employees by offering benefits to those who work part-time.



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Exchange Management

- *Standardizing Health Plans:*Price competition is most likely to occur when participants are comparing similar plans. Strongly consider requiring insurers to offer a standardized plan or set of plans. Doing so will require insurers to compete on price, service, or carrier network.

- *Government Employee Participation:*Consider requiring state (and possibly county and city) government employee participation in the health insurance. Government employee participation provides a solid exchange base population, which increases the likelihood of the exchange succeeding.

Encouraging Small Business Participation (Additional)

- *Early Enrollment*:In 2013, the exchange should start recruiting small businesses through brokers and business organizations (e.g. chambers of commerce). Consider a first year tax credit to small businesses that sign up early. This approach will also provide strong feedback to why some might be hesitant to participate.

- *Simplicity, Simplicity, Simplicity*: The success of the exchange among small businesses is directly related to how well the exchange integrates into the daily operations of their businesses. For example, the exchange should present an employer with a single bill for all its employees registered in an employer-sponsored plan. The employer should also have the ability for online payment, as well as the option for automatic payment.

Why are companies dropping their health plans or why did they never offer health insurance?
- Cost
- Administrative burden
- Confusion about their role in providing insurance and the options available

What are the most compelling value propositions for employers?
- Defined contribution plans (predictable and controllable costs)
- Small employer tax credits
- Reduced administrative burdens
- Simplicity in enrolment

How would small businesses learn about the new Exchange?
- Advertising via television, Internet, print
- Letters could be sent to employers with 50 or less employees
- Town hall meetings and related organized events
- Research groups charged with gathering information from the public (i.e. their needs, concerns, suggestions, and wants). This approach puts the exchange in good light and increases word of mouth.

Function of a Health Exchange

The implementation of state-based health insurance exchanges have become the centerpiece of the health reforms within the Patient Protection and Affordable Car Act of 2010 (PPACA). If theory coincides with practice, the exchanges will act as an organized marketplace, comparable to a stock exchange, facilitating the growth of individual and small-business coverage while providing universal access to affordable rates. A successful exchange will result in the following:

- Choice and competition
- Transparency
- Reforming the insurance market
- Expanding coverage

***Choice and Competition*:** An exchange will present an individual or employer with an array of private health insurance plans to fit their budget and needs. Furthermore, these exchanges will create a foundation in which those seeking insurance can easily compare plans and rates. The underlying objective of an exchange is to facilitate competition among plans based on the price of coverage. The goal is to stimulate a growth in choices based on price, value, and quality.

Transparency: The PPACA has made clear that insurers participating in an exchange must disclose their terms and conditions in a plain language and a comparable form. Insurers seeking to sell their policies through an exchange must disclose the following information: claims-payment policies and practices, financial information, data on enrollment and disenrollment as well as on claims denials and rating practices, information on cost sharing for out-of-network coverage, and enrollees' rights. Additionally, an exchange will have the ability to communicate with linguistic or cultural minorities.

Reforming the Insurance Market: Choice, competition, and transparency will assist in reforming the health insurance market. Additionally, insurers participating in an exchange are required to justify all premium increases and abide by all mandates stipulated in the PPACA. An exchange will play an active role through granting or denying the certification of a plan.

Expanding Coverage:The ultimate goal of an exchange is to expand coverage. The exchange increases small business participation by allowing employers to contribute a defined amount to employee benefits. Employees can use the employer contribution, plus needed employee contributions, to purchase their choice of health plan. This approach helps employers better predict costs. The exchange is also a mechanism for distributing subsidies to employees who qualify, thus making health insurance affordable to individuals.

Issues to Address

Although the PPACA has succeeded in implementing some regulation and issuing guidance, the burden of executing an exchange will reside with the state. The following are major issues that a state must address based on the successes and failures of past exchanges:

- *Number of Participants.*Economies of scale are an exchanges best friend. One of the primary reasons for the failures of past exchanges rests in their inability to attain large enough participation rates. As reported in *Making Exchanges Work in Health Reform*, an acceptable pool for an insurer to market in would be at least 100,000 persons. We believe this number will deviate depending on the population size, the average health of residents, and illnesses isolated to that geographic region. The bottom line is a state will need to have a large enough pool to maintain bargaining strength and to convince insurers that acceptable risk is present. Achieving an acceptable rate would mitigate other concerns as well, such as administrative costs, high premiums, and lack of coverage choices.

- *Marketing an Exchange.*The PPACA has provided statutes and incentives, which will assist in the growth of an exchange. The most prominent of mandates goes into effect in 2014, requiring that all individuals purchase health insurance. The hope is that those individuals who do not currently hold health insurance will purchase their policies through an exchange. In addition, the government will provide a small-employer tax credit during the first two years after an exchange goes online. Have

acknowledged as much, the current small business tax credits are likely to have a marginal impact on participation because they are temporary and minimal.

- *Structure*. An important question that a state must ask is whether they should maintain separate individual and small group exchanges or pool them together into a single exchange. A combined pool offers less volatility and larger diversification, allowing for an increased spread of risk. Conversely, a single market could create regulatory complexity.

- *Making Exchanges Work for Employers*.To avoid adverse selection an exchange must expand its market pool as quickly as possible. Presenting itself in a way that is attractive to the small business owner will allow the exchange to tap quickly into additional markets. Current and past exchanges attempted to better integrate the exchange into the daily operations of small businesses, making enrollment easy and maintenance even easier.

- *Regulatory Role*.The role of a state's exchange is a potential source of significant controversy. The exchange must mirror the wants of the population; doing so could prove to be a key factor in its growth. The PPACA allows an exchange to operate through either a government agency or a not-for-profit entity. Not-for-profit organizations can offer more flexibly, free from superfluous procedural requirements.

The State of Mississippi is not exempt from the above challenges. The state will need to address each concern as it pertains to their state's specific issues, customs, business practices, etc. The State of Mississippi has commissioned Milliman, Inc., a national health care econometrics firm, to perform an analysis of their state budget, as it relates to the health reforms. A few key findings were:

- Between 206,000 and 415,000 people will be added to Medicaid.
- The 10-year impact to the state budget will be between $858 million and $1.66 billion.
- Using a moderate scenario, estimates put the addition to Medicaid around 310,000 persons and an average yearly spending of $126 million.
- The cost of the Medicaid expansion, per year, will far exceed the amount projected to spend on public safety, military, and veterans affairs agencies combined.

The PPACA stipulates that there will be full federal funding to cover the increased costs of expanding Medicaid up until January 1, 2017. At this date, all state exchanges will need to be self-sufficient in covering increased Medicaid costs. The PPACA does not directly address how those costs will funded other than providing the option of charging insurers a fee for operating within the exchange.

Arguments against a Health Exchange

Research has shown that many of the arguments against an exchange are supported by distorted and sometimes blatantly false facts. This underscores the notion that states must take an active role in educating the public prior to full implementation of the exchange. It cannot be stressed enough that the success of an exchange and the prevention of state deficits rests on the participation of the public. Despite the many misunderstandings about exchanges, two arguments hold weight:

- *Regulation*.Many fear that a state run exchange is too inefficient. Bureaucratic policies and political shaping undermines the ease and simplicity that many desire.

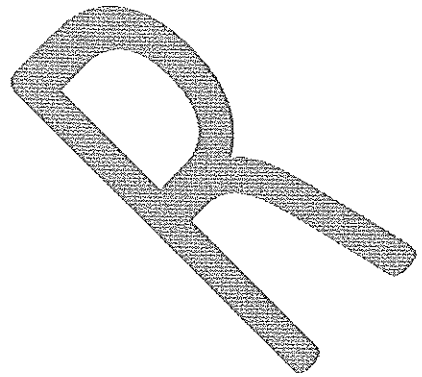
- *Administrative Cost*.Regardless of which route a state takes in the creation of an exchange, the related administrative costs are unavoidable. An exchange is burdened with a variety of administrative costs, such as processing applications, financial reconciliation, maintaining websites, and marketing.

Key Features within the Utah Exchange:

- Created a website that acts as an information portal to health care.
- Provides consumers with the opportunity to compare plans and rates.
- Allows employers to set up a defined contribution plan for their employees on the website
- Allows individuals to combine health contributions from multiple employers.

Key Features within the Massachusetts Exchange:

- Created a separate program for individuals receiving subsidies, Commonwealth Care.The program covered 51 percent of the newly insured.
- Created a separate program for individuals who do not qualify for subsidies, Commonwealth Choice.Covered 5 percent of the newly insured.
- Combined Medicaid and the Children's Health Insurance Program into one program, MassHealth.Covered 17 percent of the newly insured.
- Automatically enrolled those who were below 100 percentfederal poverty level (FPL) into the Commonwealth Care program.
- Created the Care Quality and Cost Council following implementation, which is charged with improving quality and containing costs.
- Commonwealth Care subsidies are funded by the state's Medicaid program.
- Combined both the small business and individual market into a single exchange.
- Created the exchange in stages; first for individuals, followed by small-businesses in increments.



Section 7: Methodology

Research Objectives

In accordance with the Mississippi Insurance Department's goal of designing an effective exchange for Mississippians, the state has embarked on answering the following research objectives: :

- What are the factors driving success and failure of other public exchanges throughout the country?
- Why do some small businesses offer health insurance while others fail to offer health insurance?
- Why do employees who have access to health insurance neglect to enroll?
- From where are Mississippi's uninsured individuals originating?
- What types of experience and services can an exchange provide that will maximize participation on the exchange by small businesses and its employees?
- What will be the most effective strategy to market and implement the exchange once it is built?

Research Methodology

There are general principles that apply to the success of any health exchange. However, political, psychographic, and demographic differences throughout the state necessitate a customized design of the Mississippi exchange. It is imperative that the Mississippi exchange meets the needs of Mississippians and that the exchange be executed with high efficiency in order to maximize impact while preserving taxpayer dollars. Therefore, a multi-phased research approach was designed to solicit the insights of as many people as possible. This process includes:

Phase I:

- Secondary Research
  - Obtain and evaluate research surrounding public exchanges
  - Amalgamate the research and summarize

- In-Depth Interviews
  - Develop discussion guides, set appointments, and provide honorariums for participation
  - Conduct interviews with individuals who have helped implement health exchanges, including those in Massachusetts and Utah
  - Conduct initial interviews with key stakeholders in Mississippi with the following objectives:
    - Introduce the Insurance Department's focus on hearing from as many stakeholders in order to build the optimal exchange
    - Determine who all the stakeholders are in Mississippi and how to reach out to them
    - Develop initial hypotheses surrounding what components will most ensure the success of the exchange
    - Determine on which items there is greatest consensus among the disparate stakeholders

Phase II and III

- Based on Phase I, determine which individuals to interview in the subsequent phases. While the strategy will be flexible, it likely includes:
  - Town-hall/cottage meetings with small business owners and employees. These presentations and discussions will occur throughout the state and will include a presentation and illustration of the "skeleton" concept and then will seek the input of all participants. These presentations will be coordinated through:
    - Local Chambers of Commerce and Economic Development Agencies

- Local public associations and organizations (such as Rotary, Elks, and Kiwanis)
- Local churches, city councils, schools and elected officials

- The town-hall/cottage meetings will occur throughout the state in as many cities as possible (approximately 15) and will strive to represent the diversity of the state. As many business owners and stakeholders as possible will be invited to participate.

- Survey of small business owners surrounding their primary needs with health insurance, the number of different plans that should be available through the exchange and how the exchange can best resolve their health insurance needs

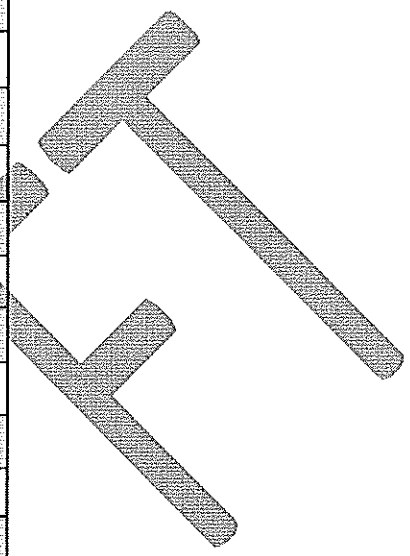
- A survey of small business owners and individuals surrounding the ideal online experience as well as the appropriate messaging and implementation strategy

During the month of March, 2011 Phase I was conducted. After conducting a thorough literature review, the Mississippi Insurance Department and its partners (Leavitt Partners and the Cicero Group) relied on qualitative research, including in-depth interviews and focus groups, to provide a valid foundation for future research. Over 60 interviews were conducted, most of which lasted approximately 60 minutes in length. Some of the interviews were conducted in small focus group settings.

In-Depth Interview Participants

Role
Community Health Leader 1
MS **Health Policy Analyst 1**
Community Health Leader 2
Health Consumer Advocate 1
Health Consumer Advocate 2
Health Consumer Advocate 3
State Medicaid Representative 1
State Medicaid Representative 2
State Medicaid Representative 3
State Medicaid Representative 4
State Insurance Expert Representative 1
State Insurance Expert Representative 2
Insurance Carrier Representative 1
Insurance Carrier Representative 2
Insurance Carrier Representative 3
Insurance Carrier Representative 4
Insurance Carrier Representative 5
Insurance Carrier Representative 6

Planning and Development Districts Representative 1
Planning and Development Districts Representative 2
Planning and Development Districts Representative 3
Planning and Development Districts Representative 4
State of Mississippi House of Representatives 1
State of Mississippi House of Representatives 2
State of Mississippi House of Representatives 3
State of Mississippi Senate1
Business Organization Representative 1
Business Organization Representative 2
Business Organization Representative 3
Business Organization Representative 4
Business Organization Representative 5
Business Organization Representative 6
Business Organization Representative 7
Health Care Provider Representative 1
Broker Representative 1
Broker Representative 2
Broker Representative 3
Broker Representative 4
Broker Representative 5
Broker Representative 6
Gaming Industry Representative 1
Gaming Industry Representative 2
Exchange Expert 1
Exchange Expert 2
Exchange Expert 3



Small Group Discussion Participants: Small Business Owners

Name	Organization Size	Offers Health Benefits
Angie	Less than 10	Yes
Janice	10 to 19	No
John	10 to 19	Yes
Kaye	Less than 10	Yes
Lance	30 to 39	Yes
Mike	Less than 10	Yes
Mimi	Less than 10	Yes
David	Less than 10	Yes
Theresa	10 to 19	No

Small Group Discussion Participants: Insurance Agents/Brokers

Name	Primary Areas of Service
Clarence	Jackson / Delta
Kurt	Jackson / Delta
Don	Jackson
Gail	Jackson
Madelyn	Jackson / Delta
Nita	Jackson
Robert	Jackson / Delta
Stephan	Jackson
Susan	Jackson

Leavitt Partners brings together partners from across governments and global industry that share a vision and passion for making a difference. Leavitt Partners applies core principles and strategies, learned over three decades of experience in business and government, to serve clients. Leavitt Partners holds unique qualifications, experience, and reach back capabilities exemplified in health benefits exchange projects. This seasoned experience enhances Leavitt's quality solution, allows for innovation, and brings high energy, process synergy, and experiential substance to assist in successfully meeting the State of Oklahoma's needs. Leavitt Partners offers an experienced, broad-based, and knowledgeable team led by former HHS Secretary and three-term governor Michael O. Leavitt.
Leavitt Partners offers a range of advisory services to clients interested in health insurance exchanges, including:

- Advising clients about the process, policies, politics, and people involved in creating exchanges
- Providing timely and in-depth analysis of state, federal, and marketplace exchange activity
- Providing customized guidance to states on how to move carefully and cost-effectively to best serve their citizens
- Advising state governments on the technical considerations related to the establishment of exchanges

Leavitt Partners advises clients in the practice areas of health care and food safety. Our team includes individuals with deep experience in health care restructuring and domestic and international food safety. We apply this experience, knowledge, and a network of global relationships to supplement the thinking of senior executive teams, facilitate connections, solve problems, create value, and deliver results.
We endorse a collaborative approach that builds upon the perspective of our team and our analytical capabilities to meet client needs. For example:

- **We work collaboratively** – Each client has access to the entire Leavitt Partners organization.
- **We use our experience to bring perspective** – Our value-add stems from the combination of unique experiences, knowledge, and relationships that allow us to add perspective others do not have.
- **We gather, assimilate, and translate information** – We stay current by gathering and assimilating data and inside information critical to our clients' success and then we translate it to strategic relevance.

Our value to a client is optimized when these six characteristics are met:

- We have a clear communication channel with a defined senior executive team, collectively and individually.
- We function within the existing strategic process of the company.
- We have a formal work plan with accountability to the senior executive team.
- We participate in periodic formal work sessions that allow for collaborative discussion.
- We interact regularly and "as needed" with members of the senior executive team.
- We have access to internal information services such as news clips, management memos, and other common materials that inform and convey the strategic decisions of the senior executive team.

Our headquarters are located:
Leavitt Partners, LLC - Salt Lake City Office
299 South Main Street, Suite 2300
Salt Lake City, Utah 84111-2278
801.538.5082 phone; 801.961.1111 fax

ABOUT CICERO GROUP

The Cicero Group is a premier market research, economic analysis, and strategy-consulting firm headquartered in Salt Lake City, Utah. The company consists of 35 full-time professionals (statisticians, strategists, moderators, etc) and a 125-person data collection call center. Cicero Group companies are known for their responsiveness, robust analyses, and actionable key insights.

Cicero Group companies include:
- Cicero Research
- Dan Jones & Associates
- Education Direction

Cicero is an HCAPS certified provider with more than 30 years of experience conducting research for federal and state agencies as well as private, public and not-for-profit companies and organizations. Cicero has worked with hundreds of clients. The following is a sample client listing:

- Utah Department of Health
- Zions Bank
- Coventry Health
- Health America
- AltiusHealth care
- Intermountain Health care
- Regence BlueCross BlueShield
- Peach State Health Plan
- Salix Pharmaceuticals
- Cadence
- Pfizer
- Bravo Health
- Stanford University
- University of Utah
- Harvard University
- Washington D.C. Public Schools
- Portland Public Schools
- U.S. Department of Education
- Covad
- Centex Homes
- California Charter School Association
- Oklahoma Department of Education
- Cache County School District
- PHEAA/AES
- SunGard Higher Education
- Republic Services
- Vonage
- Hewlett Packard
- Lending Tree
- Clear / Clearwire
- Greif Chemical
- Disney
- Microsoft
- AEG Live
- Bain & Company
- Questar
- Delta Petroleum
- Dow Chemical
- Gateway
- GPS
- NuSkin
- Overstock
- 8x8
- Penn Mutual
- Pew Charitable Trust
- Symantec
- CB Richard Ellis
- Unishippers
- Brown University
- KIPP
- High School Futures
- Utah Board of Education
- Wells Fargo
- Evansville Public Schools
- Rocky Mountain Power
- MASS 2020

Cicero Group belongs to the following professionalorganizations:
- American Marketing Association (AMA),
- Marketing Research Association (MRA),
- American Association of Public Opinion Research (AAPOR),
- Qualitative Research Consultants Association (QRCA).

Key Differentiators

Cicero Group distinguishes itself from competitors through execution, research quality, client support, and years of experience conducting research projects.

- **Execution**

  Cicero companies offer best-in-class market research, economic analysis, and strategy consulting to some of the largest companies in the world. We understand the importance of meeting tight timelines on budget. Our well-defined processes and protocols allow us to quickly and accurately execute campaigns.

- **Research Quality and Rigorous Analysis**

  Cicero prides itself on offering the highest quality research methodology, survey design, data collection, and analysis. Cicero conducts diverse economic and statistical analyses including, but not limited to, logit and probit regression, ANOVA, choice-based conjoint/hierarchical baysian analysis, discriminate segmentation, factor, principal competent, market simulation, competitive analysis, SWOT, macro-economic impact modeling, price elasticity, survival analysis, market opportunity analysis, hierarchical value mapping, and much more.

- **Responsiveness**

  Project details change rapidly. Responsiveness is particularly important in answering the strategic research questions included in this proposal. The client will have access to a senior-member of the project team 24 hours a day by telephone or email to answer questions or provide clarification. It is our intention that this project is both collaborative and interactive.

- **Experience**

  With over 30 years conducting market research and strategy consulting, Cicero Group stands alone in local research experience. The company name is widely known among residents, which can produces higher completions rates on survey projects.

Our headquarters are located:
Cicero Group - Salt Lake City Office
515 East 100 South, Suite 300
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LEAVITT PARTNERS Cicero

A Leavitt Partners / Cicero Group Publication

ATTACHMENT E

ONLINE SURVEY EXAMPLES

SMALL BUSINESSES, EMPLOYEES, AND STAKEHOLDERS

Last year President Obama signed a federal health care law. The State of Mississippi is doing all it can to ensure that any health care changes that occur are as beneficial as possible to the state.

If the state does not build a health insurance solution, the federal government will mandate their own approach. It is critical that we receive feedback from throughout Mississippi so we create a solution for Mississippians, by Mississippians.

Please take 10-12 minutes to honestly and openly answer this survey. Your responses will be aggregated with others and kept completely anonymous.

Next >>

The Mississippi Insurance Department (MID) is considering a solution to improve access to health insurance for individuals. MID would like to ensure the solution provides significant benefit to all individuals. Your feedback is critical in designing the health insurance solution. Please take 10-12 minutes to honestly and openly answer this survey. Your responses will be aggregated with others and kept anonymous.

Next >>

Which of the following best describes your current employment status?

- ○ Business owner / employer
- ○ Employed full-time (non owner)
- ○ Employed part-time (non owner)
- ○ Not employed
- ○ Retired
- ○ Other, please specify:

Next >>

How important are the following in your decision to work for an employer?

	Not At All Important 1	2	3	4	Very Important 5
Salary / wages	○	○	○	○	○
Company culture	○	○	○	○	○
Company reputation	○	○	○	○	○
Health insurance benefits	○	○	○	○	○
The types of clients with whom the company works	○	○	○	○	○
Geographic location	○	○	○	○	○
Company policies (e.g. paid vacation, sick leave, paid tuition, etc)	○	○	○	○	○
Other, please specify:	○	○	○	○	○

To what degree do you support the Patient Protection and Affordable Care Act, sometimes referred to as "ObamaCare"?

Strongly Oppose	Oppose	Undecided	Support	Strongly Support
○	○	○	○	○

Next >>

How important do you believe the following are to your patients in their decision to work for an employer?

	Not At All Important 1	2	3	4	Very Important 5	Don't Know
The types of clients with whom the company works	○	○	○	○	○	○
Company reputation	○	○	○	○	○	○
Geographic location	○	○	○	○	○	○
Salary / wages	○	○	○	○	○	○
Health insurance benefits	○	○	○	○	○	○
Company policies (e.g. paid vacation, sick leave, paid tuition, etc)	○	○	○	○	○	○
Company culture	○	○	○	○	○	○
Other, please specify:	○	○	○	○	○	○

To what degree do you support the Patient Protection and Affordable Care Act, sometimes referred to as "ObamaCare"?

Strongly Oppose	Oppose	Undecided	Support	Strongly Support
○	○	○	○	○

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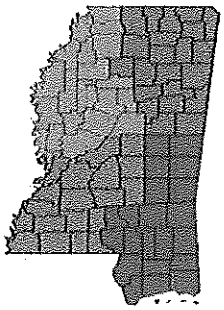
In which region of Mississippi do you live (see map)?



- ○ Northeast (Purple – e.g. Olive Branch, Tupelo, Starkville)
- ○ Northwest (Orange – e.g. Clarksdale, Tunica, Greenville)
- ○ Southwest (Green – e.g. Jackson, Vicksburg, Brandon)
- ○ Southeast (Blue – e.g. Hattiesburg, Biloxi, Gulfport)
- ○ Other

What role do you play in your organization's health insurance decisions?

- ○ I alone make the health insurance decisions for our organization
- ○ Others within the organization present health insurance options, but I make the final health insurance decisions
- ○ I, along with a small group of other leaders in our organization, make the health insurance decisions for our organization
- ○ Another individual(s) within our organization makes the health insurance decisions
- ○ An outside party makes the health insurance decisions for our organization
- ○ We do not offer health insurance to our employees or members

Next >>

In which state is your company primarily located?

- ○ Alabama
- ○ Arkansas
- ○ Florida
- ○ Georgia
- ○ Louisiana
- ○ Mississippi
- ○ North Carolina
- ○ South Carolina
- ○ Tennessee
- ○ Other

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Are you:

- ○ Male
- ○ Female
- ○ Prefer not to answer

What is your age?

- ○ Under 18
- ○ 18-24
- ○ 25-29
- ○ 30-34
- ○ 35-44
- ○ 45-54
- ○ 55-64
- ○ 65 and older

Which of the following best describes your ethnicity?

- ○ White
- ○ Black or African American
- ○ Asian
- ○ American Indian or Alaskan Native
- ○ Native Hawaiian or Other Pacific Islander
- ○ Hispanic or Latino
- ○ Other, please specify:
- ○ Prefer not to answer

In 2010, what was your household income before taxes?

- ○ $14,999 or less
- ○ $15,000 to $24,999
- ○ $25,000 to $34,999
- ○ $35,000 to $49,999
- ○ $50,000 to $74,999
- ○ $75,000 to $99,999
- ○ $100,000 to $149,999
- ○ $150,000 or more
- ○ Prefer not to answer

Next >>

Do you currently have health insurance?

- ○ Yes, I currently have health insurance
- ○ No, I do not currently have health insurance

Next >>

How did you decide on your health insurance plan?

- ○ I took whatever my employer was offering
- ○ I alone made the decision
- ○ I receive government health care (e.g.Medicaid, Medicare)
- ○ I made the decision with my spouse or partner
- ○ An outside party (insurer, broker, etc) made the decision for me
- ○ I signed up for whatever my family was currently on
- ○ Other, please specify:

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How much do you agree or disagree with the following statements?

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree	Not Applicable
I would have a better understanding of my health insurance plan if I chose it	○	○	○	○	○	○
An insurance broker would enroll me in the best possible plan that met my needs	○	○	○	○	○	○
I wish I was in charge of choosing my own health insurance plan	○	○	○	○	○	○
If I needed help in enrolling in a health insurance plan, I would prefer an online tutorial to telephone support	○	○	○	○	○	○
I trust the health insurance plan my employer offers	○	○	○	○	○	○
I would need assistance if I were to choose my own health insurance (e.g. broker, online tutorials, etc)	○	○	○	○	○	○

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A health insurance exchange is a marketplace where individuals can compare and select from a variety of plan options offered by different insurance companies.

The goals of a health insurance exchange are to:

- Increase the accessibility of health insurance to small groups and organizations
- Reduce the number of individuals without health insurance
- Increase transparency in the health insurance market
- Increase competition among health insurers

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The health insurance exchange will present individuals with health plan options from which they can choose. There is a trade-off between choice and simplicity. The more health plan options presented the more complex the enrollment process. Making the enrollment presentation simple may reduce the number of plan options presented.

When it comes to providing health insurance options to your employees, how many plan options would you like to see presented in the enrollment process?

- ○ Three or fewer health plan options (most simple)
- ○ Four to eight health plan options (moderately simple)
- ○ Nine to twelve health plan options (moderately complex)
- ○ All health plan options (most complex)
- ○ Don't know

In which of the following ways would your organization most prefer to receive education and information about the health insurance exchange?

- ○ In-person presentation by an insurance broker or agent
- ○ Dedicated 24/7 e-mail/chat support with questions answered by a health insurance exchange expert
- ○ Dedicated 24/7 toll-free telephone support with questions answered by a health insurance exchange expert
- ○ Town hall meeting conducted by a health insurance exchange expert
- ○ Health insurance exchange website with information tutorials and education videos
- ○ Would not utilize any of the above options to learn more about the health insurance exchange
- ○ Other, please specify:

How would you most prefer for your organization to enroll annually in a health insurance plan?

- ○ Insurance agent or broker who travels to your business and assists employees with enrollment
- ○ Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment
- ○ Health insurance exchange experts who travel to your business and assists employees with enrollment
- ○ E-mail/chat with a health insurance exchange expert who assists employees with enrollment
- ○ Health insurance exchange website enrollment process that has online tutorials and education videos
- ○ Paper enrollment application that is filled out individually and returned by mail
- ○ Other, please specify:

Individuals vary in the amount they pay attention to these kinds of surveys. If you have read this question carefully, please write the word "yes" in the "Other, please specify" box below.

- ○ Strongly Disagree
- ○ Disagree
- ○ Neither Agree nor Disagree
- ○ Agree
- ○ Strongly Agree
- ○ Other, please specify:

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Suppose you had 100 points of value to distribute among the benefits that could result from a Mississippi health insurance exchange. The benefit that you most prefer would get the most points (or maybe all 100 of the points). A benefit that you prefer less may receive fewer or no points.

Please distribute 100 points among the options below to reflect the degree to which you value each.

Your total must sum to 100.

Simplify health insurance enrolment and administration	0
Attract and retain the best employees by offering health benefits	0
More easily compare health insurance plan options	0
Reduce business costs associated with sick, unhealthy, or injured employees	0
A 10% decrease in health insurance premiums	0
Other, please specify:	0
Total	0

Through which of the following ways would hearing about the Mississippi health insurance exchange most increase your interest?

Select up to 3 options

- ☐ Church, religious group, or pastor
- ☐ Fellow business owners
- ☐ Radio advertisement
- ☐ Insurance agents or brokers
- ☐ State, county, and local leaders
- ☐ Business and community organizations (e.g. chambers of commerce, Elks Lodge, trade associations, etc)
- ☐ Family, friends, and colleagues
- ☐ Billboard
- ☐ Online advertising and emails
- ☐ Health providers (e.g. physicians and nurses)
- ☐ Direct mail-piece to my office
- ☐ Television advertisement
- ☐ Read about it at a community center (e.g. post office, library, etc)
- ☐ Article or special report in the news
- ☐ Health exchange enrollment bus in your town
- ☐ Print advertisement
- ☐ Other, please specify:

The new federal health care law requires that a health insurance exchange be available in every state by 2014. By whom would you prefer the health insurance exchange be operated?

- ○ The federal government should operate the state health insurance exchange
- ○ The State of Mississippi should operate the state health insurance exchange
- ○ Don't know / undecided

<< Back | Next >>

To what extent do you agree or disagree with the following statements?

	Strongly Disagree	Somewhat Disagree	Neither Agree nor Disagree	Somewhat Agree	Strongly Agree
Sick, unhealthy, or injured employees cost my business more than offering health insurance	○	○	○	○	○
The most important characteristic to increasing access to health care is to decrease premium costs	○	○	○	○	○
I support a solution sponsored by Mississippi to improve access to health insurance	○	○	○	○	○
It is currently easy to compare the different health plan options available to Mississippians	○	○	○	○	○
Increasing access to health insurance is critical to economic growth in Mississippi	○	○	○	○	○
I could not understand the complexities of health insurance without an insurance broker	○	○	○	○	○

<< Back | Next >>

Which of the following best describes the health insurance your organization offers?

- ○ Health insurance is offered only to full-time employees
- ○ Health insurance is offered to full-time and part-time employees
- ○ Health insurance has never been offered to any employees
- ○ Health insurance is not currently being offered to any employees, but was offered in the past

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Through which of the following ways would hearing about the Mississippi health insurance exchange most increase your interest?

Select up to 3 options

- ☐ Online advertising and emails
- ☐ Church, religious group, or pastor
- ☐ Print advertisement
- ☐ Radio advertisement
- ☐ Family, friends, and colleagues
- ☐ Health providers (e.g. physicians and nurses)
- ☐ Health exchange enrollment bus in your town
- ☐ Insurance agents or brokers
- ☐ Television advertisement
- ☐ Read about it at a community center (e.g. post office, library, etc)
- ☐ State, county, and local leaders
- ☐ Article or special report in the news
- ☐ Direct mail-piece to my office
- ☐ Community organizations (e.g.community health center, YMCA/YWCA, local non-profits, etc)
- ☐ Billboard
- ☐ Employer
- ☐ Other, please specify:

<< Back | Next >>

Including you, how many employees are in your organization?

Full-time employees	1-9
Part-time employees	None

Next >>

How interested are you in learning more about Mississippi's health insurance exchange?

Not interested at all	DisInterested	Neither interested nor disInterested	Interested	Very Interested
○	○	○	○	○

<< Back Next >>

Learn More about the Mississippi Exchange!

We will be sharing more about the Mississippi health benefits exchange. We want this to be a highly collaborative process. We need your feedback to create an exchange tailored to the needs of Mississippians. Please share your contact information below so that we may share more with you in the future.

First Name

Last Name

Address

Address 2

City

State

Zip Code

<< Back | Next >>

Thank you for your responses. The State of Mississippi is very interested in your input and will make you aware of future health care developments.

Now suppose you had the same options as the previous question, but the following fees apply. Considering these fees, please select which method(s) you prefer for your organization to enroll annually in a health insurance plan?

Select all that apply

- ☐ Paper enrollment application that is filled-out individually and returned by mail ($100 annual fee)
- ☐ Insurance agent or broker who travels to your business and assists employees with enrollment ($500 annual fee)
- ☐ Health insurance exchange website enrollment process that has online tutorials and education videos (free)
- ☐ Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment ($150 annual fee)
- ☐ E-mail/chat with a health insurance exchange expert who assists employees with enrollment ($100 annual fee)
- ☐ None of the above
- ☐ Health insurance exchange experts who travel to your business and assists employees with enrollment ($400 annual fee)

Next >>

ATTACHMENT F

MISSISSIPPI INSURANCE DEPARTMENT

TOWN HALL MEETINGS

Insurance Department
MISSISSIPPI

TOWN HALL MEETING

The Mississippi Insurance Department needs feedback from YOU on how to increase access to health insurance for all Mississippians.

SCHEDULE

MONDAY, June 20		
8:30 – 9:30 AM	Meridian	Riley Center
5:30 – 6:30 PM	Starkville	MSU Hunter Henry Center
TUESDAY, June 21		
8:30 – 9:30 AM	Tupelo	BancorpSouth Conference Center
12:30 – 1:30 PM	Olive Branch	Whispering Woods Conference Center
5:30 – 6:30 PM	Oxford	UM Triplett Alumni Center, Butler Auditorium
WEDNESDAY, June 22		
8:30 – 9:30 AM	Clarksdale	Coahoma CC, Pinnacle Building
12:30 – 1:30 PM	Cleveland	Delta State University Jobe Auditorium
5:30 – 6:30 PM	Greenville	Washington Co. Extension Office Auditorium
THURSDAY, June 23		
8:30 – 9:30 AM	Jackson	Hilton Hotel Jackson
12:30 – 1:30 PM	Pearl	Hinds CC-Rankin Campus, Muse Center
5:30 – 6:30 PM	Clinton	South Pointe Business Park
FRIDAY, June 24		
8:30 – 9:30 AM	Hattiesburg	Lake Terrace Convention Center
12:00 – 1:00 PM	Gulfport	MGCCC-Jefferson Davis Campus, Arena Theater

FOR MORE INFORMATION, PLEASE CONTACT:
(601) 359-2012

PAID FOR USING GRANT FUNDS

Liz Barnett - MID PRESS RELEASE: MID Town Hall Meetings Let Mississippians Have Voice On Health Exchanges

From: Donna Cromeans
To: 1-Mike Chaney; Mark Haire; Mike Chaney
Date: 6/13/2011 4:40 PM
Subject: MID PRESS RELEASE: MID Town Hall Meetings Let Mississippians Have Voice On Health Exchanges
CC: 4- Sandy Ray; Aaron Sisk; Andy Case; Bonnie Shows; Carol Parvin; Chad Bridges; Christina Kelsey; David Browning; Debra Caldwell; Debra Vernon; Donna Cromeans; Elizabeth Bell; HealthCare Reform News; Jasper Welsch; Jo Webster; Joel Jones; John Hornback; John Wells; Joseph Ammerman; Kim Causey; Lee Anne Robinson; Linda Boozer; Linda Chase; Lisa Carraway; Michelle Partridge; Nancy Cross; Nancy Stuart; Reggie Bell; Ricky Davis; Robert Perkins; Roy Obryant; Stephanie Ganucheau; Vanessa Miller

For Immediate Release

June 13, 2011

MID Town Hall Meetings Let Mississippians Have Voice On Health Exchanges

Jackson, MS-The Mississippi Insurance Department will be travelling the state in upcoming weeks seeking public input on a health insurance exchange from business owners and employers.

In March of 2010 the U.S. Congress passed the Patient Protection and Affordable Care Act mandating the establishment of a health insurance exchange in each state by 2014.

A health insurance exchange is a marketplace where individuals and businesses can compare and shop for health insurance. States that do not create a health insurance exchange by 2014 will be forced to adopt a federally-run health insurance exchange. Mississippi has received positive national press for its decision to create an exchange tailored to the unique health needs of the state.

In Mississippi, health care is an economic issue as well as a household concern. In 2010, 18 percent of Mississippians were uninsured and the state ranked first in adult obesity, heart disease deaths and adults reporting no physical activity in the past month.

Sick and injured employees can cost Mississippi businesses thousands of dollars in lost productivity each month. A well-structured health insurance exchange can help resolve these issues, which will ultimately save Mississippi businesses time and money.

To ensure the exchange is best suited to meet the needs of Mississippians, the Mississippi Insurance Department is holding town hall meetings in the following locations on the listed dates to discuss possible solutions and what small businesses are saying based upon a statewide survey. For more information consumers may follow the Department on Twitter @MSInsuranceDept.

SCHEDULE

	MONDAY, June 20	
8:30 - 9:30 AM	**Meridian**	**Riley Center**
5:30 - 6:30 PM	**Starkville**	**MSU Hunter Henry Center**
	TUESDAY, June 21	
8:30 - 9:30 AM	**Tupelo**	**BancorpSouth Conference Center**
12:30 - 1:30 PM	**Olive Branch**	**Whispering Woods Conference Center**
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5:30 - 6:30 PM	**Clinton**	**South Pointe Business Park**
	FRIDAY, June 24	
8:30 - 9:30 AM	**Hattiesburg**	**Lake Terrace Convention Center**
12:00 - 1:00 PM	**Gulfport**	**MGCCC-Jefferson Davis Campus, Arena Theater**

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Donna J. Cromeans

Public Relations Director

Mississippi Insurance Department

(601)359-3579

Cell - (601)826-9600

MID now on Twitter! Follow us  **@MSInsuranceDept**

ClarionLedger.com

Miss. examines creation of health insurance exchanges

Written by

Jeff Ayres

8:46 PM, Jun. 23, 2011|

The state of Mississippi has until Jan. 1, 2014, to set up health insurance exchanges for individuals, small businesses and others as part of last year's federal health care overhaul.

Officials are trying to figure out how to most effectively set up and operate the program.

About 60 people attended a meeting Thursday in Jackson on how the exchanges work and how they can best be set up and administered in Mississippi.

"If we fail to do this, the federal government will step in and do it for us," warned Aaron Sisk, senior attorney for the Mississippi Insurance Department.

The exchanges, part of the health care reform package approved last year, are designed to increase access to health insurance and encourage greater competition among providers.

Supporters say they would liken the exchanges to one-stop shops where people can compare plans, coverage and prices in a flexible, transparent manner.

Mississippi is looking to create exchanges for individual and small-group plans. Criteria for participating insurance providers is being worked out. Participation isn't mandatory, but supporters say high participation is needed to help spread risk more broadly.

Whether the program will lower the cost of health care will be determined over time, although prospects are encouraging, says Randy Shumway, president of The Cicero Group, a Utah consulting firm assisting the state in crafting its plan.

"It's not a panacea," he said of the exchanges. "It's not going to be a silver bullet that solves everything. (But) it does solve a lot of things."

There are relatively few providers of individual health care plans in Mississippi,

ClarionLedger.com

says Jackson resident Pam Shaw.

The individual-plan exchange, if set up properly, could help draw more providers to the state and perhaps lower costs to the public, she said.

"Anything that gives Mississippians more access to health care is a major plus. We need that," she said.

One group of people who could get new paths to health insurance are part-time workers, who often can't get coverage through their employers' plans, Shumway said.

The state's small-group exchange could include a defined-contribution option in which employers select a specific amount to contribute toward each employee's coverage. Those employees then would use that money to purchase a particular plan.

Having separate ex-changes for individuals and businesses is important, especially as Mississippi's 160,000 self-employed would use the individual exchange and keep their risk from affecting businesses, says Ron Aldridge, state director of the National Federation of Independent Business.

But premiums need to be reduced for more small businesses that can't currently afford to offer benefits to start doing so, he said.

"Unless we lower the premiums, it's not going to help a lot," Aldridge said.

The individual-plan exchange could draw many members of the state's retired population, adds Kurt Hellmann, director of governmental affairs for AARP's Mississippi office.

He said he's still learning details of how the exchanges work, but said they could provide "choice and, down the road, lower costs" for seniors.

State insurance officials are traveling to 13 cities this week to talk about the exchanges. They hosted separate forums Thursday in Jackson, Pearl and Clinton.

At each stop, participants have been surveyed on various aspects of the exchanges.

Of those surveyed so far, 82 percent of employees say competitive health benefits are important to attract and retain talent, versus 64 percent of employers, Shumway said.

Just 15 percent of all respondents said it's

ClarionLedger.com

easy to compare health insurance plans currently.

While the exchanges aim to open competition in a free-market setting, 82 percent of those surveyed said plan options should be limited to eight or less for efficiency, Shumway said.

Health care reform remains a sour subject for many - almost 70 percent of those surveyed by Cicero in Mississippi oppose it, Shumway said.

But Sisk added the insurance exchanges have firm support from those in favor of and against the overall reform.

The system as it exists isn't sufficient, and health insurance exchanges can help chip away at the larger problem, Sisk added.

"This is felt anytime we go to the doctor. This is felt anytime we get a prescription filled," he said.

The series of meetings wrap up today with forums in Hattiesburg and Gulfport.

The Mississippi Health Insurance Exchange meeting draws a crowd at the Jackson Hilton.

print

Health care forum opens up dialogue on state's exchange

by Michaela Gibson Morris/NEMS Daily Journal
06.22.11 - 06:24 am
TUPELO - Northeast Mississippians had a chance to chew on plans for a state health exchange at a public forum Tuesday.

"We have a slim window to create an exchange that meets the needs of the state of Mississippi," said Aaron Sisk, senior attorney with the Mississippi Insurance Department, as he opened a Tuesday morning community forum in Tupelo with 40 people attending.

Under federal health care reform laws, states must have an exchange in place Jan. 1, 2014, or use a federal health care exchange.

Health exchanges are central hubs where health insurance plans can be compared side by side and purchased. It allows for a range of coverage options. Companies would compete on service, price and networks.

"The idea is to create greater access and flexibility," said Randy Shumway, chief executive of the Cicero Group, a research and marketing company which is leading forums across the state to gather input on the state health exchange program.

The insurance department contracted with Utah-based Leavitt Partners and Cicero Group to gather input from stakeholders and develop the health insurance exchange. The preliminary research results from interviews and surveys with insurance professionals, elected officials, consumer advocates, employers, employees and community leaders show that most people want:

- A state-created exchange instead of a federal one;

- A simple enrollment process;

- A simple way to compare and select plans;

- Access to real person with health insurance expertise, in addition to a website or customer service call center that can answer questions.

"It's not going to solve all the problems," Shumway said, but it should increase access and flexibility in health insurance.

The Mississippi Insurance Department is modeling the exchange after Utah's health exchange, which began in January 2010 with 11 small employer groups and now has more than 130 groups covering more than 3,500 people.

About a quarter of the participating companies did not offer insurance to their employees before joining the exchange.

Four of the five largest health insurance companies doing business in Utah are

represented on exchange and they have 146 different health insurance plan designs.

Although a broker is not required, most companies use a broker to help employees navigate the Utah exchange.

Tupelo comments

The Tupelo meeting drew comments from health insurance consumers, doctors, insurance brokers and employers.

Insurance brokers in particular had lots of questions and were wary about the exchanges.

Skip Johnson, an insurance broker attending the meeting, said he was concerned the health exchanges would have the unintended consequence of undermining existing group health care coverage.

Other insurance professionals were concerned about Mississippi having sufficient population to be attractive to health insurance companies, especially considering the population's generally poor health status.

The forums are a good first step, said Roy Mitchell, executive director of the Mississippi Health Advocacy Program, but it will be important to get more consumers involved in the process.

"We want a plan for Mississippians designed by Mississippians," said Mitchell, who attended meetings in Starkville, Tupelo and Olive Branch, "but for that to work, there truly has to be consumer involvement in design and ongoing administration of the exchanges."

On the exchange

- For more information on the proposed Mississippi Health Exchange, visit www.mid.state.ms.us or email

mshealthexchange@mid.state.ms.us.

Health insurance town hall meeting held

Reported by: Robert Byers
Email: rbyers@wtva.com
Last Update: 6/21 2:33 pm

Print Story | Share

TUPELO, Miss. (WTVA) - At a town hall meeting in Tupelo Tuesday, residents, business owners and others came out to learn more about proposed changes in the way Mississippians get health care insurance.

The Mississippi Department of Insurance talked about a health insurance exchange, which is a marketplace where individuals and businesses can compare and shop for health insurance.

States that do not create such a program by 2014 will be forced to adopt a federally-run health insurance exchange.

Aaron Sisk with the Mississippi Insurance Department said, "Health insurance has always been regulated at the state level and we're trying to maintain that as much as possible."

One person attending the meeting talked about the importance of all groups having input.

Wayne Slocum with the Mississippi Section of American College of OB-GYN said, "As obstetrician-gynecologists we really feel like contraception is important, we feel like coverage for high-risk pregnancies are important. We want to make sure that the citizens of Mississippi have an opportunity to select from various insurance products that are in their best interests."

While nothing is set in stone about the future of insurance coverage in this country, changes will take place.

Sisk said, "This is new territory we're embarking on. So, it's important we get feedback from the people of Mississippi both good and bad."

Besides in Tupelo, the insurance department is traveling the state to get input from residents.

It's a reform many of those at the meeting say they know is a work in progress.

Slocum said, "We want it to be geared primarily for citizens of Mississippi but we also don't want to reinvent the wheel if it's been done on a national level already."

THE COMMERCIAL APPEAL
Memphis, Tennessee
Printer-friendly story
Read more at commercialappeal.com

Olive Branch town hall draws health care queries

By Toni Lepeska

Wednesday, June 22, 2011

Area residents had plenty of questions Tuesday at a town hall meeting in Olive Branch about the new federal health care reform legislation, but the session was more about distributing information than taking questions.

Officials tried to answer the questions but emphasized that the purpose of the meeting was narrower -- to disseminate information and collect feedback on the creation of a health benefit exchange.

An exchange would be a central location for small business owners and individuals to compare benefits and costs of policies. The federal government is requiring states to create an exchange or participate in a federal one by 2014.

"I was here mainly to gauge public interest," said Davy Hunt, a Southaven insurance agent. "People call me with the same questions they ask these guys."

The state Insurance Department held the meeting, its fourth in 13 cities, at Whispering Woods Hotel & Conference Center. Representatives polled the audience about their understanding of health care reform and what they would want from a health benefit exchange.

About 15 people attended. Patrick Terrell, a real estate agent who said he is self-insured, wanted to know if he would eventually be required to buy health insurance.

Officials said no one would be forced to participate in an exchange created by the state of Mississippi, but everyone will have to be insured under the Affordable Care Act. Fines will be levied against nonparticipants, and subsidies will be offered to help some pay for premiums.

Officials emphasized that because of the controversial political nature of health care reform, mandates may change but some sort of reform is essential. Mississippi officials thought creation of a health benefit exchange would boost competition and improve the flow of information.

"There's no question the health care system as we know it is broken," said Aaron Sisk, who heads the life and health division of the state Insurance Department. "There's no simple, quick fix."

Sisk said he came away from the meeting feeling a need for more meetings to help get people informed.

"There's a need for information," Sisk said. "A lot of people feel in the dark."

hattiesburgamerican.com

Input sought on health insurance options

Written by

LA TONYA FRELIX

9:23 PM, Jun. 24, 2011|

The Mississippi Insurance Department has taken to the highway to seek input as it works toward creating a health insurance exchange to comply with the Affordable Care Act of 2010.

On Friday, representatives stopped at Lake Terrace Convention Center for a town hall meeting - one of 13 across the state - that solicited input on how the state will f ormulate an exchange that will serve as a marketplace where individuals and businesses can compare and shop for health insurance.

The meeting gave participants the opportunity to discuss possible solutions and what small businesses are saying across the state about health insurance options.

"We're better suited to create and run an exchange that works best for the state of Mississippi," said Aaron Sisk, senior attorney for MID. "We're looking to build an exchange for Mississippians by Mississippians. This is why we're here today. We need your help."

In March 2010, Congress passed the Patient Protection and Affordable Care Act mandating the establishment of a health insurance exchange in each state by 2014.

A health insurance exchange is a marketplace where individuals and businesses can compare and shop for health insurance. States that do not create a health insurance exchange by 2014 will be forced to adopt a federally-run health insurance exchange.

Sisk reassured the handful of attendees the exchange would not be forced upon people but would serve as another delivery option. "It's our hope that it (the exchange) will encourage a marketplace that is competitive and therefore ultimately lower premiums but we can't make promises on that," he said.

Randy Shumway, CEO of Cicero Group, a market research company, is compiling data regarding what Mississippians want in an exchange.

hattiesburgamerican.com

Information from the town hall meetings will be used by the state insurance department to create a mockup of desired items to be included in the exchange. The mockup will be presented to the public and tweaked accordingly.

"Mississippi is adamantly committed to talking to as many people as possible to insure we include everyone at the table to create a system that maximizes benefit for the maximum number of people," he said. "They're going to go slow to do it right."

Public Asked for Input on Creation of Health Insurance Exchange

PUBLISHED BY DANIEL CHERRY ON 23 JUN 2011 04:26PM

The Mississippi Insurance Department is traveling across the state gathering public opinion on creating a health insurance exchange. MPB's Daniel Cherry reports how the exchange will affect some residents for better or worse.

The Patient Protection and Affordable Care Act says all states must establish a health insurance exchange by 2014 or be forced to adopt a federally run program. Mike Chaney, Mississippi's Insurance Commissioner, says the state has a variety of unique health concerns that Mississippians are best suited to handle.

"We talk about what's required to have an affordable insurance package in the state, and that feedback is coming from the citizens of the state. It's not designed by a bunch of folks in a room with big egos. It's designed by people who truly care about what's needed in the state in Mississippi."

The exchange will create a marketplace where individuals and businesses can shop for health insurance. Kreig Bell is an insurance broker. He says about 90 percent of his clients are businesses. He's worried about where he'll fit in if businesses have the option of letting individuals shop for insurance themselves.

"They're pretty much going to say, 'Kreig, I'm sorry, but this is affecting our bottom line such that we're going to have to send them on to the individual exchange, and there goes my business. Hopefully I'm not bagging groceries anytime soon.'"

But small business owner Sandra Mobley says she doesn't see businesses dropping insurance plans because they have the option to let individuals handle shopping themselves. She says good benefits attract the best employees.

"Now people with families, they want to know. That would be the only thing. To keep employees and high morale. I still believe that group (insurance) will be in existence because those employers are still willing to pay to keep good employees."

The Health Care Bill says all states have to comply with the exchange, but it doesn't say how. Insurance Commissioner Mike Chaney says public opinion is the best way to figure out how to benefit the most people.

ClintonNews.com
A GANNETT COMPANY

June 15, 2011

Give views on health insurance at Clinton forum

The Clinton News

The state Department of Insurance is seeking the views of residents on how to increase access to health insurance.

The department and Commissioner of Insurance Mike Chaney are hosting a public forum from 5:30-6:30 p.m. June 23 at South Point Business Park, 500 Clinton Center Drive in Clinton, that's open to all residents. Small business owners are especially invited.

For more information, contact the Insurance Department at (601) 359-2012.

Images

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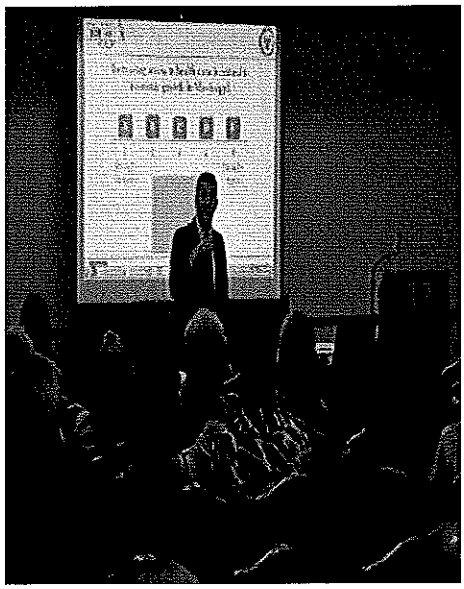

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Mississippi health insurance exchange introduced at town hall meetings

Published: Saturday, June 25, 2011, 6:30 AM

By **Harlan Kirgan, Mississippi Press**

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Randy Shumway, chief executive officer of The Cicero Group, discusses health insurance exchanges Friday at the Arena Theater at Mississippi Gulf Coast Community College's Jefferson Davis Campus in Gulfport. The presentation was the final of 13 held on the health insurance exchange in the state this week. (Harlan Kirgan/Press-Register)

GULFPORT, Mississippi -- The final stop of a 13-city tour of Mississippi to explain and gather ideas about a **health insurance exchange** was held Friday at Mississippi Gulf Coast Community College's Jefferson Davis Campus.

Aaron Sisk, a senior attorney in the Mississippi Insurance Department, said the tour is the first outreach in setting up the exchange mandated by the Patient Protection and Affordable Care Act passed by Congress in March 2010. The tour started Monday in Meridian.

"We want to educate, but more importantly we want the people of Mississippi to educate us on what issues they would like to see addressed," he said.

Sisk said the health insurance exchange aims to increase access to health care insurance and competition among providers.

"I know on the coast it is not the primary insurance need at this time, but it's one that will affect all 2.9 million Mississippians," he said.

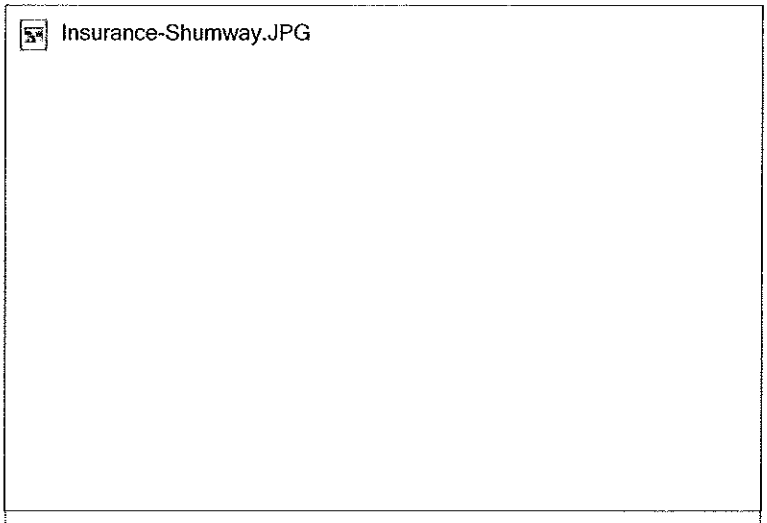
"If we fail to do something at the state level, the federal government will step in and do it for us," he said.

The state faces a Jan. 1, 2014, deadline to create its insurance exchange, he said.

Sisk and Randy Shumway, chief executive officer of The Cicero Group, which is presenting the tour program and conducting research on the exchange, pointed out the exchange predates the Affordable Care Act.

"This exchange concept is universally accepted by both Republicans and Democrats," Sisk said. "It is a good concept without any negatives. It is just an additional option. It can stand on its own without federal requirements."

Sisk said Gov. Haley Barbour has attempted to pass an insurance exchange four times in the Legislature without success.



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Randy Shumway, chief executive officer of The Cicero Group, discusses health insurance exchanges Friday at the Arena Theater at Mississippi Gulf Coast Community College's Jefferson Davis Campus in Gulfport. The presentation was the final of 13 held on the health insurance exchange in the state this week. (Harlan Kirgan/Press/Register)

On Friday, town hall participants were offered remote control-like devices to register their opinions on questions posed by Shumway.

The federal program is opposed by 69 percent of those surveyed at the town hall meetings, he said.

In Gulfport, 39 percent of the 28 people voting opposed the federal program while 43 percent supported it.

"What we have experienced is that the Affordable Care Act is kind of polarizing," Shumway said.

"People are not iffy about it. For that reason when we talk about the health benefit exchange, to be honest, we are kind of trying to separate it from the Affordable Care Act."

One exchange Shumway described is a defined contribution plan in which employers would contribute a specific amount for each employee. The employee would be free to select the health insurance plan that suits his or her needs, he said.

Gary Smith, a Pascagoula insurance agent, said, "I have 20 years in the insurance business. This is not going to cut costs. It is not going to do anything."

Smith said independent insurance agents offer the same variety of coverage. "This is what we do for a living."

But, Karlyn Stephens, a board member of Coast Family Health Center, said access is one of the prime reasons for the Affordable Health Care Act.

"Everybody needs health care in Mississippi," she said. "If it doesn't affect you, it affects your children."

Stephens said she wants the exchange to represent the needs of people and not be run by those with self-interests.

Sisk said the plan is to create an advisory board "with as many stakeholders as we can identify."

Insurance Department
MISSISSIPPI

A Health Insurance Solution By Mississippians, For Mississippians

Town Hall Meeting

Agenda

- Introduction
- Town Hall Discussion
- Executive Summary
- Mississippi and the Affordable Care Act
- Designing a Health Insurance Exchange for Mississippi
- How Does the Health Insurance Exchange Help Businesses
- Challenges for the Health Insurance Exchange
- Frequently Asked Questions
- Questions and Answers

Insurance Department
MISSISSIPPI

Who Are We?

- **Mississippi Insurance Department**
- **Mission: Encourage competitive insurance marketplace and ensure Mississippians have the maximum amount of consumer protection**
- **Commissioner Mike Chaney**
- **Holding town hall meetings across the state to talk about what Mississippi is doing to assist businesses with health insurance**

Meridian	Clarksdale	Clinton
Starkville	Cleveland	Hattiesburg
Tupelo	Greenville	Gulfport
Olive Branch	Jackson	
Oxford	Pearl	

Town Hall Discussion

1. **Provide context about the Affordable Care Act and the State of Mississippi health exchange.**

2. **Share the findings from the Mississippi Insurance Department's research.**

3. **Seek feedback from business owners to shape the optimal health exchange.**

Summary

1. Federal law requires the creation of a health exchange by 2014. Mississippians believe the state, and not the federal government, is best equipped to design that exchange and tailor it to the needs of Mississippians.

2. A health insurance exchange is a tool for increasing access to health insurance by creating a marketplace where businesses and individuals can easily select and compare health plans.

3. A health exchange will increase transparency, simplify enrollment, and reduce the administrative burden experienced by businesses offering health insurance. The exchange is just one of a combination of solutions needed to increase access to health care.

4. There are many challenges to implementing a health insurance exchange in Mississippi. But the state is committed to working collaboratively with businesses to create an exchange by Mississippians, for Mississippians.

In 2010, Congress passed the Affordable Care Act (ACA) with the intent of expanding health care to all Americans. The law requires that everyone be insured. Many will qualify for Medicaid. Others must purchase insurance or face a penalty.

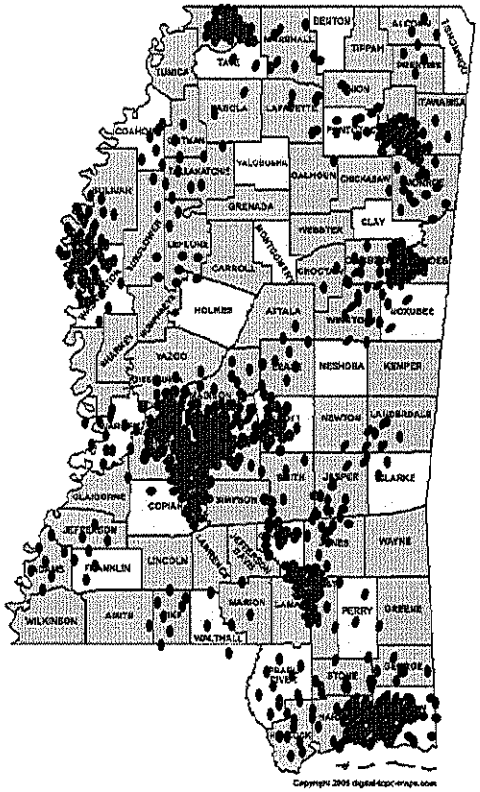
Uninsured and Medicaid Rates in Mississippi

Mississippi 2011	**18%** Uninsured or 1 in 5 	**24%** Eligible for Medicaid or 1 in 4 
Mississippi 2017 Projections after ACA Implementation	Uninsured Rate **3%**	Medicaid Eligibility Rate **34-38%**

What questions do Mississippi businesses have about the ACA?

- How will the ACA impact my business?
- If everyone has to be insured, will I be forced to offer insurance to my employees?
- What is the state doing to help businesses with the challenges of the ACA?
- What is going to happen to my taxes?

The State of Mississippi is proactively seeking feedback to create health insurance solutions. Over one thousand small businesses and individuals across Mississippi have shared feedback in person, by mail, telephone, and online.

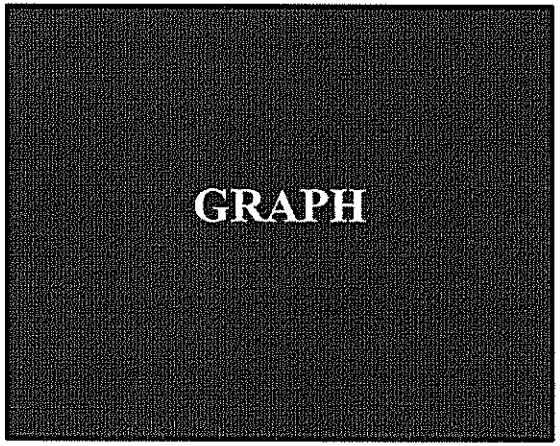


Who Participated

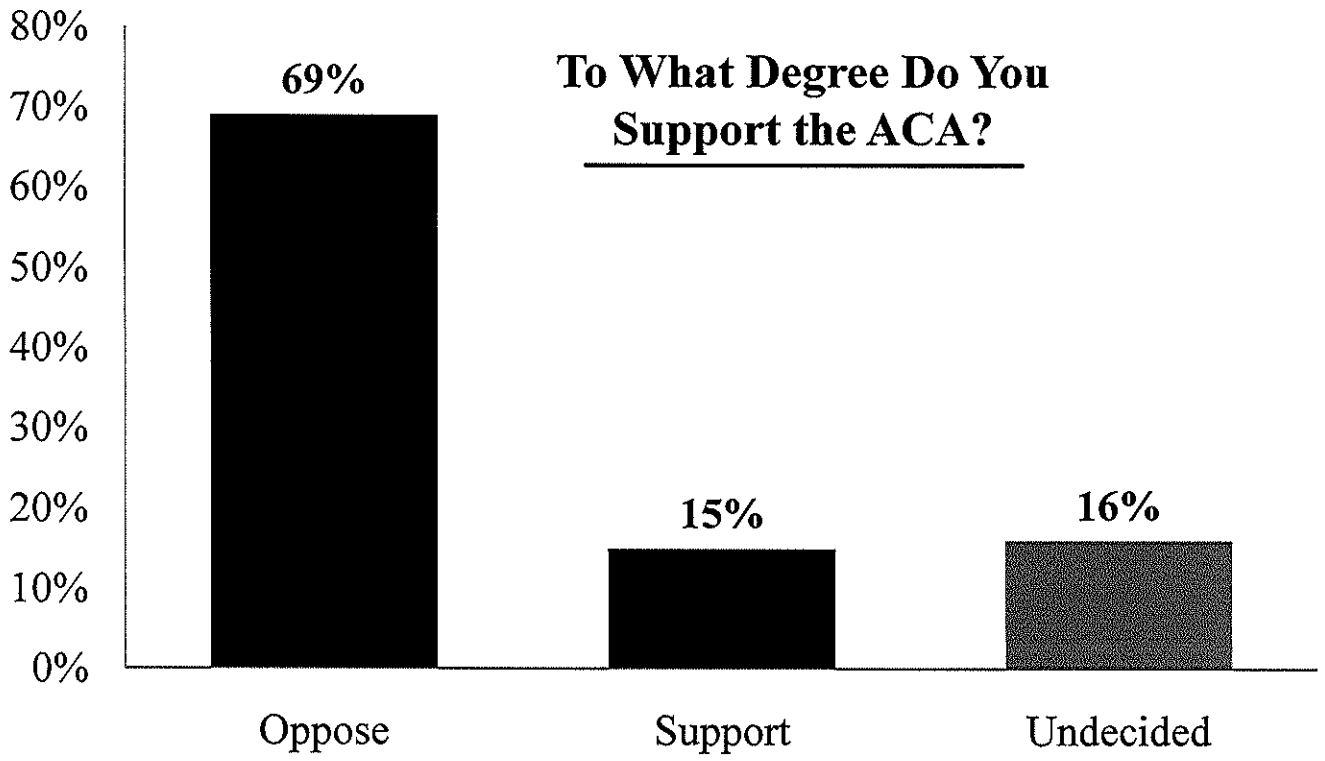
- Small Businesses
- Employees
- Business Associations
- Economic Development Leaders
- Consumer Advocates
- Legislators
- Health Care Providers
- Insurance Carriers
- Broker Representatives
- Policy Analysts

To what degree do you support the Affordable Care Act?

A	B	C	D	E
1	2	3	4	5
Strongly Oppose				Strongly Support



How do Mississippians feel about the ACA? The vast majority of respondents oppose the Affordable Care Act.



The primary theme we've heard is that the State of Mississippi should do all it can to implement state solutions to health reform.

Health insurance is broken. But….

"We need a solution built by Mississippians, for Mississippians."

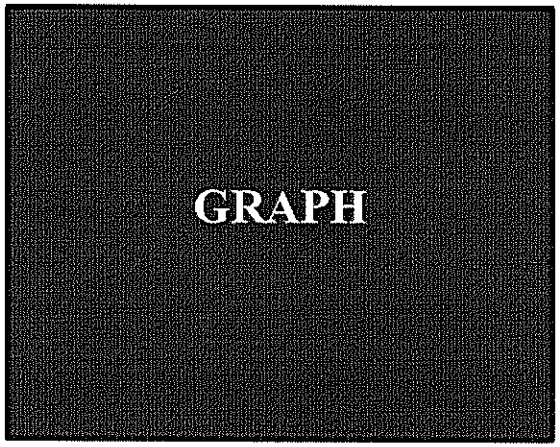
The ACA affects businesses in several ways…

1. **Small groups can opt into a state health exchange.**
2. **Small tax credits for participating in the exchange.**
3. **Penalties for businesses with 50+ full-time employees that do not offer insurance.**

What is the Health Insurance Exchange?

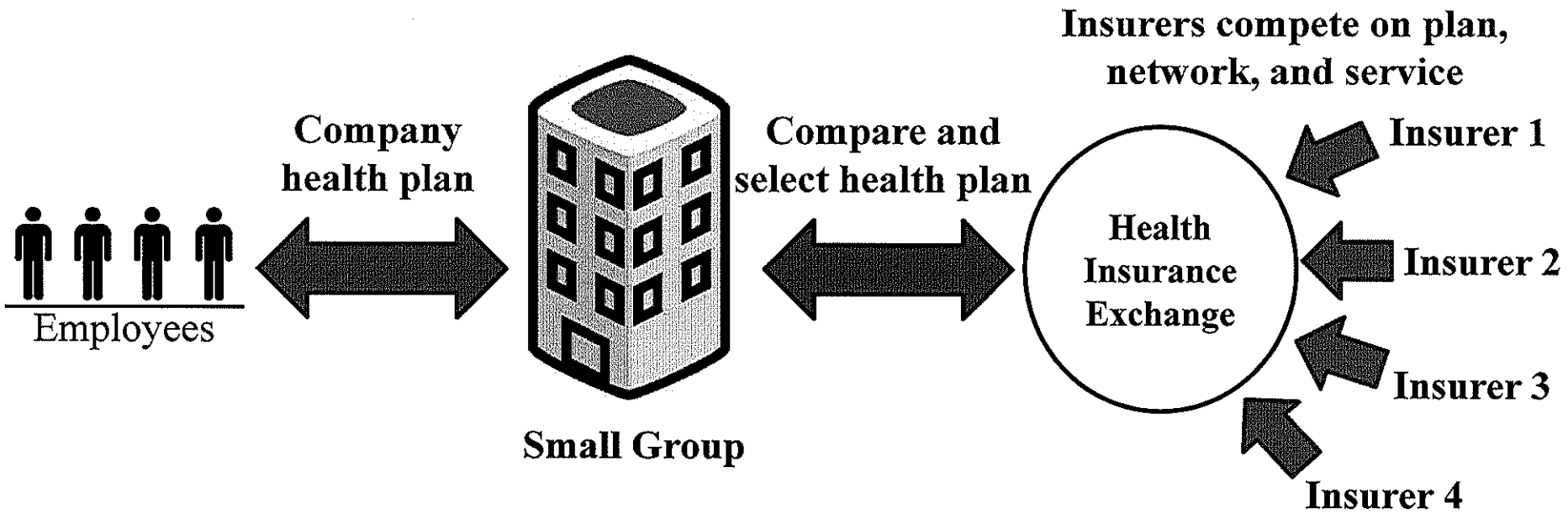
How would you rate your current level of knowledge about a health insurance exchange?

A	B	C	D	E
1	2	3	4	5
No Knowledge At All				Perfect Knowledge



A health insurance exchange is a marketplace where individuals and businesses can compare and shop for health insurance. A health insurance exchange is a competitive solution, not a government entitlement program.

How a Health Insurance Exchange Works



A health insurance exchange can solve many common issues that prevent employers from offering health insurance.

Health Insurance Challenges	Health Insurance Exchange	Health Insurance Exchange Solutions
Lack of Transparency	Health Insurance Exchange	Easily compare plan options among insurers
Administrative Burden		Easy to Manage Policies
Unpredictable Costs		Tools for predicting and managing costs
Difficult Enrollment		Simple enrollment process
One-Size-Fits-All Plans		Employees can select customized plans

The health insurance exchange is not by itself a silver-bullet for improving health care, but it is a critical component in expanding coverage and improving the health insurance markets.

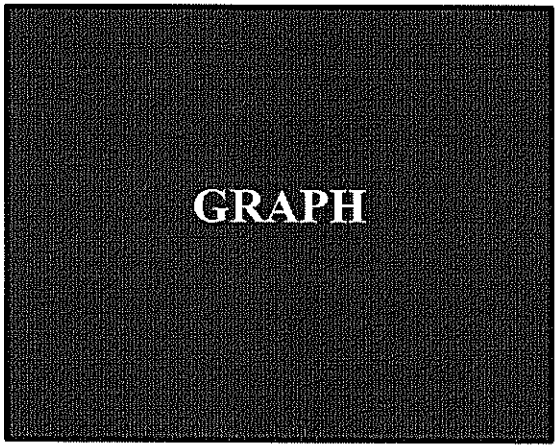
Problems the Health Insurance Exchange Solves

Health Care Challenges

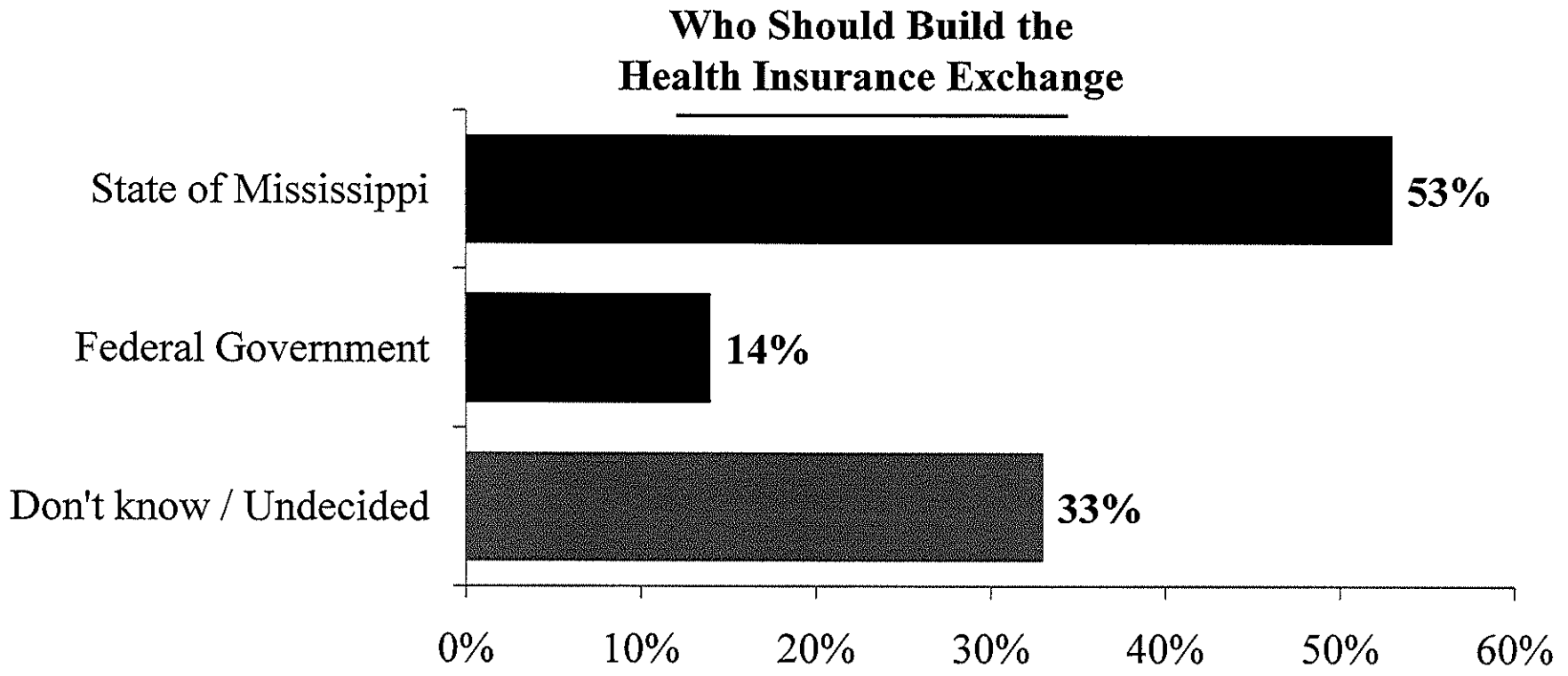
- Unpredictable price increases
- Complexity of insurance
- Lack of transparency
- Minimal competition
- Challenging enrollment processes
- Administrative burden of offering insurance
- High monthly premiums

By whom would you prefer the insurance exchange be operated?

A	B	C
The Federal Government	The State of Mississippi	Undecided



The ACA requires that a health insurance exchange be in place by 2014. If the state does not create an exchange, Mississippi will be automatically enrolled and required to pay for using the federal health insurance exchange.



Why should Mississippi build the health insurance exchange rather than the federal government?

State Health Exchange

- Tailored to the needs of Mississippians
- Better able to understand and allocate resources
- Lower administration costs that can be passed on to consumers

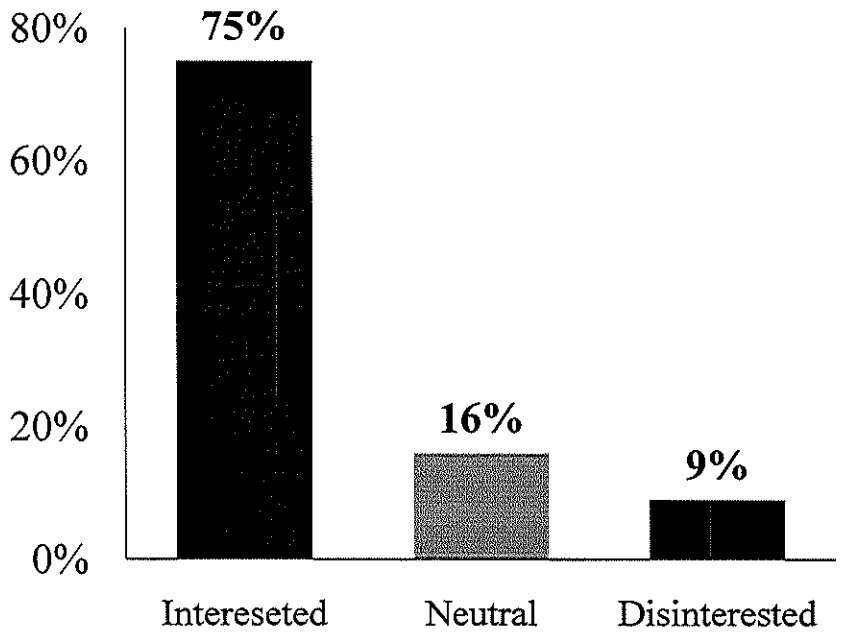
Federal Health Exchange

- Generic exchange (i.e. one-size-fits-all)
- Increased costs to states for higher Medicaid rates

Insurance Department
MISSISSIPPI

Businesses in Mississippi are in interested in learning more about the health insurance exchange for it's possibilities of expanding insurance options and simplifying the process of selecting and comparing plans.

How Interested Are You in Learning More about the Health Insurance Exchange



Reasons for Interest

- Would like better health options
- Solution may lower costs
- Simplify insurance process

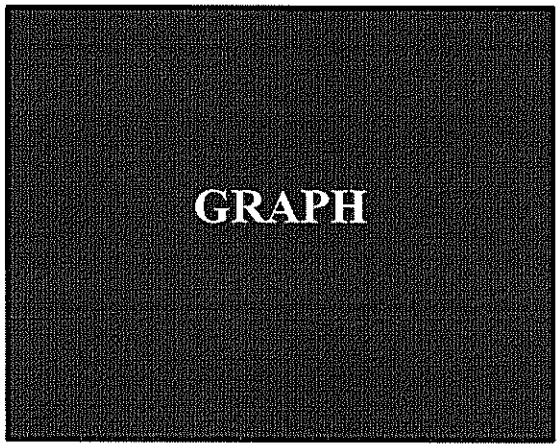
"I am interested because of the simplicity in being able to compare plans."

"I am **not** interested because it looks like another government run program that will only cost taxpayers more money"

How Does A Health Exchange Directly Help Businesses?

Increasing access to health care is critical to economic growth in Mississippi.

A	B	C	D	E
1	2	3	4	5
Strongly Disagree				Strongly Agree



What are some of the challenges businesses face with health insurance in Mississippi?

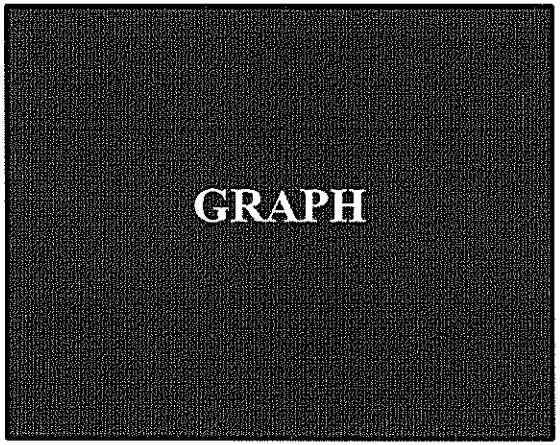
1. Increased costs, lack of transparency, over-sized one-size-fits-all options, and administrative hassles are causing employers to stop providing health benefits.

2. Opposition to the Affordable Care Act is causing increased uncertainty and unease.

3. Elected officials, representing diverse constituents, differ on how the state can best align with the Affordable Care Act and simultaneously optimize the health care provided to Mississippians.

Which of the following best describes the health insurance your organization offers?

A	B	C	D
Offer to full-time and part-time employees	Offer only to full-time employees	Have never offered	Do not currently offer, but did in the past

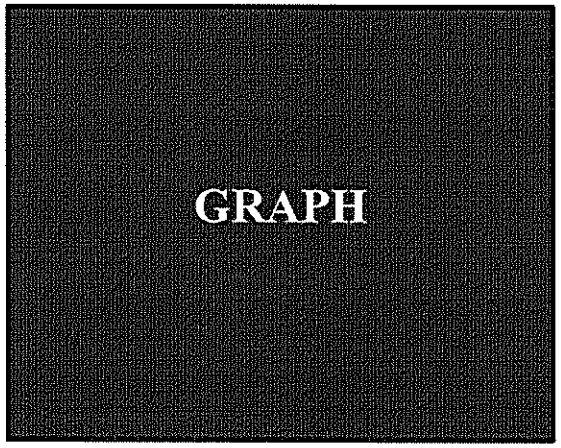


How do businesses feel about the health insurance market in Mississippi?

Statement	Percent of Mississippi Business Agreeing with Statement
"Increasing access to health insurance is critical to economic growth in Mississippi."	75%
"I support a solution sponsored by Mississippi to improve access to health insurance."	72%
"It is currently easy to compare the different health plan options available to Mississippians."	15%

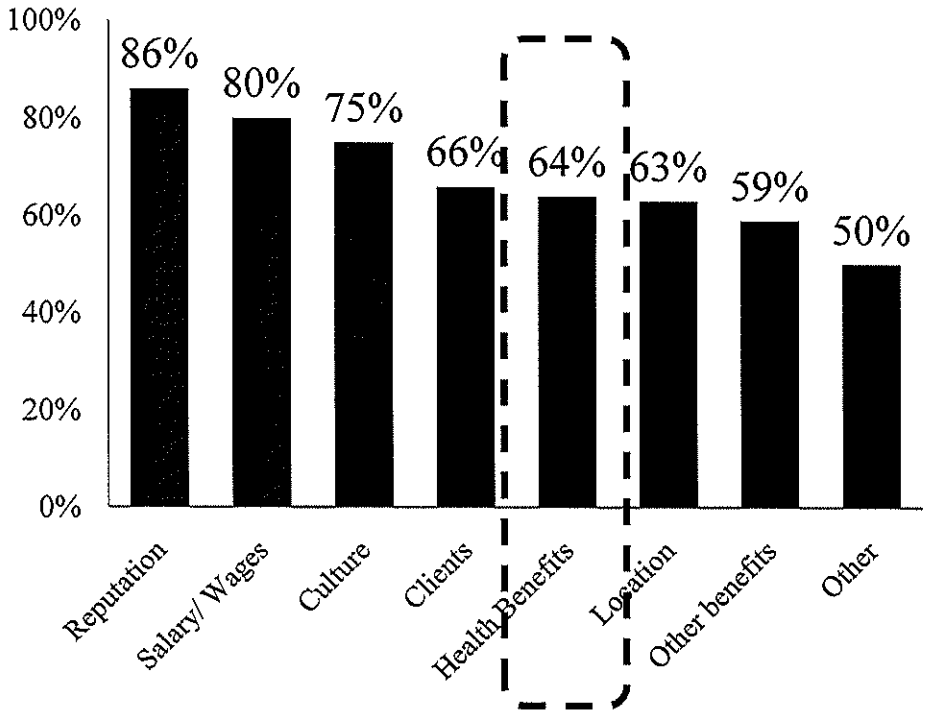
How important are health benefits in attracting and retaining quality employees?

A	B	C	D	E
1	2	3	4	5
Not At All Important				Very Important

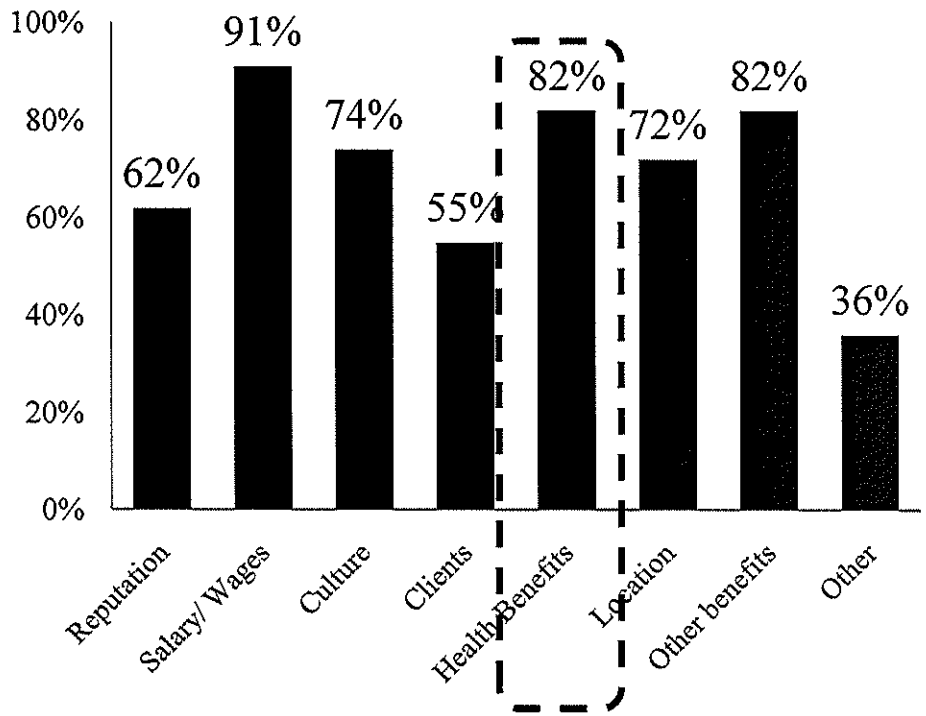


Health insurance benefits are more important in attracting the best employees than most employer respondents realized.

How to Attract and Retain Employees: Employer Responses



Most Important Factors When Choosing An Employer: Employee Responses



Other than decreasing costs, businesses in Mississippi see the health exchange as a tool for attracting the best employees and reducing the costs of unhealthy employees.

What outcomes do Mississippi businesses expect from a health insurance exchange?

Outcome of Exchange	
10% decrease in health insurance premiums	32%
Attract and retain the best employees by offering health benefits	18%
Simplify health insurance enrollment and administration	16%
Reduce business costs associated with sick, unhealthy, or injured employees	15%
More easily compare health insurance plan options	13%
Other	6%

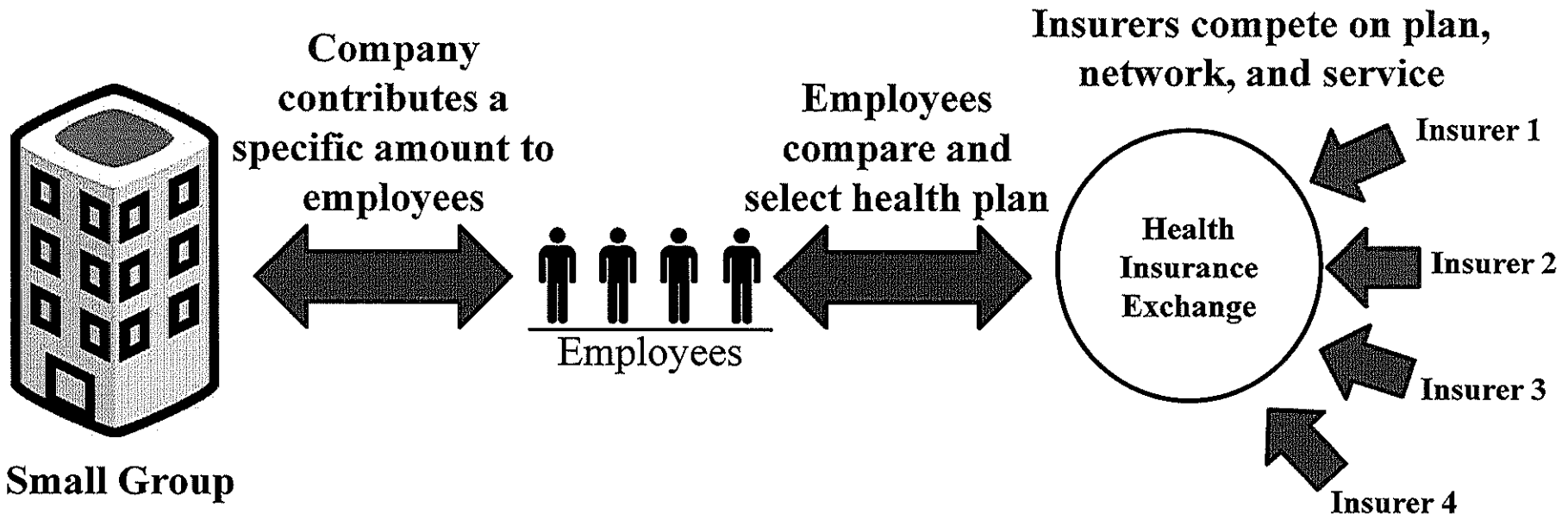
Important finding from research…

Mississippi businesses and employees recognize a direct link between health insurance accessibility and economic growth.

What about Managing Costs?

The health insurance exchange could allow for a Defined Contribution model where employers select a specific amount they will contribute to employee plans. Employees can then take that money and select a plan for themselves.

How a Defined Contribution Model Works



Defined Contribution plans have several benefits for both employers and employees.

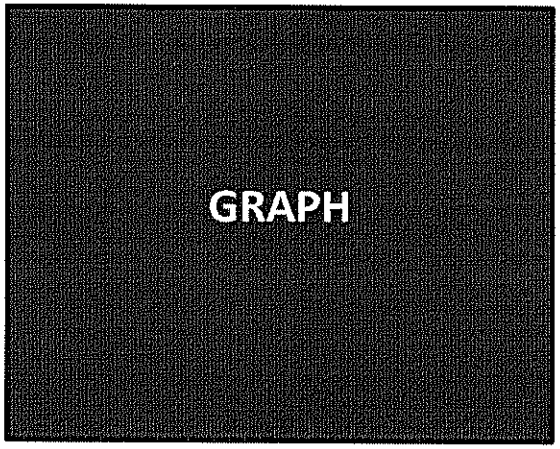
1. Costs are more predictable since the employer can choose the amount they will contribute each year to health plans.

2. Employers no longer have to select plans for employees thus reducing enrollment and administrative burdens.

3. Employees can select plans that are customized to their needs.

After hearing about a Defined Contribution Plan, how interested are you in participating in such a program?

A	B	C	D	E
1	2	3	4	5
Not At All Interested				Very Interested

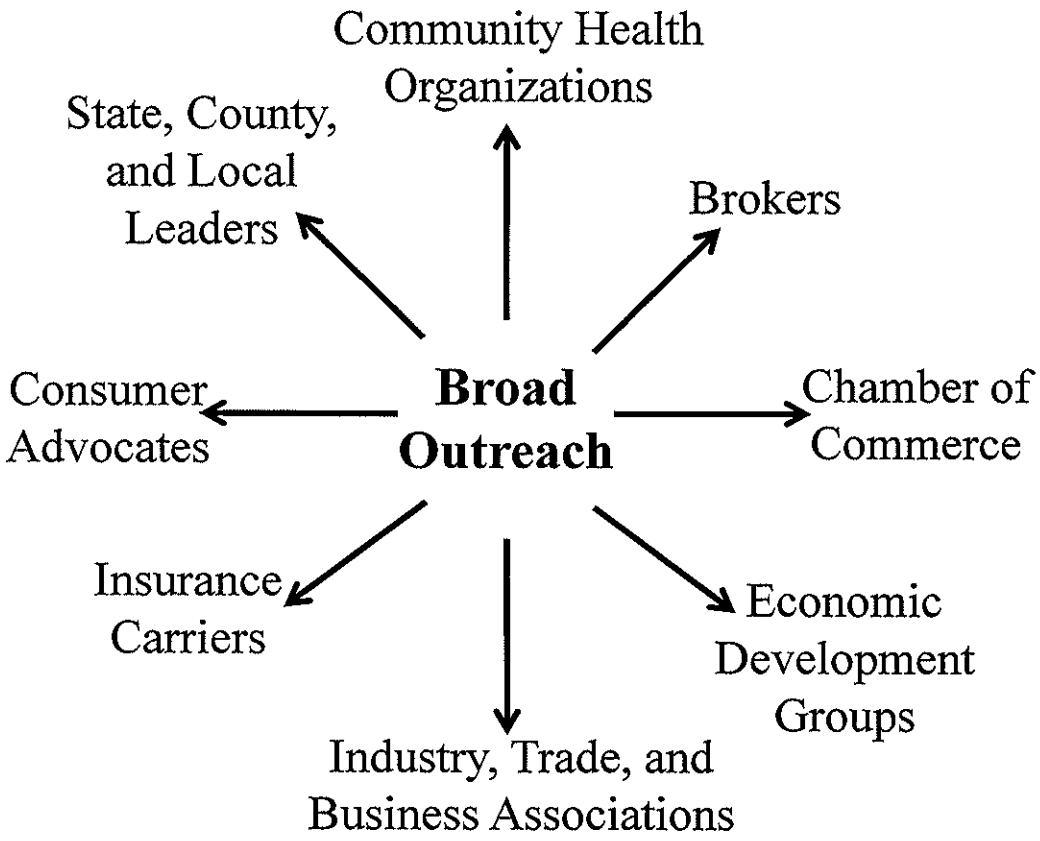


How Should the Mississippi Health Exchange Be Designed?

Every aspect of the health insurance exchange must be designed with the intent of getting businesses out of health insurance administration and back to running their businesses.

1. **Broad Outreach and Marketing**
2. **Simple Enrollment Process**
3. **Simple to Compare and Select Plans**
4. **Easy to administer plans**

Broad outreach and marketing will facilitate higher participation rates.



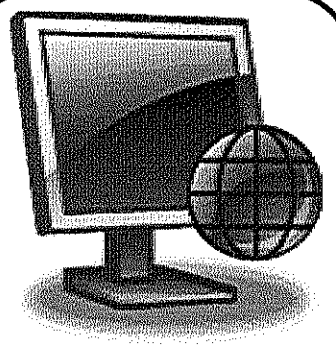
Simple Marketing

Mississippians are diverse; health care and health solutions are complex.

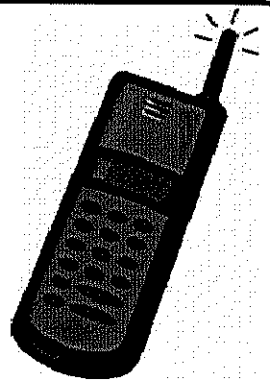
Marketing must be simple and straight-forward designed to bridge various backgrounds.

Mississippians must be able to access and enroll in the exchange through many different methods.

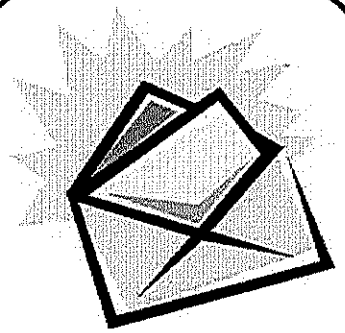
Many Points of Access and Assistance



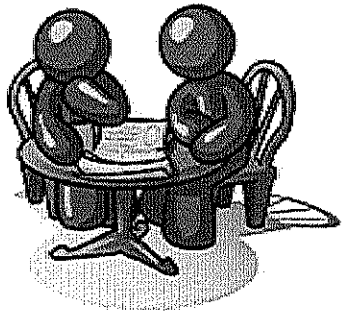
Internet



Phone



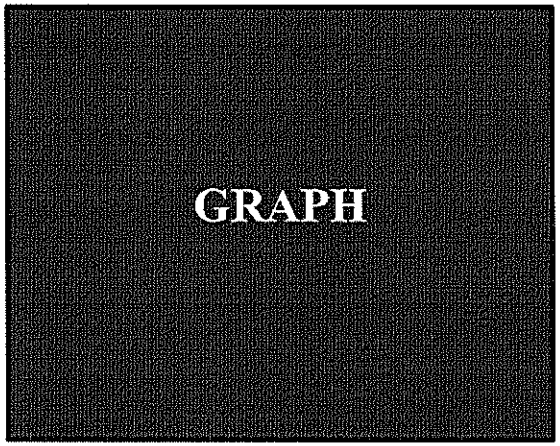
Mail



In-person

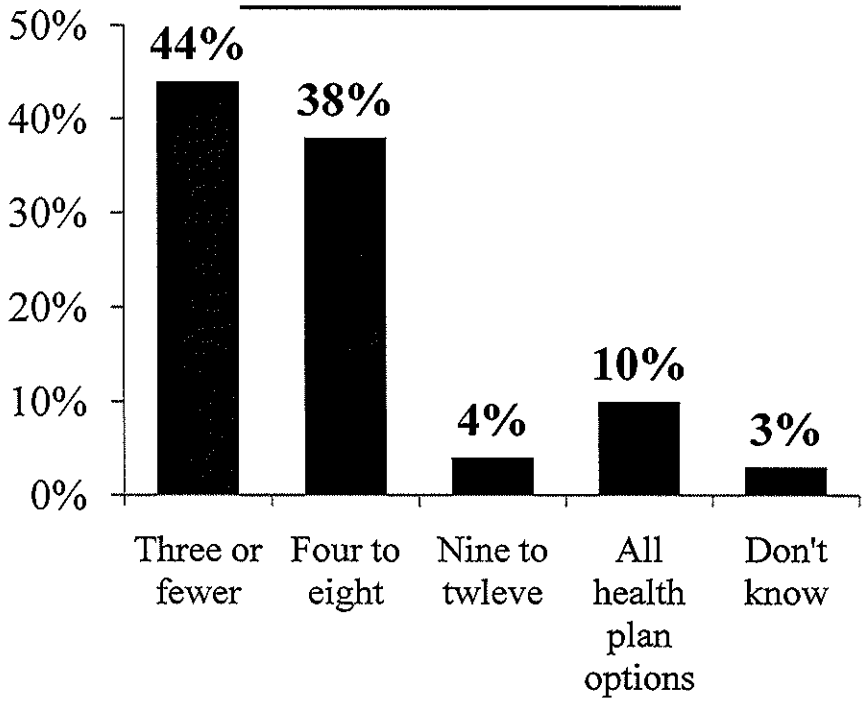
When it comes to providing health insurance options to your employees, how many plan options would you like to see presented in the enrollment process?

A	B	C	D
Three or Fewer Health Plan Options	4-8 plan options	9-12 plan options	All Health Plan Options



It must be easy to accurately compare and select health insurance plan options.

How many plan options would you prefer the health insurance exchange show?

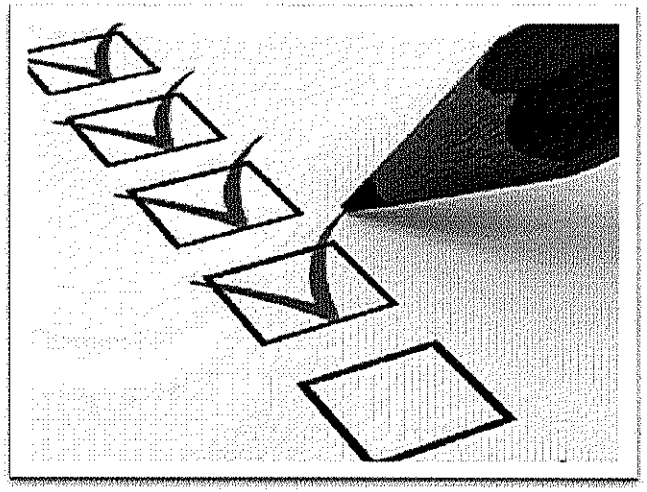


1. **Present fewer plan options.**
2. **Make it easy to compare plan options.**
3. **Easy to choose the best solution, not just the least expensive.**

Business owners need to run their businesses. The exchange must be simple for businesses to administer health plan options.

Easy Administration

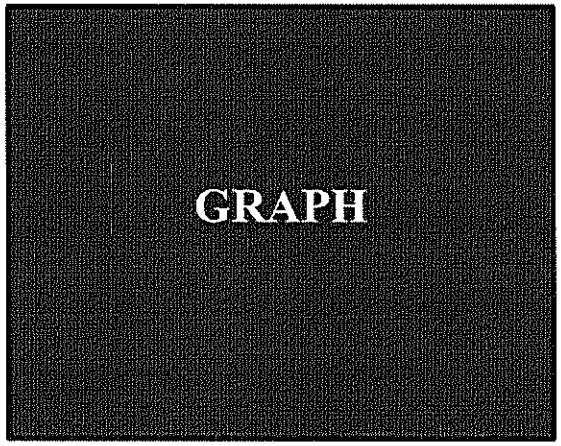
- Billing and payment
- Adding and dropping employees
- Updating employee personal information
- Informing employees of benefits
- Answering employee questions
- Plan specifics like co-pays, coverage, network, customer service numbers, etc



What about My Insurance Broker?

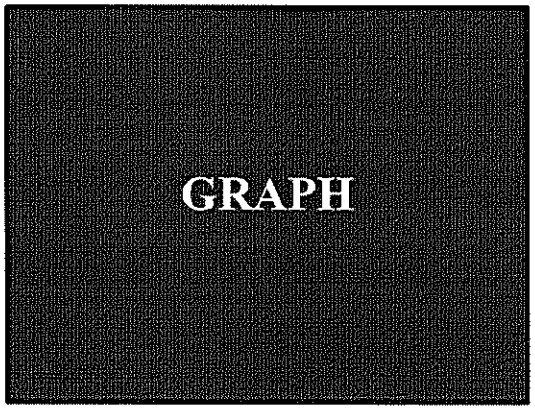
I can understand the complexities of health insurance without the help of an insurance broker.

A	B	C	D	E
1	2	3	4	5
Strongly Disagree				Strongly Agree

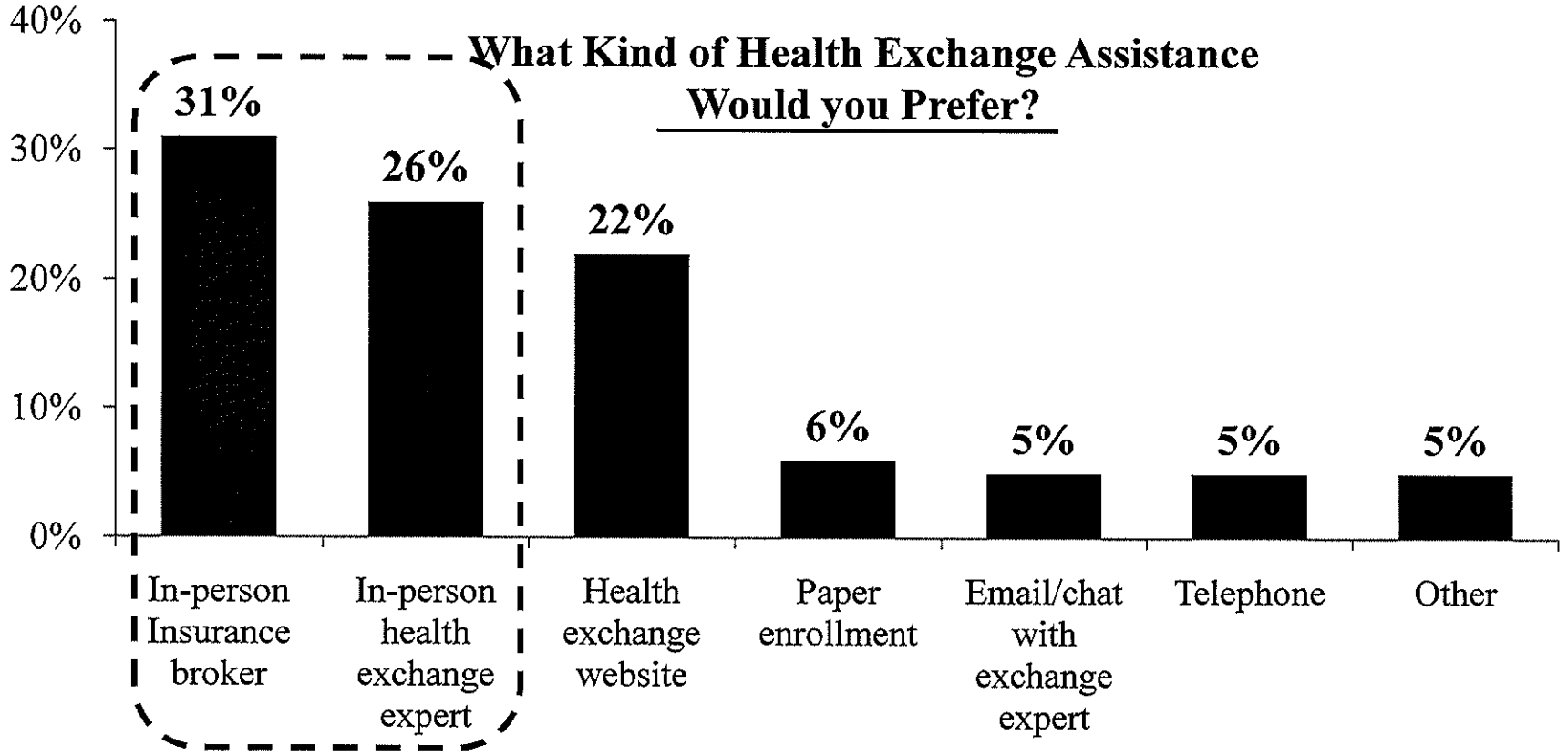


To whom would you turn for assistance when working with the heath insurance exchange?

A	B	C	D	E
Insurance Agent or Broker	Health Insurance Exchange Expert	Health Insurance Exchange Website	E-mail /Chat with Health Exchange Expert	Paper Application



Insurance brokers will need to play a critical role in the exchange.



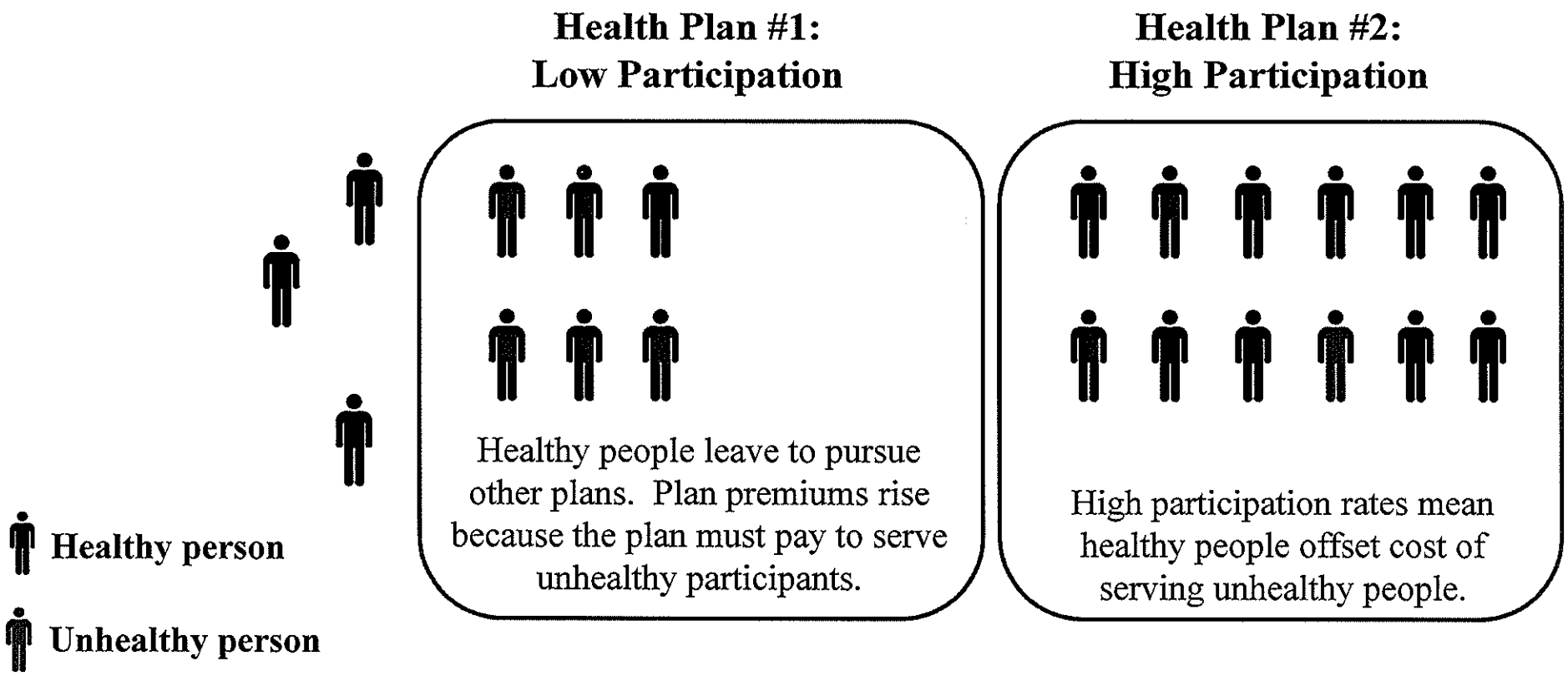
If insurance brokers do not assist with the exchange, most businesses will turn to the insurance carriers or will need the health insurance exchange to offer support.

Who will you contact if you don't have an insurance broker to assist you through the health insurance exchange?

Sources of Assistance	
Health insurance carriers	34%
Exchange must provide 24/7 telephone support	34%
Exchange must provide 24/7 email/chat support	31%
Employees will deal with on their own	16%
The employer themselves	14%
Internal human resources	12%
Friends, family, or colleagues	2%
Other	3%
Would be willing to pay for a broker	10%

What Are the Challenges of the Exchange?

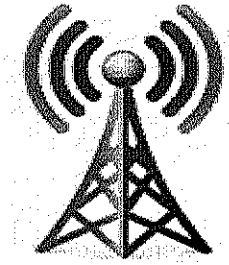
The success of any health insurance exchange hinges on high participation rates. How can the state ensure high participation rates?



Besides high participation rates, the health insurance exchange must overcome other challenges to succeed. Some of these challenges are informing rural populations, overcoming low rates of connectivity, and helping Mississippians understand health insurance and health exchanges.

Rural Challenges

How do we reach Mississippi's mostly rural population?



Technological Challenges

Mississippi is one of the least technologically connected states in the country; yet, most health exchanges rely heavily on the Internet.

Complexity of Health Insurance

We must educate Mississippians of all education levels about Health Insurance.

Summary

1. Federal law requires the creation of a health exchange by 2014. Mississippians believe the state, and not the federal government, is best equipped to design that exchange and tailor it to the needs of Mississippians.

2. A health insurance exchange is a tool for increasing access to health insurance by creating a marketplace where businesses and individuals can easily select and compare health plans.

3. A health exchange will increase transparency, simplify enrollment, and reduce the administrative burden experienced by businesses offering health insurance. The exchange is just one of a combination of solutions needed to increase access to health care.

4. There are many challenges to implementing a health insurance exchange in Mississippi. But the state is committed to working collaboratively with businesses to create an exchange by Mississippians, for Mississippians.

What Can I Do?

1. Be prepared to provide feedback through upcoming opportunities provided by the Mississippi Insurance Departments.

2. Invite employees and members of your organizations to participate in providing feedback whenever

3. Let other businesses and associates know about the Mississippi health insurance exchange.

Frequently Asked Questions

1 When will I be able to use the Mississippi Health Exchange?

Federal law requires state exchanges to be in place by January 1, 2014.

Frequently Asked Questions

2 Do I have to buy my insurance through a health insurance exchange?

No, a health insurance exchange is an alternative platform for comparing, selecting, and purchasing insurance.

Frequently Asked Questions

3 Will this make health insurance cheaper?

Not immediately. A health insurance exchange promotes competition and transparency which has the potential to decrease costs.

Frequently Asked Questions

4 Where can I learn more about the Mississippi Health Insurance Exchange?

- Aaron Sisk
- aaron.sisk@mid.state.ms.us
- (602) 359-9497

ATTACHMENT G

MISSISSIPPI INSURANCE DEPARTMENT

NEWS ARTICLES

ClintonNews.com
A GANNETT COMPANY

April 14, 2011

What you need to know about PPACA

Mike Chaney
Special to The Clinton News

I would like to take a little of your time today to talk about something that has dominated national news coverage for the last several years. It has also dominated a lot of time in the Mississippi Insurance Department.

When President Obama signed the Patient Protection and Affordable Care Act, commonly known as Obamacare, last year, it set the stage for some sweeping changes in American health care. I'd like to be clear here that if I had a vote, I would not have supported PPACA.

However, one particular facet of the law deserves special attention, and that is the health care exchange. Simply put, an exchange is a website where people can compare competing health care plans and choose one they can afford that serves them best. (Think Travelocity or Orbitz as they work in the travel industry.)

A health care exchange is not a partisan political issue. Across this nation, Republicans and Democrats alike have embraced the concept of health exchanges as a way to help individuals and small businesses more easily obtain health insurance. In fact, our own Gov. Haley Barbour has for three years introduced legislation in the Mississippi Legislature designed to set up an independent exchange in our state.

He did not succeed, but with the passage of PPACA, health exchanges became part of the law. And while I may not have supported PPACA, it is now the law of the land and it is my sworn duty to uphold that law unless it is repealed.

Also, PPACA specifies that in states that do not set up a health exchange, the federal government will come in and run an exchange in those states. I simply do not believe that the federal government can run something in Mississippi to benefit Mississippians better than we can ourselves. We at MID see this as a way to set up and run our own exchange, specifically geared to our state and our problems and advantages.

To that end, the Mississippi Insurance Department has dedicated hundreds of manhours studying the health care law and trying to develop programs and legislation to comply with that law.

It was a Herculean task because while the law specifies that states would have an exchange, the blueprint for how to set up and run one were not addressed in PPACA, leaving states to figure it out on their own. I'm very proud of the work done in our department to craft legislation that would allow us to set up an exchange while leaving room for adjustments to be made as the PPACA regulations become clearer.

Our staff did such a good job, in fact, that our legislation has been held out to other states as the "model exchange law" they should follow. The federal Health and Human Services Department came to Mississippi to learn about our legislation and went away impressed with how thoroughly we had met the challenge.

However, we knew the battle was not won. Health exchange bills had died in most states and in the

Mississippi Legislature for three previous years, so we prepared for the legislative session as best we could. We held "learning sessions" for key legislators to show the bill to them and explain it to them line by line, knowing their understanding of what we were trying to do was crucial. We also held sessions for other stakeholders in the state such as consumer representatives, health insurance companies, rural health care advocates and health care groups.

We obtained promises of support from all stakeholders but ultimately it was not enough to overcome the politics of health care reform. Promised help failed to appear and promised support vanished.

In the end, our goal to improve healthcare for all 2.9 million Mississippians and our argument that a market-based exchange, set up outside the federal law, was good for the 2.9 million people of Mississippi and would lead to better access to health insurance for all Mississippians was not enough to ensure passage.

Some opposed the bill because they could not get their own people on the governing board of the exchange, thinking erroneously that it would lead to big money for themselves and their supporters. Some opposed the bill because they oppose PPACA overall and could not see the exchange as a separate and independent entity. Some just want to let the federal government run it.

Despite the best efforts of myself and the Mississippi Insurance Department, exchange legislation that has been hailed as model legislation, died.

I will add, however, that I will not give up in the pursuit of a market-based exchange that will make coverage available to thousands of uninsured Mississippians.

ClarionLedger.com

Health exchange alive

Written by

Molly Parker

10:22 PM, Apr. 14, 2011|

Insurance Commissioner Mike Chaney says he will use his authority to meet a mandate of the nation's health care law since legislators couldn't do so, establishing a one-stop shop of insurance plans at competitive rates.

Efforts to establish a health care exchange failed during the legislative session over debate about who should operate it.

"Without an exchange, or affordable health care, you're not going to have jobs in this state," Chaney said.

The exchange, stripped to its core, is one of the few components of President Barack Obama's health care law that has bipartisan support.

"The majority opinion is that we want to create an exchange," said House Insurance Committee Vice Chairman Brandon Jones, D-Pascagoula. But where there are differences between House Democrat and Senate Republican negotiators, he said, "they're pretty important details."

Jones and other House negotiators pushed for a state agency to operate the exchange, arguing that would streamline the process for Medicaid-eligible residents and provide oversight for the billions of dollars flowing through a system handling something as critical as health care coverage.

But Gov. Haley Barbour challenged that would invite more "bureaucracy and more red tape for the beneficiaries and additional costs for taxpayers."

Therein lied the breakdown. But Chaney said he's not forfeiting to the political stalemate.

Chaney would not release specifics on how his proposal would work, but cited enabling legislation for the Mississippi Comprehensive Health Insurance Risk Pool Association, a last-resort insurer.

The law says the risk pool is to aid residents in obtaining health and accident coverage under any "state or federal program" and may "adopt such rules as are

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necessary and proper" to that end.

In a letter dated March 24 to Senate Insurance Committee Chairman Buck Clarke, Barbour expressed opposition to creating a new state agency.

"We already have a model that works in our state," he said, referring to the nonprofit risk pool, which covers about 3,600.

Barbour stated he wanted the bill to contain "clearly defining language which would prevent mandated benefits and subsides."

The state needs an exchange in place by Jan. 1, 2013, or the U.S. Department of Health and Human Services will step in and run it. Chaney said it needs to be up and r unning several months prior to that and said too much is at stake to wait until next year's legislative session for a deal.

For several years, Barbour has advocated creation of an exchange even though he is a plaintiff in a federal lawsuit challenging the constitutionality of the Patient Protection and Affordable Care Act.

In a recent letter, Barbour said a Mississippi-based exchange should "focus o n small businesses and individuals, be voluntary, and would allow individuals to choose the insurance plan that best suits their needs."

Beyond being a one-stop shop, Chaney's office says an exchange also would certify and decertify qualified health plans; operate a toll-free hotline; determine eligibility for Medicaid, CHIP or other applicable state or local public programs; and certify whether an individual is exempt from the law's mandate that requires most to have health insurance by Jan. 1, 2014.

For businesses with fewer than 50 employees, an exchange would allow employees to pick the plan that suits them and would absorb the administrative costs of packaging those plans across companies, said Clarke, R-Hollandale.

"The thing that was really disheartening was all the work that had been put into this, especially by the Department of Insurance, and the bill that we proposed in the Senate was the one that they had r eviewed by the Department of Human Services at the federal level," Clarke said. "In Washington they were telling other states to look at that model by Mississippi."

But when the bill moved to a House-Senate negotiating committee, Jones said "the negotiation process really never took off."

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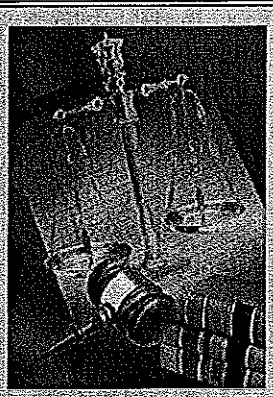
Medicaid Committee Vice Chairman Robert Johnson, D-Natchez, said it seemed more like House members were negotiating with Chaney's staff rather than senators. His main goal is for there to be a seamless process for individuals deemed Medicaid eligible by the exchange to enroll for Medicaid coverage.

A new agency or quasi-state agency running the exchange could work in tandem with the Division of Medicaid to ensure those who are eligible get coverage under the law's expansion, he said.

Individuals whose households earn less than 400 percent of the federal poverty level, or $88,000, will qualify for a federal health care subsidy beginning in 2014. The exchange will calculate the amount.

Johnson argues there still is time to get an exchange in place during the next legislative session and that, depending on what Chaney proposes, he will look into whether the Legislature should attempt to override his proposal next spring.

"If he (Chaney) rushes to try to get that done in six or seven months, that just doesn't make sense," Johnson said.



3rd Annual Mississippi Hospital Association Health Law Conference

April 6, 2011

Presented by

The Mississippi Hospital Association and HPICO

Balch & Bingham, LLP

And Wise Carter Child & Caraway, P.A.

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8:50—9:00 a.m.	**Welcome & Announcements**
9:00 – 9:30 a.m.	**OFCCP– What Does It Mean for Mississippi Hospitals—and Other Employee Relations Challenges** ***Armin J. Moeller, Jr.***
9:30 – 10:15 a.m.	**Compliance, Disclosures and Enforcement: Déjà Vu All Over Again** ***Dinetia M. Newman***
10:15 – 10:30 a.m.	**BREAK**
10:30 – 11:15 a.m.	**Impact on Medical Staff Relations of MS 01.01.01** ***D. Alan Windham, Jr.***
11:15 – 12:00 p.m.	**HITECH and ARRA—Two Years Later** ***Genie Stark Thomas***
12:00 – 1:15 p.m.	**LUNCH—*The Mississippi Health Exchange Act*** ***Aaron Sisk, Senior Attorney, MS Department of Insurance***
1:15 – 1:40 p.m.	**PPACA Update** ***D. Collier Graham***
1:40 – 2:05 p.m.	**Medicaid Appeals—Cost Report Audits, Rate Determinations & Recoupments** ***George H. Ritter***
2:05 – 2:40 p.m.	**Physician Recruitment and Non-Competition Agreements** ***Margaret H. Williams***
2:40 – 2:50 p.m.	**BREAK**
2:50—3:25 p.m.	**Fraud and Abuse Case Study** ***R. Mark Hodges***
3:25—3:45 p.m.	**Overtime—Wage and Hour Issues** ***Jennifer H. Scott***
3:45—4:10 p.m.	**CMS Revised Hospital Anesthesia Service Interpretive Guidelines** ***Gene R. Naylor***

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ARMIN J. MOELLER, JR. is a Partner in the Health Law, Labor & Employment and Litigation practice groups. In 2000, he was the recipient of the Mississippi Hospital Association (MHA) Society for Human Resources Administration's "Award of Special Distinction" in recognition of "his many years of exceptional support and services in the healthcare legal education". Armin's practice concentrates on drafting and negotiating contracts, business transactions, labor relations and employment law issues, but includes litigation, arbitration and other dispute resolution methods. Armin represents employers in race, sex, religion, age, disability, sexual/workplace harassment, discrimination, and retaliation claims; in handling EEOC, NLRB, OSHA and other agency claims through judicial process; in drafting employment, severance, non-competition and confidentiality contracts; and in affirmative action and OFCCP compliance. Armin also counsels employers concerning human resources issues and conducts client training programs. Armin has negotiated information technology project agreements with leading technology companies and has litigated claims against information technology companies.

DINETIA M. NEWMAN is a partner in the Health Law Practice Group and the Business Section in Balch & Bingham LLP's Jackson, Mississippi office. Her practice involves representation of providers and suppliers including hospitals and health systems, physicians, ambulatory surgical centers and other Medicare Parts A and B providers and suppliers on a variety of operational, transactional and payment matters involving both federal and state law. She is a frequent speaker and author regionally and nationally.Ms. Newman currently serves on the Board of Directors of the American Health Lawyers Association, is AHLA's President-Elect Designate, a past president of the Mississippi Chapter of Healthcare Financial Management Association, and a past chair of the Health Law Section of The Mississippi Bar, and past president of Northeast Mississippi Habitat for Humanity. Ms. Newman authored chapters in the 2010 Health Law Handbook, the Representing Physicians Handbook and 2009 Medicare and Medicaid Reimbursement Update (portion of Chapter 5). A graduate of Rhodes College, Ms. Newman obtained her J.D. summa cum laude from the University of Mississippi School of Law, has been practicing health law for the past 22 years and was named a Mississippi Super Lawyer in 2006, 2008-2010.

D. ALAN WINDHAM JR. is an associate in the Litigation Section and member of the Healthcare Litigation Group in Balch & Bingham LLP's Jackson, Mississippi office. Alan is actively involved in the firm's Healthcare Group representing clients in a wide variety of litigation, including medical malpractice cases and disputed Certificate of Need proceedings. As a member of the firm's business litigation and products liability and casualty groups, Alan has broad experience in a wide variety of litigation, including general personal injury cases, insurance coverage, real estate litigation, commercial litigation, creditors' rights, and mass tort products liability litigation. Alan has also represented clients in arbitration proceedings.

GENIE STARK THOMAS is counsel in the Health Law Practice Group and the Business Section in Balch & Bingham LLP's Jackson, Mississippi office. Genie represents hospitals, health systems, physicians and ancillary health providers on a variety of operational, transactional, compliance, governance, general business and regulatory healthcare matters, including Stark, Anti-kickback, HIPAA privacy and security compliance, RAC, MIC and other payor audits and appeals, EMTALA, Certificate of Need and tax-exempt issues. Prior to joining Balch & Bingham LLP, Genie served as Associate General Counsel for Mississippi Baptist Health Systems, Inc. In that role, Genie designed and operated a centralized contracting process, managed all real estate acquisitions, dispositions and medical office building leasing, coordinated all system and affiliate transactions and financings, negotiated significant IT and other operational contracts for the system and its affiliates, served as RAC Appeals team leader with responsibility for designing, coordinating and implementing MBHS's appeals of RAC and other payment denials, and provided numerous in-services and counseling on a variety of compliance and legal matters.

AARON SISK has served as a Senior Staff Attorney for the Mississippi Department of Insurance since November of 2006. Originally from Madison, MS, Aaron received his Juris Doctor in May of 2003 from the University Of Mississippi School of Law and became an active member of the Mississippi Bar in October of that same year. Prior to that, Aaron completed his undergraduate education at Mississippi State University, earning a B.A. in Sociology with a certificate in Criminal Justice.
Aaron serves as the Director of the Insurance Department's Life and Health Actuarial Division. In this role, Aaron works closely with Department actuaries and industry representatives to assure compliance with Mississippi and Federal statutes and regulations. Aaron is also charged with implementing and enforcing for the Department all insurance reforms associated with the Patient Protection and Affordable Care Act of 2010.

Commissioner Mike Chaney
Deputy Comm'r Mark Haire

Ins Dept Extern Emanuel Shoto

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R. MARK HODGES is a shareholder in the firm of Wise Carter Child & Caraway in Jackson, where he has worked since his graduation from Vanderbilt University School of Law (J.D., Order of the Coif) in May of 1987. Mark practices primarily in the area of health care law with an emphasis in the areas of healthcare litigation, regulatory compliance/enforcement defense, and medical practice management and healthcare transactions. He received his undergraduate degree (B.A., magna cum laude) from the University of Southern Mississippi Honors College in 1984 where he was a member of Omicron Delta Kappa. In law school, he won the Vanderbilt Mock Trial Competition and served on the Vanderbilt National Mock Trial Law Team. He received the Vanderbilt Moot Court Service Award, the BNA Outstanding Law Student Award, and the Stanley D. Rose Dissertation Award while at Vanderbilt. He holds membership in the American Health Lawyers Association, the American Bar Association Health Law Section, and the Mississippi Bar, where he has served as a member of the executive committee of the Bar's Health Law Section. Mark advises healthcare providers and their support organizations on operational issues including regulatory compliance, risk management and the structuring of contractual and strategic alliances.

MARGARET H. WILLIAMS is a shareholder who joined the firm in January of 1979 and currently serves as Chairman of the firm's Board of Directors. She obtained her B.A., summa cum laude from Mississippi State University in 1976. She received her J.D., cum laude, from the University of Mississippi in 1978 where she was Note Editor of the Mississippi Law Journal and a member of Phi Kappa Phi. She served on the Board of Directors of the Hinds County Bar Association from 1997 to 1999 and was elected to the Board of Bar Commissioners for the Mississippi Bar Association in 1999. Margaret has been selected as a Fellow of the Mississippi Bar Foundation and is a past chairman of the Mississippi Law Institute. She has a general commercial practice, with vast experience in structuring a wide variety of health care acquisitions, mergers, joint ventures, networks, physician employment and recruitment agreements, financings and other matters in accordance with Stark, Anti-Kickback and Anti-Trust laws. She also has special expertise in government contracts and public hospital laws. Ms. Williams has been named as one of Mississippi's Leading Business Women by the Mississippi Business Journal. She was selected as the outstanding Woman Lawyer for 2003 by the Mississippi Women Lawyers Association and has been listed in Best Lawyers in American in the areas of Health Care Law, Corporate Law and General Business Law for the past several years. She has also been selected for inclusion in Chambers USA and as a Mid-South SUPER LAWYER.

GEORGE H. RITTER George Ritter is a shareholder in the firm of Wise Carter Child & Caraway, PA. His practice includes medical staff disputes, healthcare litigation and defense of medical malpractice claims. He also focuses on railroad, products liability, and insurance bad faith litigation. George obtained his undergraduate degree (B.A., 1981, *cum laude*) and legal education (J.D., 1986, *cum laude*) at the University of Mississippi, where he was Research Editor of the Mississippi Law Journal and a member of Phi Kappa Phi honorary and the National Honor Society. He is a member of the Mississippi Bar Association, the American Bar Association, the American Board of Trial Advocates, the American Academy of Hospital Attorneys, Defense Research Institute, Mississippi Defense Lawyers Association and the National Association of Railroad Trial Counsel. George has published numerous law journal and periodical articles and is a frequent speaker on healthcare and hospital legal issues.

EUGENE R. Naylor is a shareholder in the firm of Wise Carter Child & Caraway and practices in the area of general health care law with emphasis in hospital administration, medical staff issues, health information management and the representation of hospitals and physicians in the defense of medical malpractice litigation. He received his undergraduate degree from the University of Southern Mississippi (B.S. 1982) and law degree from Cumberland School of Law (J.D. 1985) and was law clerk for the presiding circuit judge, 8th Judicial Circuit, Alabama. He has been asked to speak on the subjects of health care risk management, physician and nursing practice, health information management, including addresses to membership of the American and Mississippi Health Information Management Associations, Mississippi Hospital Association Society for Health Care Risk Management, Alabama Society of Neonatologists and NAMMS. He currently serves on the board of the Mississippi Hospital Association Society for Health Care Risk Management.

D. COLLIER GRAHAM, Jr. is a shareholder in the firm of Wise Carter Child & Caraway, PA. He received a B.A. (*cum laude*) from Vanderbilt University in 1980 and a J.D. from the University of Mississippi School of Law in 1983. He received the American Jurisprudence Award in Torts. Collier's practice is focused on the needs of healthcare clients in matters of professional liability, risk management licensure, medical staff organization and relations, regulatory compliance and enforcement and reimbursement issues. He is privileged to represent the interest of hospitals, physicians and other providers throughout the state.

JENNIFER HUGHES SCOTT is an attorney with Wise Carter Child & Caraway, P.A. Ms. Scott received a Juris Doctor from Mississippi College School of Law, in Jackson, Mississippi, and is licensed in Mississippi. She received a Bachelor of Arts from Mississippi University for Women and a Master of Arts in English from Mississippi State University. She practices primarily in the areas of employment law and workers' compensation. Ms. Scott is a member of the Mississippi Bar and the American Bar Association, as well as the Defense Research Institute and the National Workers' Compensation Coalition.

ATTACHMENT H

MISSISSIPPI COMPREHENSIVE HEALTH INSURANCE

RISK POOL ASSOCIATION

AMENDED AND RESTATED
ARTICLES, BYLAWS AND OPERATING RULES

OF

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

A NONPROFIT LEGAL ENTITY

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Page

ARTICLE I. NAME AND PURPOSE

The Comprehensive Health Insurance Risk Pool Association (the "Association") is a nonprofit legal entity created pursuant to the Mississippi Comprehensive Health Insurance Risk Pool Association Act, Sections 83-9-201 through 223 of the Mississippi Code of 1972, as amended (the "Act"). The purpose or purposes for which the Association is organized are as follows:

(1) allow the availability of a health insurance program and to allow the availability of health and accident insurance coverage to those citizens of the State of Mississippi who (a) because of health conditions cannot secure such coverage, or (b) desire to obtain or continue health insurance coverage under any state or federal program designed to enable persons to obtain or maintain health insurance coverage, subject to the limitations and requirements contained in the Act,

(2) execute all powers granted to the Association under the Act, and

(3) without limiting the generality of the foregoing powers and purposes, doing every other thing or act necessary or expedient in carrying on the business of the Association which may be permitted by the Act or applicable law.

Notwithstanding any other provisions of these amended and restated articles, bylaws and operating rules, the Association shall not conduct or carry on any activities or do anything not permitted to be conducted or carried on by an organization which is exempt from taxation under Section 501(c) of the Internal Revenue Code and the Regulations thereunder as the same now exist or as they may be hereafter amended from time to time. (Amended August 27, 2009).

ARTICLE II. OFFICE AND REGISTERED AGENT

The principal office of the Association and the street address of the Association's registered office is 190 East Capitol Street, Suite 800, Jackson, Mississippi 39201, and the name of the registered agent at that office is David L. Martin. The Association may have such other offices, either within or without the State of Mississippi, as the board of directors may designate or as the business of the Association may require from time to time. (Amended August 27, 2009).

ARTICLE III. DURATION

The duration of the Association shall be the maximum permitted pursuant to the Act or applicable law.

ARTICLE IV. MEMBERS

SECTION 1. Members. The Association shall have no capital stock. The members of the Association are (1) all insurance companies, nonprofit health care services plans, fraternal benefit societies, health maintenance organizations, and to the extent consistent with federal law all self-insurance arrangements covered by the Employee Retirement Income Security Act of 1974, as amended, that provide health care benefits in the State of Mississippi, (2) all other

entities providing plans of health insurance coverage or health benefits subject to state insurance regulation, (3) all reinsurers reinsuring health insurance coverage in the State of Mississippi or all insurers from whom any person providing health insurance coverage for any Mississippi resident procures insurance for itself in the insurer with respect to all or part of the health insurance coverage risk of the person, and (4) all third party administrators who are paying or processing health insurance claims for any Mississippi resident.

Members that are insurance companies, nonprofit health care services plans, fraternal benefit societies, health maintenance organizations, self-insurance arrangements, other entities providing plans of health insurance coverage or health benefits subject to state insurance regulation or reinsurers which cease providing health care benefits or reinsuring health insurance coverage in Mississippi and members that are third party administrators which cease processing health insurance claims for Mississippi residents shall cease to be members of the Association effective the day following such cessation of authorization or claims processing. Former members of the Association shall remain liable for any assessment levied pursuant to Article XIV of these amended and restated articles, bylaws and operating rules for periods with respect to which the former member was a member of the Association.

For purposes of determining membership in the Association and calculating the amount of an assessment levied against a member pursuant to Article XIV, Section 2 of these amended and restated articles, bylaws and operating rules "health insurance coverage" shall mean any hospital and medical expense incurred policy, nonprofit health care services plan contract, health maintenance organization subscriber contract or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise. "Health insurance coverage" shall not include the following: coverage only for accident or disability income insurance; coverage issued as a supplement to liability insurance; liability insurance including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; and other similar insurance coverage specified in federal regulations issued pursuant to Public Law 104-191 under which benefits for medical care are secondary or incidental to other insurance benefits. "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar limited benefits specified in federal regulations issued pursuant to Public Law 104-191. "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness; or hospital indemnity or other fixed indemnity insurance. "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance: Medicare supplemental health insurance; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS); or similar supplemental coverage provided to coverage under a group health plan.

The board of directors may adopt definitions as may be necessary in order to further determine membership in the Association and calculate assessments and such definitions shall be included herein by amendment to these amended and restated articles, bylaws and operating rules. Any insurance company, nonprofit health care services plan, fraternal benefit society, health maintenance organization, self-insurance arrangement or other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation, reinsurer or third party administrator desiring a determination with respect to whether a particular policy or contract is within the definition of health insurance coverage as set forth in the Act shall submit a written request for determination to the Association. Any such written request for a determination shall be handled in the same manner as a grievance as provided for in Article XV of these amended and restated articles, bylaws and operating rules. (Amended August 14, 1995, August 27, 2009).

SECTION 2. Distributions. The members of the Association shall not be entitled to distributions from the Association except as provided by these amended and restated articles, bylaws and operating rules. Furthermore, except as provided by these amended and restated articles, bylaws and operating rules, the Association shall not afford or provide any pecuniary gain, incidentally or otherwise, to its members, and no part of the net income of the Association and no part of its assets shall inure to the benefit of any member or individual or to any corporation organized for profit.

Upon the liquidation, dissolution or winding up of the Association, whether voluntary or involuntary, the members of the Association shall be refunded excess assessments in proportion to the assessments of each member, provided however that no member shall be refunded an amount greater than the amount of assessments paid by such member to the Association. For purposes of this paragraph "excess assessments" shall mean the amount of aggregate assessments paid to the Association together with interest thereon that exceeds the amount necessary to pay claims and administrative expenses incurred during the periods for which assessments were made. Distributions in addition to the refund of excess assessments to the members shall be made to such non-profit organization or organizations as may be determined by the board of directors and approved by the Mississippi Commissioner of Insurance, provided such purposes are within the intent of Section 501(c) of the Internal Revenue Code and Regulations thereunder as the same now exist or as they may be hereafter amended.

SECTION 3. Annual Meeting. The annual meeting of the members shall be held on the first Tuesday in the month of April, in each year, beginning with the year 1992, at the hour of ten (10) o'clock, A.M., or such other time and date as may be determined by the directors, for the purpose of appointing directors required by the Act to be appointed by the members and for the transaction of such other business as may properly come before the meeting. If the day fixed for the annual meeting shall be a legal holiday in the State of Mississippi, such meeting shall be held on the next succeeding business day.

If such appointment of directors shall not occur on the day designated herein for any annual meeting of the members, or at any adjournment thereof, the board of directors shall cause the appointment to be made at a special meeting of the members as soon thereafter as conveniently may be.

SECTION 4. Special Meetings. The Association shall hold a special meeting of members (1) on call of its board of directors; or (2) if at least ten percent (10%) of the members sign, date and deliver to the Association's secretary one or more written demands for the meeting describing the purpose or purposes for which it is to be held. If not otherwise fixed under the provisions of these amended and restated articles, bylaws and operating rules or applicable law, the record date for determining members entitled to demand a special meeting is the date the first member signs the demand.

SECTION 5. Place of Meeting. The board of directors may designate any place, either within or without the State of Mississippi, for any annual meeting or for any special meeting of members. A valid waiver of notice signed by all members entitled to notice may designate any place, either within or without the State of Mississippi, as the place for any annual meeting or for any special meeting of members. Unless the notice of the meeting states otherwise, members' meetings shall be held at the Association's principal office.

SECTION 6. Notice of Meeting. The Association shall notify all known members of the date, time and place of each annual meeting and special meeting of members by mail no fewer than ten (10) nor more than sixty (60) days before the meeting date. Notice of the date, time and place of each annual meeting and special meeting of members shall also be published in a newspaper of general circulation in Jackson, Mississippi, no fewer than five (5) nor more than thirty (30) days before the meeting date.

Notice of an annual meeting need not include a description of the purpose or purposes for which the meeting is called. Notice of a special meeting must include a description of the purpose or purposes for which the meeting is called. Only business within the purpose or purposes described in the meeting notice may be conducted at a special members' meeting.

If an annual or special meeting of members is adjourned to a different date, time or place, notice need not be given of the new date, time or place if the new date, time or place is announced at the meeting before adjournment, unless a new record date for the adjourned meeting is or must be fixed under Article IV, Section 7 of these amended and restated articles, bylaws and operating rules.

SECTION 7. Fixing of Record Date. The board of directors of the Association may fix the record date in order to determine members entitled to notice of a members' meeting, to demand a special meeting, to vote or to take any other action. A record date may not be more than seventy (70) days before the meeting or action requiring a determination of members. The record date for determining members entitled to notice of and to vote at an annual or special meeting of members is the day before the first notice is delivered to members. A determination of members entitled to notice of or to vote at a members' meeting is effective for any adjournment of the meeting unless the board of directors fixes a new record date, which it must do if the meeting is adjourned to a date more than one hundred twenty (120) days after the date fixed for the original meeting.

SECTION 8. Voting Lists. After fixing a record date for a meeting, the Association shall prepare an alphabetical list of the names of all its members who are entitled to notice of a members' meeting. The list must show the address of and number of votes of each member.

The members' list must be available for inspection by any member beginning two (2) business days after notice of the meeting is given for which the list was prepared and continuing through the meeting, at the Association's principal office or at a place identified in the meeting notice in the city where the meeting will be held. A member, his agent or attorney shall be entitled on written demand to inspect and, subject to the requirements of applicable law, to copy the list during regular business hours and at his expense, during the period it is available for inspection. The Association shall make the members' list available at the meeting, and any member, his agent or attorney is entitled to inspect the list at any time during the meeting or any adjournment.

SECTION 9. Quorum. Ten percent (10%) of the members at an annual or special meeting of members, represented in person or by proxy, shall constitute a quorum. If less than ten percent (10%) of the members are represented at an annual or special meeting, a majority of the members so represented may adjourn the meeting from time to time without further notice except as may be required by Article IV, Section 6 of these amended and restated articles, bylaws and operating rules. At such adjourned meeting at which a quorum shall be present or represented, any business may be transacted which might have been transacted at the meeting as originally noticed. Once a member is represented for any purpose at a meeting, the member is deemed present for quorum purposes for the remainder of the meeting and for any adjournment of that meeting unless a new record date is or must be set for that adjourned meeting.

SECTION 10. Proxies. A member may appoint a proxy to vote or otherwise act for him by signing an appointment form, either personally or by his attorney-in-fact. An appointment of a proxy is effective when received by the secretary or other officer or agent authorized to tabulate votes of the Association. An appointment is valid for eleven (11) months unless a longer period is expressly provided in the appointment form. An appointment of a proxy is revocable by the member.

Subject to any express limitation on the proxy's authority appearing on the face of the appointment form, the Association is entitled to accept the proxy's vote or other action as that of the member making the appointment.

SECTION 11. Voting by Members. Each member shall be entitled to one (1) vote in person or by proxy on each matter voted on at a members' meeting.

SECTION 12. Action by Members Without A Meeting. Action required or permitted to be taken at a members' meeting may be taken without a meeting if the action is taken by all the members. The action must be evidenced by one or more written consents describing the action taken, signed by all the members, and delivered to the Association for inclusion in the minutes or filing with the Association records. The record date for determining members entitled to take action without a meeting is the date the first member signs such consent. Action taken under this section is effective when the last member signs the consent, unless the consent specifies a different effective date. A consent signed under this section has the effect of a meeting vote and may be described as such in any document.

SECTION 13. Association's Acceptance of Votes. If the name signed on a vote, consent, waiver or proxy appointment corresponds to the name of the member, the Association, if acting

in good faith, is entitled to accept the vote, consent, waiver or proxy appointment and give it effect as the act of the member.

The Association is entitled to reject a vote, consent, waiver or proxy appointment if the secretary or other officer or agent authorized to tabulate votes, acting in good faith, has reasonable basis for doubt about the validity of the signature on it or about the signatory's authority to sign for the member.

ARTICLE V. BOARD OF DIRECTORS

SECTION 1. General Powers. All Association powers shall be exercised by or under the authority of, and the business and affairs of the Association managed under the direction of, its board of directors, subject to any limitation set forth in these amended and restated articles, bylaws and operating rules.

SECTION 2. Number, Appointment, Election, Tenure and Qualifications. The number of directors of the Association shall be nine (9), consisting of: four (4) individuals appointed by the Mississippi Commissioner of Insurance; three (3) members appointed by the members; the Chair of the Senate Insurance Committee; and the Chair of the House Insurance Committee. The Chair of the Senate Insurance Committee and the Chair of the House Insurance Committee shall be nonvoting, ex officio members of the board.

Directors that are appointed by the Mississippi Commissioner of Insurance shall be appointed at each annual meeting of members, except for the initial appointments and the filling of vacancies. Appointment to the board of directors by the Mississippi Commissioner of Insurance shall be evidenced by a certificate of appointment signed by the Mississippi Commissioner of Insurance or his duly authorized representative.

Directors that are appointed by the members of the Association shall be appointed at each annual meeting of members, except for the initial appointments and the filling of vacancies. In making such appointment the members receiving the greatest number of votes, on a non-cumulative basis, shall be appointed to the board of directors, provided that the other requirements for board membership are met.

Of the initial directors to be appointed by the Mississippi Commissioner of Insurance, one (1) shall serve for a term of one (1) year, two shall serve for a term of two (2) years, and one (1) shall serve for a term of three (3) years, such terms to be determined by the Mississippi Commissioner of Insurance. Of the initial directors to be appointed by the members, one (1) shall serve for a term of one (1) year, one (1) shall serve for a term of two (2) years, and one (1) shall serve for a term of three (3) years, such terms to be determined by the members. The terms of all other directors shall be for a period of three (3) years.

Of the directors appointed by the Mississippi Commissioner of Insurance: two (2) shall be chosen from the general public and shall not be associated with the medical profession, a hospital or an insurer; one (1) shall be representative of medical providers; and one (1) shall be representative of health insurance agents. Directors appointed by the Mississippi Commissioner of Insurance shall file with the Association a written certificate of eligibility stating under oath

that they are eligible to accept such appointment. Of the directors appointed by the members at least one (1) shall be a Mississippi domestic insurer.

A decrease in the number of directors does not shorten an incumbent director's term. The term of a director appointed or elected to fill a vacancy expires at the next members' meeting at which directors are appointed or elected. Despite the expiration of a director's term, he continues to serve until his successor is appointed or elected and qualifies or until there is a decrease in the number of directors. A director need not be a resident of this state or, except for directors appointed by members, a member of the Association. (Amended April 11, 2003, August 27, 2009).

SECTION 3. Resignation of Directors, Removal of Directors. A director may resign at any time by delivering written notice to the board of directors, to its chairman or to the Association. A resignation is effective when the notice is delivered unless the notice specifies a later effective date.

The Mississippi Commissioner of Insurance may remove one or more of the directors appointed by the Mississippi Commissioner of Insurance with or without cause. The members may remove one or more of the directors appointed by the members with or without cause. A director appointed by the members may be removed only if the number of votes cast to remove him exceeds the number of votes cast not to remove him. A director may be removed by the members only at a meeting called for the purpose of removing him, and the meeting notice must state that the purpose, or one (1) of the purposes, of the meeting is removal of the director.

SECTION 4. Regular Meetings. A regular meeting of the board of directors shall be held without other notice than this bylaw immediately after, and at the same place as, the annual meeting of members.

SECTION 5. Special Meetings. Special meetings of the board of directors may be called by or at the request of any two (2) directors. Special meetings of the board of directors must be preceded by at least two (2) days' notice of the date, time and place of the meeting. If no place for the meeting has been designated in the notice, the meeting shall be held at the principal office of the Association. The notice need not describe the purpose of the special meeting.

SECTION 6. Place of Meetings. The board of directors may hold regular or special meetings in or out of this state.

SECTION 7. Quorum. A quorum of the board of directors consists of a majority of the number of voting directors fixed by Article V, Section 2 of these amended and restated articles, bylaws and operating rules. If less than the number necessary for a quorum is present at a meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

SECTION 8. Manner of Acting. If a quorum is present when a vote is taken, the affirmative vote of a majority of directors present is the act of the board of directors.

SECTION 9. Action Without A Meeting. Action required or permitted to be taken at a board of directors' meeting may be taken without a meeting if the action is taken by all members

of the board. The action must be evidenced by one or more written consents describing the action taken, signed by each director, and included in the minutes or filed with the Association records reflecting the action taken. Action taken under this section is effective when the last director signs the consent, unless the consent specifies a different effective date. Such a consent has the effect of a meeting vote and may be described as such in any document.

SECTION 10. Vacancies. Vacancies on the board of directors with respect to directors appointed by the Mississippi Commissioner of Insurance shall be filled for the remaining period of the term by the Mississippi Commissioner of Insurance. Vacancies on the board of directors with respect to directors appointed by the members of the Association shall be filled for the remaining period of the term by a majority vote of the remaining board members. A vacancy that will occur at a specific later date (by reason of a resignation effective at a later date or otherwise) may be filled before the vacancy occurs, but the new director may not take office until the vacancy occurs.

SECTION 11. Compensation. By resolution of the board of directors, a director may be reimbursed from the assets of the Association for actual and necessary expenses, if any, of attendance at each meeting of the board of directors in the manner and amount provided in Section 25-3-41 of the Mississippi Code of 1972, as amended, but members of the board shall not otherwise be compensated by the Association for their services. No such payment shall preclude any director from serving the Association in any other capacity and receiving compensation therefor.

SECTION 12. Executive and Other Committees. The board of directors may create an executive committee and one or more other committees and appoint members of the board of directors to serve on them. Each committee must have two (2) or more members, who serve at the pleasure of the board of directors. To the extent specified by the board of directors or in these amended and restated articles, bylaws and operating rules, each committee may exercise the authority of the board of directors. Provisions of these bylaws governing meetings, action without meetings, notice and waiver of notice, and quorum and voting requirements of the board of directors, apply to committees and their members as well.

SECTION 13. Participation by Telephonic or Other Means. The board of directors may permit any or all directors to participate in a regular or special meeting by, or conduct the meeting through the use of, any means of communication by which all directors participating may simultaneously hear each other during the meeting. A director participating in a meeting by this means is deemed to be present in person at the meeting.

SECTION 14. Conflict of Interest. A director shall be deemed to have a conflicting interest with respect to a transaction brought before the board of directors for action if: (1) the director, a member of the director's family, or an affiliate (as defined in Section 83-6-1 of the Mississippi Code of 1972, as amended) of the director is a party to the transaction; (2) the director, a member of the director's family, or an affiliate (as defined in Section 83-6-1 of the Mississippi Code of 1972, as amended) of the director has a financial interest in the transaction; or (3) a party to the transaction is (a) an entity of which the director is a director, general partner, agent or employee, (b) a person or entity that controls one or more of the entities specified in subclause (a) or an entity that is controlled by, or is under common control with, one or more of

the entities specified in subclause (a), or (c) an individual or entity who is a general partner, principal or employer of the director. Each director and each designated representative of a director shall file annually with the Association a written statement of conflicting interest transactions or potential conflicting interest transactions. If a director or its designated representative is deemed to have a conflicting interest with respect to a transaction, the director or the designated representative shall disclose in writing to the board the conflicting interest and play no part, directly or indirectly, in the board's deliberations or vote on the transaction.

Action respecting a conflicting interest transaction is effective if the transaction received the affirmative vote of a majority (but no fewer than two (2)) of those directors on the board or on a duly empowered committee of the board who do not have a conflicting interest respecting a transaction. A majority (but no fewer than two (2)) of all the directors on the board, or on a committee, who do not have a conflicting interest respecting a transaction constitute a quorum for purposes of action that complies with this section.

ARTICLE VI. OFFICERS

SECTION 1. Officers. The officers of the Association shall be a chairman of the board, a vice chairman of the board, a secretary and a treasurer, each of whom shall be elected by the board of directors and any such other officers as the board of directors may from time to time deem necessary in order to conduct the business of the Association. The offices of secretary and treasurer may be held by the same person.

SECTION 2. Election and Term of Officers. The officers of the Association to be elected by the board of directors shall be elected annually by the board of directors at the regular meeting of the board of directors immediately following the annual meeting of the members. If the election of officers shall not be held at such meeting, such election shall be held as soon thereafter as conveniently may be. Each officer shall continue to serve until his successor is elected and qualifies or until his death or until he shall resign or shall have been removed in the manner hereinafter provided.

SECTION 3. Resignation or Removal of Officers. An officer may resign at any time by delivering written notice to the board of directors, the chairman of the board or to the Association. A resignation is effective when the notice is delivered unless the notice specifies a later effective date.

Any officer may be removed by the board of directors whenever in its judgment, the best interests of the Association will be served thereby, but such removal shall be without prejudice to the contract rights, if any, of the person so removed. Election or appointment of an officer or agent shall not of itself create contract rights.

SECTION 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the board of directors for the unexpired portion of the term.

SECTION 5. Chairman of the Board. The chairman must be a member of the board of directors at the time of election to such office. The chairman shall be the principal executive officer of the Association and, subject to the control of the board of directors, shall have general

supervision and control of the business and affairs of the Association. He shall, when present, preside at all meetings of the members and of the board of directors. He may sign, with the secretary or any other proper officer of the Association thereunto authorized by the board of directors, any deeds, mortgages, bonds, contracts, or other instruments which the board of directors has authorized to be executed, except in cases where the signing and execution thereof shall be expressly delegated by the board of directors or by these bylaws to some other officer or agent of the Association, or shall be required by law to be otherwise signed or executed; and in general shall perform all duties incident to the office of chairman and such other duties as may be prescribed by the board of directors from time to time.

SECTION 6. Vice Chairman of the Board. The vice chairman must be a member of the board of directors at the time of election to such office. In the absence of the chairman or in the event of his death, inability or refusal to act, the vice chairman shall perform the duties of the chairman, and when so acting, shall have all the powers of and be subject to all the restrictions upon the chairman. The vice chairman shall perform such other duties as from time to time may be assigned to him by the chairman or by the board of directors.

SECTION 7. Secretary. The secretary shall (a) prepare and keep the minutes of the directors' and members' meetings in one or more books provided for that purpose; (b) see that all notices are duly given in accordance with the provisions of these bylaws or as required by law; (c) be custodian of the association records; (d) authenticate records of the Association; (e) keep a register of the post office address of each member which shall be furnished to the secretary by the Mississippi Department of Insurance; and (f) in general perform all duties incident to the office of secretary and such other duties as from time to time may be assigned to him by the chairman or by the board of directors.

SECTION 8. Treasurer. The treasurer shall (a) have charge and custody of and be responsible for all funds and securities of the Association; (b) receive and give receipts for monies due and payable to the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with these bylaws; and (c) in general perform all of the duties incident to the office of treasurer and such other duties as from time to time may be assigned to him by the chairman or by the board of directors. If required by the board of directors, the treasurer shall give a bond for the faithful discharge of his duties in such sum and with such surety or sureties as the board of directors shall determine.

SECTION 9. Compensation. The board of directors may fix the compensation of the officers provided that such officers to be compensated are not members of the board of directors. No such payment shall preclude any officer from serving the Association in any other capacity and receiving compensation therefor.

ARTICLE VII. ADMINISTRATION

SECTION 1. Administering Insurer. The board of directors shall select a member, through a competitive bidding process, to serve as administering insurer and administer the health insurance plan of the Association. The board of directors shall evaluate bids submitted based on criteria established by the board of directors, which shall include (a) the member's

proven ability to handle large group accident and health insurance; (b) the efficiency of the member's claims-paying procedures; and (c) an estimate of total charges. The administering insurer shall serve for a period of three (3) years. At least one (1) year prior to the expiration of each three-year period of service by an administering insurer, the board of directors shall invite all members to submit bids to serve as the administering insurer for the succeeding three-year period. The selection of the administering insurer for the succeeding period shall be made at least six (6) months prior to the succeeding three-year period. The administering insurer shall perform the duties set forth in and pursuant to the terms and conditions of the contract between the Association and the administering insurer.

SECTION 2. Other. The board of directors may employ or retain such other persons, firms or corporations to perform such administrative functions as are necessary for the performance of the duties imposed upon the Association. The board of directors may use the mailing address of such person, firm or corporation as the official address of the Association. Such persons may include an Administrator or Executive Director with such authority as may be delegated by the board of directors to implement and carry out broad directives of the board of directors made pursuant to its statutory authority and duties. Such person shall be knowledgeable about insurance matters and administratively capable of implementing the board's directives. Such persons may also include attorneys at law, actuaries, accountants, claims personnel and such other specialists or persons whose advice or assistance is deemed by the board of directors to be necessary to the discharge of its duties imposed by law. The board of directors may agree to compensate such persons so as to best serve the interests of the Association and the public. Such persons, firms or corporations shall keep and maintain such records of their activities as may be required by the board of directors. (Amended March 4, 1993).

ARTICLE VIII. CONTRACTS, LOANS, CHECKS AND DEPOSITS

SECTION 1. Contracts. The board of directors may authorize any officer or officers, agent or agents, to enter into any contract or execute and deliver any instrument in the name of and on behalf of the Association, and such authority may be general or confined to specific instances.

SECTION 2. Loans. No loans shall be contracted on behalf of the Association and no evidences of indebtedness shall be issued in its name unless authorized by a resolution of the board of directors. Such authority may be general or confined to specific instances.

SECTION 3. Checks, Drafts, Etc. All checks, drafts or other orders for the payment of money, notes or other evidences of indebtedness issued in the name of the Association, shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by resolution of the board of directors.

SECTION 4. Deposits. All funds of the Association not otherwise employed shall be deposited from time to time to the credit of the Association in such banks, companies or other depositories as the board of directors may select.

ARTICLE IX. INDEMNIFICATION

SECTION 1. Right of Indemnity. The Association shall indemnify its officers and directors, including but not limited to the individual representatives of the member insurers serving on the board of directors, for all reasonable expenses incurred on account of any action taken or not taken by them in the performance of their powers and duties, unless such persons shall be finally adjudged to have committed a breach of duty involving gross negligence, bad faith, dishonesty, willful misfeasance or reckless disregard of the responsibilities of his office or position. Such expenses shall include, but not be limited to, attorneys' fees, judgments, decrees, fines, penalties and amounts paid in settlement actually and necessarily incurred in the defense of any action, suit or proceeding, whether civil, criminal, administrative or investigative, including all appeals, brought against such persons, their testators or intestates.

SECTION 2. Right of Association to Insure. The Association may purchase and maintain insurance on behalf of an officer or director against liability asserted against or incurred by him in that capacity or arising from his status as a director, officer, employee or agent, whether or not the Association would have power to indemnify him against such liability under applicable law.

ARTICLE X. NOTICE

Notice shall be in writing unless oral notice is reasonable under the circumstances. Notice may be communicated in person; by telephone, telegraph, teletype or other form of wire or wireless communication; or by mail or private carrier. If these forms of personal notice are impracticable, notice may be communicated by a newspaper of general circulation in the area where published; or by radio, television or other form of public broadcast communication.

Written notice to members, if in a comprehensible form, is effective when mailed, if mailed postpaid and correctly addressed to the member's address shown in the Association's current record of members.

Except as provided above with respect to notice to members, written notice, if in a comprehensible form, is effective at the earliest of the following:

(1) When received;

(2) Five (5) days after its deposit in the United States mail, as evidenced by the postmark, if mailed postpaid and correctly addressed;

(3) On the date shown on the return receipt, if sent by registered or certified mail, return receipt requested, and the receipt is signed by or on behalf of the addressee.

Oral notice is effective when communicated if communicated in a comprehensible manner.

ARTICLE XI. WAIVER OF NOTICE; ASSENT TO ACTIONS

A member or director of the Association may waive any notice required by applicable law or these amended and restated articles, bylaws and operating rules, before or after the date and time stated in the notice. Except as provided below, the waiver must be in writing, be signed by the member or director entitled to the notice, and delivered to the Association for inclusion in the minutes or filing with the association records.

A director's attendance at or participation in a meeting waives any required notice to him of the meeting unless the director at the beginning of the meeting (or promptly upon his arrival) objects to holding the meeting or transacting business at the meeting and does not thereafter vote for or assent to action taken at the meeting. A member's attendance at a meeting (i) waives objection to lack of notice or defective notice of the meeting unless the member at the beginning of the meeting objects to holding the meeting or transacting business at the meeting, and (ii) waives objection to consideration of a particular matter at the meeting that is not within the purpose or purposes described in the meeting notice, unless the member objects to considering the matter when it is presented.

A director who is present at a meeting of the board of directors or a committee of the board of directors when action is taken is deemed to have assented to the action taken unless: (1) he objects at the beginning of the meeting (or promptly upon his arrival) to holding it or transacting business at the meeting; (2) his dissent or abstention from the action taken is entered in the minutes of the meeting; or (3) he delivers written notice of his dissent or abstention to the presiding officer of the meeting before its adjournment or to the Association immediately after adjournment of the meeting. The right of dissent or abstention shall not be available to a director who votes in favor of the action taken.

ARTICLE XII. ACCOUNTING, RECORDS AND REPORTS

SECTION 1. Fiscal Year. The fiscal year of the Association shall begin on January 1 and end on December 31 in each year.

SECTION 2. Audits. The Association shall conduct periodic audits to assure the general accuracy of the financial, claims and assessment data submitted to the Association. The Association shall have an annual audit of its operations made by an independent certified public accountant.

SECTION 3. Examination. The Association shall submit to and fully cooperate in an annual examination by the Mississippi Department of Insurance. To the extent that the Mississippi Commissioner of Insurance requires as the result of such an annual examination, the board of directors will (a) contract with an outside independent actuarial firm to assess the solvency of the Association and for consultation as to the sufficiency and means of the funding of the Association, and the enrollment in and the eligibility, benefits and rate structure of the health insurance plan to ensure the solvency of the Association; and (b) close enrollment in the health insurance plan at any time upon a determination by the outside independent actuarial firm that funds of the Association are insufficient to support the enrollment of additional persons.

SECTION 4. Records. Minutes of the proceedings of each board meeting and committee meeting shall be written. The original of these minutes shall be retained by the secretary of the board of directors or by such other person as the board may designate. Copies of minutes, reports, records and documents shall be furnished to each board member, to the Mississippi Commissioner of Insurance and to any member upon request and receipt by the Association of payment of copying charges the amount of which shall be determined by the board of directors; provided, however, that such minutes, reports, records and documents relating to the portions of such proceeding which were closed, because of the confidential nature of the matters addressed, shall also be confidential and distribution of such minutes, reports, records and documents shall be limited to the members of the board of directors and the Association's attorneys, employees or agents, considered by the board of directors to be necessary or pertinent to the discussion of the matters addressed or performance of the actions taken during such confidential proceedings.

ARTICLE XIII. HEALTH INSURANCE PLAN

SECTION 1. Major Medical Expense Coverage. The Association shall offer to every eligible person major medical expense coverage pursuant to a health insurance plan adopted by the board of directors but only to the extent that funds of the Association are reasonably anticipated to be sufficient to support the enrollment of such eligible person. The health insurance plan shall provide benefits in accordance with the Act and subject to the terms and conditions of the insurance policy adopted by the board of directors and approved by the Mississippi Department of Insurance. Although the insurance policy is required by the Act to be an annually renewable policy, it is the intent of the Association to renew each policy on its anniversary date or to issue a policy of similar benefits so long as the person remains eligible to obtain coverage from the Association and to the extent that funds of the Association are reasonably anticipated to be sufficient to support such renewal or issuance. (Amended February 12, 1996).

SECTION 2. Optional Coverage. The Association may offer to every eligible person additional types of health insurance policies to provide for optional coverages. The Association may also establish rules, conditions and procedures for reinsuring risks of members desiring to issue Association coverages to individuals otherwise eligible for plan coverages in their own name. (Amended August 14, 1995).

SECTION 3. Eligibility. In order to be eligible to obtain coverage from the Association, a person shall (a) have been rejected by one (1) insurance company, nonprofit health care services plan, fraternal benefit society, health maintenance organization, self-insurance arrangement or any other entity providing a plan of health insurance or health benefits subject to state insurance regulation for coverage substantially similar to the Association coverage without material underwriting restriction at a rate equal to or less than the Association plan rate; (b) have been a legal resident of Mississippi for six (6) consecutive months prior to application for coverage by the Association; (c) not be eligible for Medicaid or Medicare benefits; (d) not have received $1,000,000 in benefits from the Association or any organization similar to the Association; (e) not have equivalent coverages under another contract or policy except that a person may maintain (i) other coverage for the period of time the person is satisfying a preexisting condition waiting period under Association coverage and (ii) Association coverage for the period of time the person is satisfying a preexisting condition waiting period under

another health insurance policy intended to replace the Association coverage; (f) not be an inmate or resident of a public institution; and (g) not have premiums paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider. The board of directors shall promulgate a list of medical or health conditions, the existence of which would eliminate the necessity of a person demonstrating rejection of coverage but shall in no way operate to waive any of the other eligibility requirements set forth herein. The list of medical or health conditions may be amended by the board of directors from time to time. The residency requirement shall be waived with respect to any person who changes his domicile to Mississippi and who at the time domicile is established in Mississippi is insured by an organization similar to the Association.

It is the intent of the Association to serve as the State of Mississippi's alternative mechanism to the individual market rules under the Health Insurance Portability and Accountability Act of 1996 as approved August 21, 1996 ("HIPAA"). As a result and in order to comply with the requirements of HIPAA, effective July 1, 1997 or such later date as the Centers for Medicare and Medicaid Services, United States Department of Health and Human Services, shall have provided to the Association a letter or other written documentation indicating to the effect that the Association is an acceptable alternative mechanism under HIPAA, federally defined eligible individuals shall not be required to obtain rejections for coverage prior to obtaining coverage from the Association and no prior residency requirement nor any preexisting condition exclusions shall apply to any federally defined eligible individual. For purposes of this paragraph, "federally defined eligible individual" shall mean an individual (a) for whom, as of the date on which the individual seeks coverage from the Association, the aggregate of the periods of creditable coverage is eighteen (18) or more months; (b) whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan (or health insurance coverage offered in connection with such a plan); (c) who is not eligible for coverage under a group health plan, Part A or Part B of title XVIII of the Social Security Act, or a state plan under title XIX of the Social Security Act or any successor program, and who does not have other health insurance coverage; (d) with respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on nonpayment of premiums or fraud; (e) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected such coverage; and (f) who has exhausted continuation coverage under such provision or program if the individual elected such continuation coverage described in subparagraph (e) of this paragraph. For purposes of determining federally defined eligible individual status, "creditable coverage" shall mean, with respect to an individual, coverage of the individual under any of the following: (a) group health plan; (b) health insurance coverage; (c) Part A or Part B of title XVIII of the Social Security Act; (d) title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) chapter 55 of title 10, United States Code; (f) medical care program of the Indian Health Services or of a tribal organization; (g) state health benefits risk pool; (h) health plan offered under chapter 89 of title 5, United States Code; (i) public health plan as defined in federal regulations; (j) health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). "Creditable coverage" does not include coverage consisting solely of coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical

payment insurance; credit-only insurance; coverage for on-site medical clinics; other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits; limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; such other similar, limited benefits as may be specified in federal regulations; coverage only for a specified disease or illness; and hospital indemnity or other fixed indemnity insurance. A period of creditable coverage shall not be counted with respect to the enrollment of an individual if after such period and before the enrollment date the individual experienced a significant break in coverage, defined as a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

It is the intent of the Association to establish a pilot program to enable persons that lose individual health coverage under certain circumstances and through no fault of their own to obtain coverage with no preexisting condition exclusions. For the period of such program as established by the board of directors no preexisting condition exclusions shall apply to any state eligible individual. For purposes of this paragraph, "state eligible individual" shall mean an individual (a) for whom, as of the date on which the individual seeks coverage from the Association, the aggregate of the periods of creditable coverage is eighteen (18) or more months; (b) whose most recent prior creditable coverage was under an individual health insurance policy written by an insurer licensed to transact insurance in the State of Mississippi; (c) who is not eligible for coverage under a group health plan, Part A or Part B of title XVIII of the Social Security Act, or a state plan under title XIX of the Social Security Act or any successor program, and who does not have other health insurance coverage; (d) with respect to whom the most recent coverage within the period of aggregate creditable coverage was terminated through no fault of the individual such as the carrier's withdrawal from the state, discontinuance of a market or liquidation, rehabilitation or conservation and was not terminated based on nonpayment of premiums or fraud; (e) who, if offered the option of continuation coverage under a COBRA continuation provision or under a similar state program, elected such coverage; and (f) who has exhausted continuation coverage under such provision or program, if the individual elected such continuation coverage described in subparagraph (e) of this paragraph. For purposes of determining state eligible individual status, "creditable coverage" shall mean, with respect to an individual, coverage of the individual under any of the following: (a) group health plan; (b) health insurance coverage; (c) Part A or Part B of title XVIII of the Social Security Act; (d) title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) chapter 55 of title 10, United States Code; (f) medical care program of the Indian Health Services or of a tribal organization; (g) state health benefits risk pool; (h) health plan offered under chapter 89 of title 5, United States Code; (i) public health plan as defined in federal regulations; (j) health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). "Creditable coverage" does not include coverage consisting solely of coverage only for accident, or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; other similar insurance coverage under which benefits for medical care are secondary or incidental to other insurance benefits; limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; such other

similar, limited benefits as may be specified in federal regulations; coverage only for a specified disease or illness; and hospital indemnity or other fixed indemnity insurance. A period of creditable coverage shall not be counted with respect to the enrollment of an individual if after such period and before the enrollment date the individual experienced a significant break in coverage, defined as a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage.

The coverage of any person who ceases to meet the eligibility requirements of this section may be terminated immediately. Any person who terminates coverage with the Association shall not be eligible for coverage unless twelve (12) months have elapsed since the person's latest termination. Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is otherwise eligible for coverage may apply for coverage with the Association and if such coverage is applied for within sixty (60) days after the involuntary termination and if premiums are paid for the entire period of coverage, the effective date of the coverage shall be the date of termination of the previous coverage. (Amended April 15, 1992, August 14, 1995, July 1, 1997, January 1, 2003, August 27, 2009).

SECTION 4. Excess Coverage. The Association shall be the payer of last resort of benefits whenever any other benefit or source of third party payment is available. The coverage provided by the Association shall be considered excess coverage, and benefits otherwise payable under the Association coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable by any insurer or insurance arrangement or any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program. No amounts paid or payable by Medicare or any other governmental program or any other insurance, or self-insurance maintained in lieu of otherwise statutorily required insurance, may be made or recognized as claims under such policy or be recognized as or towards satisfaction of applicable deductibles or out-of-pocket maximums or to reduce the limits of benefits available. The Association shall have a cause of action against a participant for the recovery of the amount of any benefits paid to the participant which should not have been claimed or recognized as claims because of the provisions hereof or because otherwise not covered. Benefits due from the Association may be reduced or refused as a setoff against any amount recoverable hereunder. (Amended August 14, 1995, August 27, 2009).

SECTION 5. Agent Referral Fee. The Association shall pay a referral fee as established by the board of directors to each insurance agent who refers an applicant to the Association if the applicant's application is accepted by the Association.

ARTICLE XIV. ASSESSMENTS

SECTION 1. Organizational Assessments. The Association shall levy organizational assessments against members of the Association in accordance with the requirements of the Act and in the manner and amounts to be determined by the board of directors. Organizational

assessments shall be equal in amount for all members, but shall not exceed One Hundred Dollars ($100.00) per member for all such organizational assessments.

SECTION 2. Operational Assessments. The Association shall levy operational assessments against members of the Association in accordance with the requirements of the Act and in the manner and amounts to be determined by the board of directors based on actuarial valuations of reserves necessary to provide for claims paid and administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. Operational assessments shall not exceed Three Dollars ($3.00) per covered person per month. For purposes of this paragraph "covered person" shall mean any Mississippi resident (excluding dependents) who is eligible to receive benefits from any insurance company, nonprofit health care services plan, fraternal benefit society, health maintenance organization, self-insurance arrangement or any other entity providing a plan of health insurance coverage or health benefits subject to state insurance regulation or with respect to whom a reinsurer provides health care benefits or reinsures health insurance risk. Excluded from the definition of covered person are persons covered under Federal and State employee programs and persons covered under any short-term, accident, dental-only, vision-only, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance. The Association shall make reasonable efforts designed to ensure that each covered person is counted only once with respect to any assessment. For that purpose, the Association shall require each insurer that obtains excess or stoploss insurance to include in its count of covered persons all individuals whose coverage is insured (including by way of excess or stoploss coverage) in whole or part. The Association shall allow a reinsurer to exclude from its number of covered persons those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stoploss insurer for the purpose of determining its assessment under this section. The number of covered persons reported by each member shall be subject to audit and verification by the Association. (Amended August 14, 1995, April 11, 2003, August 27, 2009).

SECTION 3. Payment of Assessments, Disputes, Past Due Assessments. Assessments levied by the Association pursuant to the Act and this Article XIV of these amended and restated articles, bylaws and operating rules shall be due and payable not less than thirty (30) days after written notice of the assessment to the members. Disputes concerning liability to pay an assessment or the amount of an assessment shall not be cause to withhold payment of the assessment. Such disputes shall be submitted to the Association as a grievance in accordance with the procedures set forth in Article XV of these amended and restated articles, bylaws and operating rules after payment of the assessment. Assessments not paid in full by the due date shall accrue interest at the rate of twelve percent (12%) per annum on and after such due date. The Mississippi Commissioner of Insurance may suspend or revoke, after notice and hearing, the certificate of authority to transact insurance in this state of any member insurer which fails to pay an assessment or otherwise file any report or furnish information required to be filed with the board pursuant to the board's direction that the board determines is necessary in order for the board to perform its duties hereunder. As an alternative, the Mississippi Commissioner of Insurance may levy a forfeiture on any member insurer which fails to pay an assessment when due. Such forfeiture shall not exceed five percent (5%) of the unpaid assessment per month, but

no forfeiture shall be less than One Hundred Dollars ($100.00) per month. (Amended August 14, 1995, August 27, 2009).

SECTION 4. Deferment, Abatement of Assessments. The Association may defer or abate, in whole or in part, the assessment against a member if it is determined by the board of directors that the costs associated with making and collecting such assessment would make the assessment not economically feasible or the payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is deferred or abated, in whole or in part, the amounts by which such assessment is deferred or abated may be assessed against other members in a manner consistent with the basis for assessments set forth in these amended and restated articles, bylaws and operating rules, subject to the requirements of the Act. A member receiving a deferment or abatement shall remain liable to the Association for the amount of the deferment or abatement. In the event an assessment which was previously deferred or abated is later recovered by the Association, the Association shall credit such recovery against future assessment made against other members who paid the assessment as a result of such deferment or abatement.

SECTION 5. Credit, Refund of Overpayment of Assessments. Any claim for credit or refund of an overpayment of any assessment shall be submitted in writing to the Association within a reasonable time period. Any such written request for credit or refund shall be submitted within two (2) years from the time the assessment was due and payable or one (1) year from the time the assessment was paid, whichever of such periods expires the later, unless the member making such request provides substantial justification for later submission. Any such written request for credit or refund shall be handled in the same manner as a grievance as provided for in Article XV of these amended and restated articles, bylaws and operating rules. To the extent that the Association determines that an assessment has been overpaid, the Association shall credit such overpayment without interest against future assessment made against the member who paid the overpayment. Any unused balance of the credit remaining after one (1) year from the time of such determination of overpayment by the Association shall be paid to the member without interest in annual installments not to exceed a period of three (3) years. (Amended April 22, 2004).

ARTICLE XV. GRIEVANCES AND APPEALS

SECTION 1. Grievances. Any grievance of an applicant or participant in the health insurance plan of the Association shall be submitted to the administering insurer of the Association in accordance with procedures to be set forth in the application for coverage by the Association. Any grievance of a member or an applicant or participant in the health insurance plan of the Association not resolved by the administering insurer shall be submitted in writing to the Association at the Association's principal place of business. The board of directors or a committee established by the board of directors shall act on the grievance within thirty (30) days of receipt of the grievance by the Association unless a later date is agreed to in writing by the aggrieved party and the Association. (Amended October 13, 1993).

SECTION 2. Appeals. Any member or former member of the Association or applicant or participant in the health insurance plan of the Association aggrieved by an act of the board of directors or the Association shall appeal to the board of directors within fifteen (15) days of the

act of the board of directors or the Association before appealing to the Mississippi Commissioner of Insurance. If such member is aggrieved by the final action or decision of the board of directors on the appeal, or if the board of directors declines or fails to act on such appeal within thirty (30) days, the member, applicant or participant may appeal to the Mississippi Commissioner of Insurance within thirty (30) days after the action or decision of the board of directors or the expiration of the thirty (30) day period within which the board of directors failed to act on such appeal. The application for coverage by the Association shall provide notice that grievances and appeals shall be handled in accordance with Article XV of these amended and restated articles, bylaws and operating rules and that a copy of Article XV of these amended and restated articles, bylaws and operating rules may be obtained upon written request to the Association.

ARTICLE XVI. HEALTH INSURANCE EXCHANGE

The Commissioner of Insurance has advised the Association of his determination that the Association presents the most desirable option available for prompt implementation in Mississippi of a health benefit exchange that will facilitate the purchase of qualified health plans for individuals and small employers. The Commissioner intends by this amendment to these articles, bylaws and operating rules to approve the establishment and operation of a Mississippi Health Insurance Exchange (the "Exchange") that may be flexible enough to comply with federal and state law as it exists now and as it may be amended or enacted in the future.

On May 16, 2011, the board of directors of the Association authorized and approved the establishment and operation by the Association of the Exchange. Such authorization and approval is expressly subject to the availability of adequate funding from the Mississippi Department of Insurance and/or HHS grants until January 1, 2015, the date by which the Exchange is required to be financially self-sustaining.

It is the intent of the Association, upon receipt of such funding, to establish and operate the Exchange. The Association shall provide to the Mississippi Department of Insurance such information as may be necessary for the Department to obtain federal grants pursuant to Funding Opportunity "Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchange," CFDA Number 93.525 dated January 20, 2011, or any such other funding opportunity, to fund the Exchange through 2014.

All functions of the Exchange shall be exercised by or under the authority of, and the Exchange business and affairs managed under the direction of, the board of directors of the Association, subject to any limitation set forth in these amended and restated articles, bylaws and operating rules.

In connection with establishing and operating the Exchange, the Association shall develop (i) a complete budget through 2014, (ii) an initial plan discussing financial sustainability by 2015, (iii) a plan outlining steps to prevent fraud, waste and abuse, and (iv) a plan describing how capacity for providing assistance to individuals and small businesses in Mississippi will be created, continued and/or expanded, including provision for a call center. In developing such budget and plans, the Association may consult with and draw on the expertise available through representatives of the Mississippi Department of Insurance and outside consultants retained by

the Department regarding health insurance exchange and healthcare reform matters, any state or federal governmental agency, trade associations, or any other organizations or individuals as the Association deems appropriate.

The functions of the Exchange shall, at a minimum, include:

(A) Implementing procedures for the certification, recertification and decertification of health plans as qualified health plans, consistent with state and federal guidelines;

(B) Providing for the operation of a toll-free telephone hotline to respond to requests for assistance;

(C) Maintaining an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

(D) Assigning a rating to each qualified health plan offered through the Exchange in accordance with state and federal guidelines;

(E) Utilizing a standardized format for presenting health benefits plan options in the Exchange;

(F) Informing individuals of eligibility requirements for Medicaid, CHIP, or any applicable state, federal or local public program and providing a mechanism that will facilitate enrollment of eligible individuals in such programs;

(G) Establishing and making available by electronic means a calculator to determine the actual cost of coverage after any available premium credits, reductions or adjustments are applied;

(H) Establishing a consumer outreach program.

It is anticipated that in connection with the establishment and operation of the Exchange these amended and restated articles, bylaws and operating rules will be further amended as appropriate to be consistent with state and federal guidelines. (Amended June 13, 2011).

ARTICLE XVII. AMENDMENTS

The board of directors may amend or repeal these amended and restated articles, bylaws and operating rules and adopt new articles, bylaws and operating rules at any regular or special meeting of the board of directors subject to the approval of the Mississippi Commissioner of Insurance. (Amended June 13, 2011).

ARTICLE XVIII. APPLICABILITY

To the extent that these amended and restated articles, bylaws and operating rules are inconsistent with the Act as it may be amended from time to time, the Act governs. (Amended June 13, 2011).

APPROVAL

I, Mike Chaney, Commissioner of Insurance for the State of Mississippi, do hereby on behalf of the Mississippi Department of Insurance approve the attached new Article XVI, Health Insurance Exchange, and the renumbering of subsequent articles of the Amended and Restated Articles, Bylaws and Operating Rules of the Comprehensive Health Insurance Risk Pool Association.

WITNESS my signature on this, the 23rd day of June, 2011.

MIKE CHANEY
COMMISSIONER OF INSURANCE

By: _____
Mike Chaney
Commissioner of Insurance

CONFLICTS OF INTEREST AND BUSINESS ETHICS POLICY

ARTICLE I. PURPOSE

The purpose of the conflicts of interest and business ethics policy is to protect the Comprehensive Health Insurance Risk Pool Association's (the "Association") interest when it is contemplating entering into a transaction or arrangement that might benefit the private interest of an officer or director of the Association or might result in a possible excess benefit transaction. This policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

ARTICLE II. DEFINITIONS

SECTION 1. Interested Person. Any director, principal officer, member of a committee with governing board delegated powers or Executive Director, who has a direct or indirect financial interest, as defined below, is an interested person.

SECTION 2. Financial Interest. A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:

a. An ownership or investment interest in any entity with which the Association has a transaction or arrangement,

b. A compensation arrangement with the Association or with any entity or individual with which the Association has a transaction or arrangement, or

c. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the Association is negotiating a transaction or arrangement.

Compensation includes direct and indirect remuneration as well as gifts or favors that are not insubstantial.

A financial interest is not necessarily a conflict of interest. Under Article III, Section 2, a person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists.

SECTION 3. Policy Statement. Statements of policy applicable to each individual representative of the member companies which have been elected to the Board of Directors, each individual appointed to the Board of Directors and the Executive Director which are attached hereto as Exhibit "A."

ARTICLE III. PROCEDURES

SECTION 1. Duty to Disclose. In connection with any actual or possible conflict of interest, an interested person must disclose the existence of the financial interest and be given the opportunity to disclose all material facts to the directors and members of committees with governing board delegated powers considering the proposed transaction or arrangement.

SECTION 2. Determining Whether a Conflict of Interest Exists. After disclosure of the financial interest and all material facts, and after any discussion with the interested person, he/she shall leave the governing board or committee meeting while the determination of a

conflict of interest is discussed and voted upon. The remaining board or committee members shall decide if a conflict of interest exists.

SECTION 3. Procedures for Addressing the Conflict of Interest.

a. An interested person may make a presentation at the governing board or committee meeting, but after the presentation, he/she shall leave the meeting during the discussion of, and the vote on, the transaction or arrangement involving the possible conflict of interest.

b. The chairperson of the governing board or committee shall, if appropriate, appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.

c. After exercising due diligence, the governing board or committee shall determine whether the Association can obtain with reasonable efforts a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.

d. If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the governing board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the Association's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination it shall make its decision as to whether to enter into the transaction or arrangement.

SECTION 4. Violations of the Conflicts of Interest and Business Ethics Policy.

a. If the governing board or committee has reasonable cause to believe an interested person has failed to disclose actual or possible conflicts of interest, it shall inform the interested person of the basis for such belief and afford the interested person an opportunity to explain the alleged failure to disclose.

b. If, after hearing the interested person's response and after making further investigation as warranted by the circumstances, the governing board or committee determines the interested person has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

ARTICLE IV. RECORDS OF PROCEEDINGS

The minutes of the governing board and all committees with board delegated powers shall contain:

a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the governing board's or committee's decision as to whether a conflict of interest in fact existed.

b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

ARTICLE V. COMPENSATION

a. A voting member of the governing board who receives compensation, directly or indirectly, from the Association for services is precluded from voting on matters pertaining to that member's compensation.

b. A voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Association for services is precluded from voting on matters pertaining to that member's compensation.

c. No voting member of the governing board or any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the Association, either individually or collectively, is prohibited from providing information to any committee regarding compensation.

ARTICLE VI. ANNUAL STATEMENTS

Each director, principal officer, member of a committee with governing board delegated powers, and Executive Director shall annually sign a statement which affirms such person:

a. Has received a copy of the conflicts of interest and business ethics policy,

b. Has read and understands the policy,

c. Has agreed to comply with the policy, and

d. Understands the Association is a tax exempt organization and in order to maintain its federal tax exemption it must engage primarily in activities which accomplish one or more of its tax-exempt purposes.

ARTICLE VII. PERIODIC REVIEWS

To ensure the Association operates in a manner consistent with its tax-exempt purposes and does not engage in activities that could jeopardize its tax-exempt status, periodic reviews shall be conducted. The periodic reviews shall, at a minimum, include the following subjects:

a. Whether compensation arrangements and benefits are reasonable, based on competent survey information, and the result of arm's length bargaining.

b. Whether partnerships, joint ventures, and arrangements with management organizations conform to the Association's written policies, are properly recorded, reflect reasonable investment or payments for goods and services, and do not result in inurement, impermissible private benefit or in an excess benefit transaction.

ARTICLE VIII. USE OF OUTSIDE EXPERTS

When conducting the periodic reviews as provided for in Article VII, the Association may, but need not, use outside advisors. If outside experts are used, their use shall not relieve the governing board of its responsibility for ensuring periodic reviews are conducted.

COMPREHENSIVE HEALTH INSURANCE RISK POOL ASSOCIATION

STATEMENTS OF POLICY

These statements of policy apply to each individual representative of the member companies which have been elected to the Board of Directors, each individual appointed to the Board of Directors and the Executive Director.

POLICY STATEMENT 1

A named person may not accept any gift or favor, however nominal, which could reasonably be perceived as tending to influence any business decision made or to be made on behalf of the Association.

POLICY STATEMENT 2

A named person may not seek to use his/her position in a manner to derive a personal monetary benefit or benefit for the member by which he/she is employed.

POLICY STATEMENT 3

A named person may not utilize any nonpublic information acquired as a result of the performance of Association duties to derive any personal monetary benefit or benefit for the member by which he/she is employed, through securities trading or otherwise, directly or indirectly. All such nonpublic information, if material, shall be disseminated only within the organization, to member associations, and to industry members, but on a "need to know" basis and under circumstances where the recipient of such information has committed to keep such information confidential and not use such information to derive any personal monetary benefit.

POLICY STATEMENT 4

A named person shall immediately and fully disclose to the Association any interest in any matter which might reasonably represent a conflict of interest, or the appearance of one, within the context of the individual's duties on behalf of the Association.

POLICY STATEMENT 5

A named person should not engage in any unlawful, improper or unethical conduct on the Association's behalf.

POLICY STATEMENT 6

A named person who becomes aware of any violation or possible violation by someone else of any of these rules shall immediately report the facts and circumstances in confidence to the Chairman and Executive Director or the Association's Compliance Officer.

EXHIBIT "A"