LEAVITT PARTNERS

PREPARING FOR THE MISSISSIPPI HEALTH BENEFIT EXCHANGE: FINAL REPORT

Prepared for the

Mississippi Insurance Department

September 27, 2011

Contents

Introduction and Background

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 unique challenges and needs associated with each state, many—including Mississippi—have begun the initial phase of designing their own exchange.

Functions of a Health Exchange

The implementation of state-based health insurance exchanges are the centerpiece of the health reforms within the 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 a qualified 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. 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 are key 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 may increase 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 exchange's 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 viability 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 includes a number of provisions intended to make and keep exchanges viable. The so-called "individual mandate" goes into effect in 2014, requiring that all individuals purchase health insurance. The hope is that those individuals who do not currently carry health insurance will purchase their policies through an exchange. In addition, the federal government will provide financial incentives to qualified individuals who fall below 400 percent of the federal poverty line (FPL). As an incentive to employers, the federal government will make available a small-employer tax credit during the first two years after an exchange goes online. Current research suggests that 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*. An exchange that is attractive to business and individuals will incent adoption and expand risk pools, thereby mitigating adverse selection. 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 a

government agency, a quasi-governmental entity, 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.

Contract Background

In 2010 the State of Mississippi received a federal Planning & Establishment grant from the U.S. Department of Health and Human Services (HHS) to support planning activities related to the creation and operation of a state health benefit exchange as provided for under the Patient Protection and Affordable Care Act (PPACA). Leavitt Partners, LLC was engaged by the Mississippi Insurance Department (MID) to provide assistance with this planning process.

The contract called for a number of elements, including high-level strategic advisement, compilation of baseline information (including social, economic, and demographic data), market research and analysis, initial outreach efforts, ongoing environmental assessment, information technology (IT) gap analysis, grant assistance. Leavitt Partners subcontracted with Cicero Group, a market research firm to assist in market research and analysis activities and in initial outreach efforts. Over a nine month period, Leavitt Partners and Cicero Group visited Mississippi three times; Leavitt Partners had one additional on-site visit. These on-site visits were primarily to conduct research and engage in initial outreach. The results and findings of Leavitt Partners' and Cicero Group's work may be found in this report.

Executive Summary

This report offers key insights that are critical to designing and implementing a successful exchange in the State of Mississippi. This report has four component reports:

- Data Report I: Demographic, Social, and Economic Information for Mississippi Counties and Select Cities
- Data Report II: Demographic, Cost, & Growth Projections for the Uninsured & General Mississippi Population
- Phase I Market Research
- Phase II & III Market Research

Additional materials, including documents associated with the IT gap analysis, grant assistance, and ongoing environmental assessments are also included in this report.

The purpose of the Demographic, Social, and Economic Information for Mississippi Counties and Select Cities 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.

The purpose of the Demographic, Cost, & Growth Projections for the Uninsured & General Mississippi Population report is to provide 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.

The Phase I Market Research report includes results from more than sixty in-depth interviews[1] with Mississippi legislators, business associations, economic development leaders, consumer

[1] Notes from interviews and small business and broker mini focus groups are an overview of the discussion, not a transcription.

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

Five key insights from the Phase I report showed that Mississippians:

- **Demonstrate Confusion about the PPACA and a Health Benefits Exchange.** Participants showed a general lack of information and/or significant misinformation surrounding the Patient Protection Affordable Care Act and health insurance exchanges. Lack of information and broad misinformation has generated frustration and fear among stakeholders in Mississippi.

- **Prefer an Exchange Designed for Mississippians, by Mississippians.** Mississippians repeatedly stated that the health benefit exchange should be designed and operated by the state, rather than by the federal government. Mississippians recognize how the diversity of their state creates unique needs and challenges.

- **Value Simplicity.** Participants stressed the importance of simplicity in the outreach, design, and operation of a health insurance exchange. For example, participants recommended an exchange design that would condense health insurance plans down to two or three options. Additionally, employers emphasized the importance of creating an exchange that reduced the administrative burden of offering insurance.

- **Require Effective Outreach.** All respondents addressed the challenges of educating the general public and business community about health insurance and the health benefit exchange. However, participants also addressed the importance of leveraging the strong social and professional networks that already exist in Mississippi.

- **Request Exchange Assistance.** Almost all participants—including employers, industry groups, insurance carriers, and consumer advocate groups—stressed the importance of assistance in using the health benefit exchange. From information to enrollment to management of the exchange, assistance in multiple forms for both small businesses and employees will be critical to the success of the exchange.

To confirm and quantify the findings from Phase I, Leavitt Partners and Cicero designed a survey for Phase II of the research process. People were recruited for participation by telephone, mail, and online. Over 1,000 Mississippians participated in the survey, and most of the findings align directly with the insights gleaned from the first phase. Additionally, the survey revealed user preferences that are important to designing various logistical aspects of the exchange (e.g. outreach methods, educational formats, enrollment preferences, and plan administration).

Through town hall meetings, Phase III of the research process sought to confirm and expand upon the findings from Phases I and II. These meetings provided an environment for state officials and researchers to present the findings of the research to the residents of Mississippi and to seek feedback. The town hall meetings also laid an important foundation upon which state officials can build an effective outreach campaign for the Mississippi health benefit exchange.

Ten key issues emerged in Phases II and III of the research. They are summarized in the following list:

1. **Opposition to the Patient Protection and Affordable Care Act (PPACA).** The vast majority of Mississippians objected to the PPACA. Survey participants reported strong opposition to this act, and this resistance toward the PPACA resonated throughout the town hall meetings, particularly because of negative connotations associated with "Obamacare." To ensure acceptance and successful implementation of any PPACA mandate (i.e. a health benefit exchange), an active brand disassociation with the PPACA and the federal government will need to take place, most notably in the Gulf Coast region, where opposition was most strong.
2. **Mississippians Support a State Health Solution.** Mississippians expressed concern about the inefficiencies of the health care system in Mississippi, noting that it is too expensive, confusing, and often unfriendly. Although many individuals lack general comprehension of the health care market, the notion of a state-run health insurance exchange (as opposed to a federal-run exchange) is preferred by the majority. The vast approval is derived from the belief that a state-run exchange will decrease confusion and improve access to health care, while catering to the unique health needs of Mississippians.

3. **Affordable Health Care in Mississippi.** The primary factor that has prevented or discouraged employers from offering health insurance to their employees is cost. Small employers have listed the mitigation of insurance costs as the primary factor in their acceptance of a health benefit exchange, whether through direct (e.g. reduced premiums) or indirect (e.g. reducing time-consuming health benefit management tasks) implementations.

4. **Quality Health Care in Mississippi.** Along with the affordability of health care, Mississippians are particularly concerned about the quality of health care available to them. They expressed an unwillingness to sacrifice quality in favor of lower administrative costs. This standpoint likely stems from their recognition of the pressing health challenges present in many households in the state.

5. **Knowledge about Health Care and a Health Insurance Exchange.** Mississippi's small employers were more informed about the insurance market than were their employees. Yet, collectively, understanding of a health insurance exchange was low, indicating the need for a broad and systematic outreach campaign. Although the mediums for

outreach will vary among demographic and socioeconomic groups, there was unanimous agreement that direct education and enrollment assistance are essential to properly informing Mississippians about the role and function of the state's health benefit exchange.

6. **Simplicity in Exchange Education, Design, and Administration.** Real understanding about the health benefit exchange and the health insurance market is minimal, as survey respondents and town hall participants both expressed the need for greater clarity regarding these issues. In order to obtain widespread participation rates, the state will have to implement a simple, easy-to-understand education process. Participants defined "simplicity" in education as straight-forward marketing and informational online and offline collateral.
    a. Employers and employees both reported a need for simplifying the process of comparing and selecting plan options. They recommended a system that filters the number of plan options from many-to-few based on the unique criteria of the individual seeking insurance. Both employers and employees requested health plans be comparable on an "apples to apples" basis.

    b. Employers were particularly emphatic about health insurance not becoming or remaining "their problem" as a result of the health benefit exchange. Small businesses want to run their affairs without spending time dealing with health insurance. Therefore, information about adding and dropping employees, selecting plans, looking up coverage, answering health insurance-related questions, and so forth must be presented in a simple, user-friendly manner. The exchange must decrease the current administrative burden of offering health insurance benefits if it is to garner the support of small businesses.

7. **The Value of Health Benefits.** Both employers and employees reported health insurance as one of the most important benefits a company can offer to attract and retain quality employees. However, employers placed less weight than employees did on the degree to which health insurance influences an employee's likelihood to choose an employer. And while employees currently trust the system of employers selecting a plan for them, many employees reported a strong interest in having more control over their health plans (i.e. selection and management).

8. **The Necessity of Broad Outreach.** In the process of soliciting participation in the survey and town hall meetings, it became evident that the state's outreach will have to go beyond traditional methods to reach the citizens of Mississippi. For instance, e-mail, telephone, direct mail, online advertising, television, radio, newspaper, and in-person invitations were widely utilized to encourage participation in both the survey and town hall meetings. Despite these efforts, response rates were proportionately low (when compared to the fielding of similar studies in other states)—particularly considering the critical nature of this discussion, and the importance of health insurance in the lives of

Mississippians. If an exchange is to be successfully implemented in Mississippi, outreach efforts will need to be extensive.

The survey also discovered what outreach methods might best suit employers and employees. Employers recommend business organizations, insurance brokers, and fellow business owners as the best channels for outreach. Employees and individuals suggested employers, health providers, television, friends, family, and colleagues as being the best sources for outreach.

9. **The Importance of Individualized Assistance.** Both survey and town hall participants articulated a desire for assistance in understanding and navigating the health benefit exchange. Employers, in particular, initially expressed interest in in-person assistance, from either an insurance broker or a health exchange expert, without taking into account the potential cost to either the employer or the employee of such assistance. When potential costs, either to the employer or employee, were added, all respondents generally expressed greater interest in lower-cost forms of assistance, particularly a dedicated and interactive website with information and enrollment assistance. Regardless, the range of preferences expressed by both employers and employees indicates the importance of providing a number of different options for information about, enrollment in, and assistance with the exchange.

10. **Defined Contribution Plans.** Defined contribution plans were introduced as a potential component of the health benefit exchange at the town hall meetings. These plans allow employers to contribute a specified amount of money toward individual employee health benefits; employees then use this amount to select the coverage that is best suited to them. Employers and employees who participated in the town hall meetings expressed interest in learning more about defined contribution plans, particularly with respect to the flexibility and choice they offer both employers and employees.

This report and the materials accompanying it comprise the final report of the planning process.

DATA REPORT I: Demographic, Social, and Economic Information for Mississippi Counties and Select Cities

Executive Summary

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.

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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.

Tables

Population by County

	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 by City

	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 by County

	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 by City

	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.

DATA REPORT II: Demographic, Cost, & Growth Projections for the Uninsured & General Mississippi Population

Executive Summary

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.

Uninsured Population Information

Table 1: Uninsured Population by Industry

This table (see following page) 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.

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

This table and accompanying chart indicate 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.

	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**	

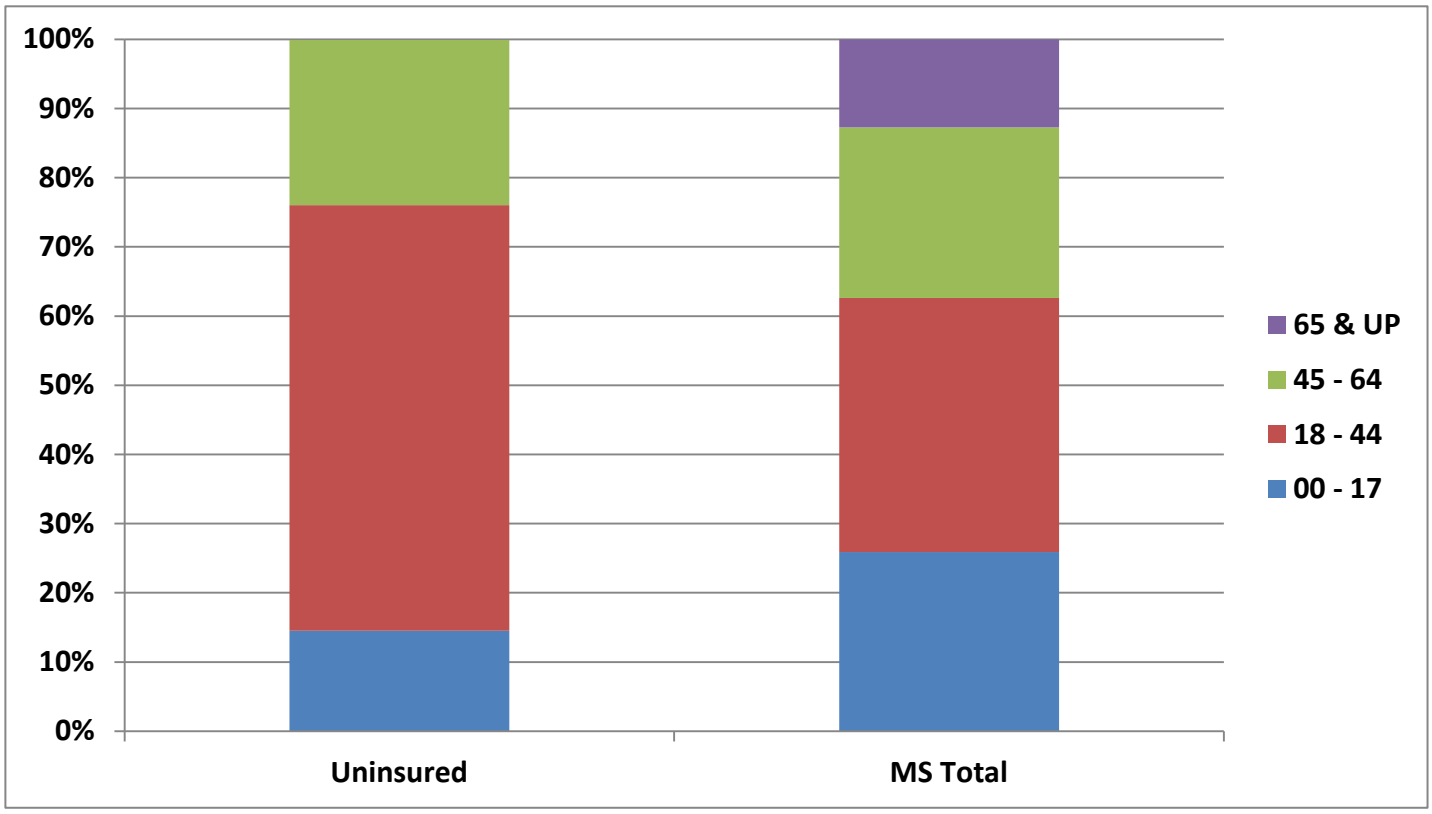


Table 3: Uninsured Population by FPL Distribution

This table and accompanying chart shows a distribution of uninsured and total population by the Federal Poverty Level. The apriori expectation 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.

	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**	

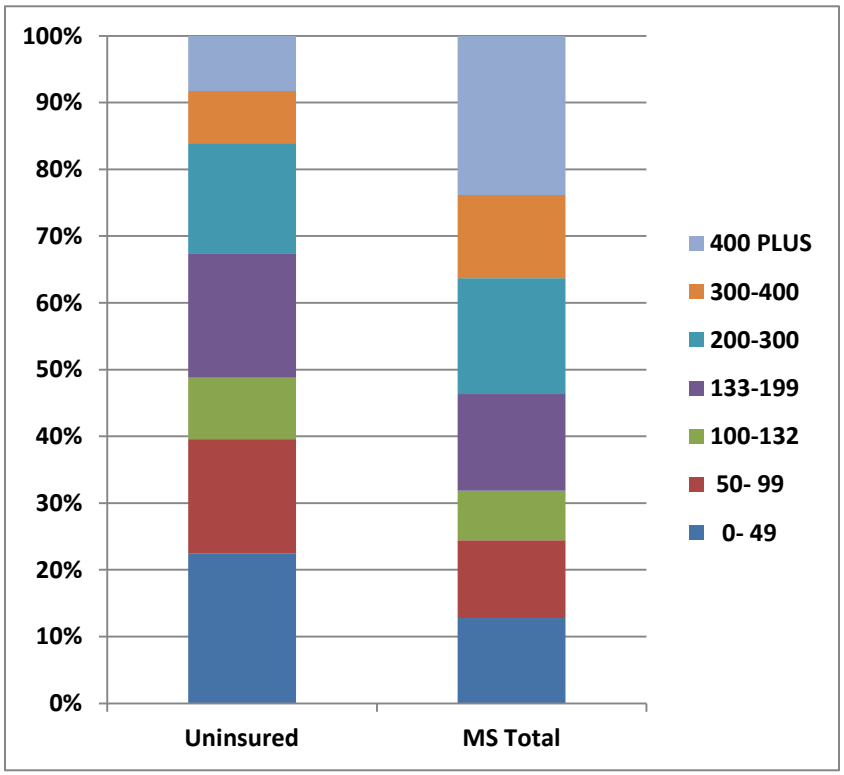


Table 4: Uninsured Population by Ethnicity

This table and accompanying chart show 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.

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**	

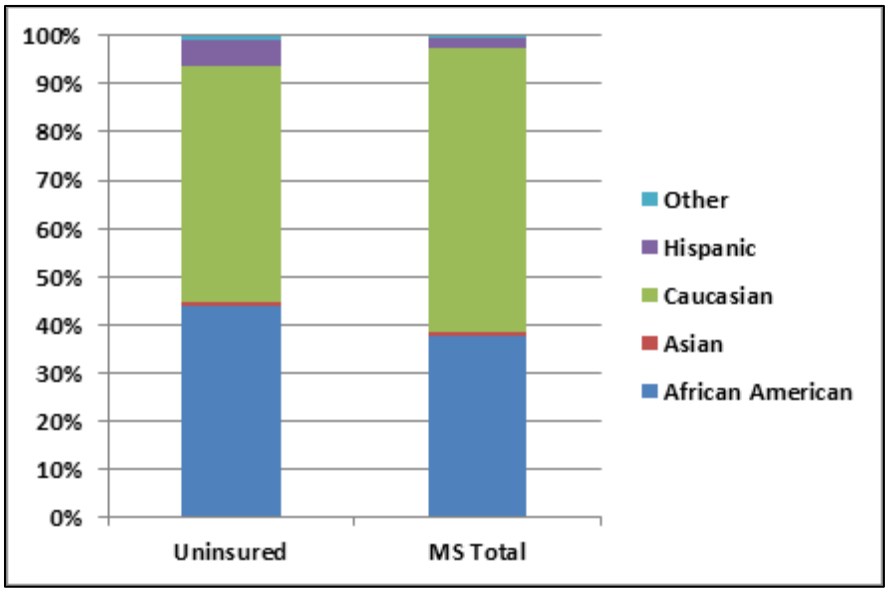


Table 5: Uninsured Population by Medicaid Eligibility

This table and accompanying chart indicate the number of Mississippians 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.

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**	

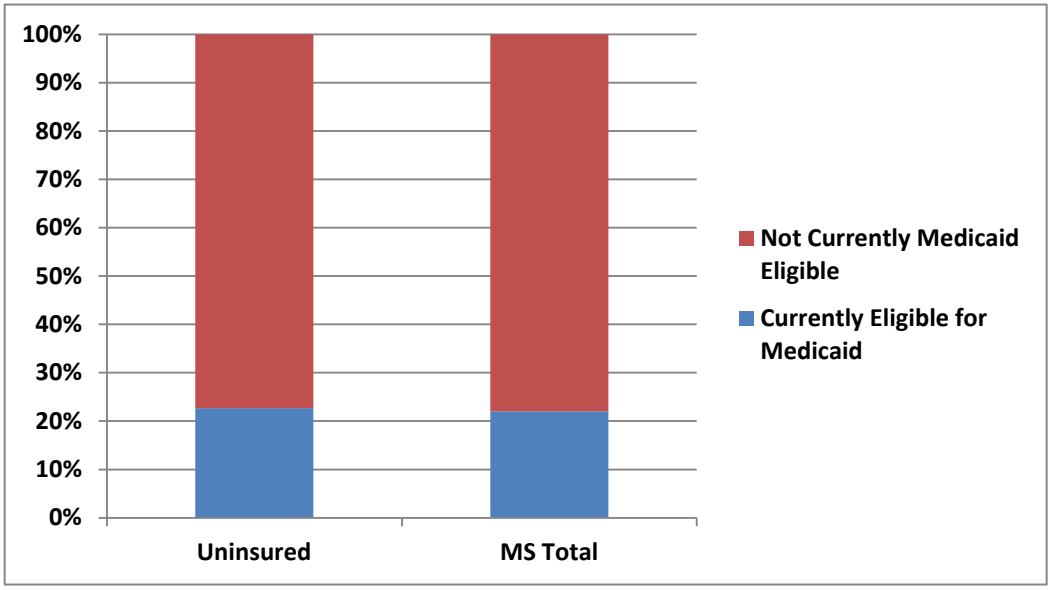


Table 6: Uninsured Population by Education

This table and accompanying chart indicate 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.

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**	

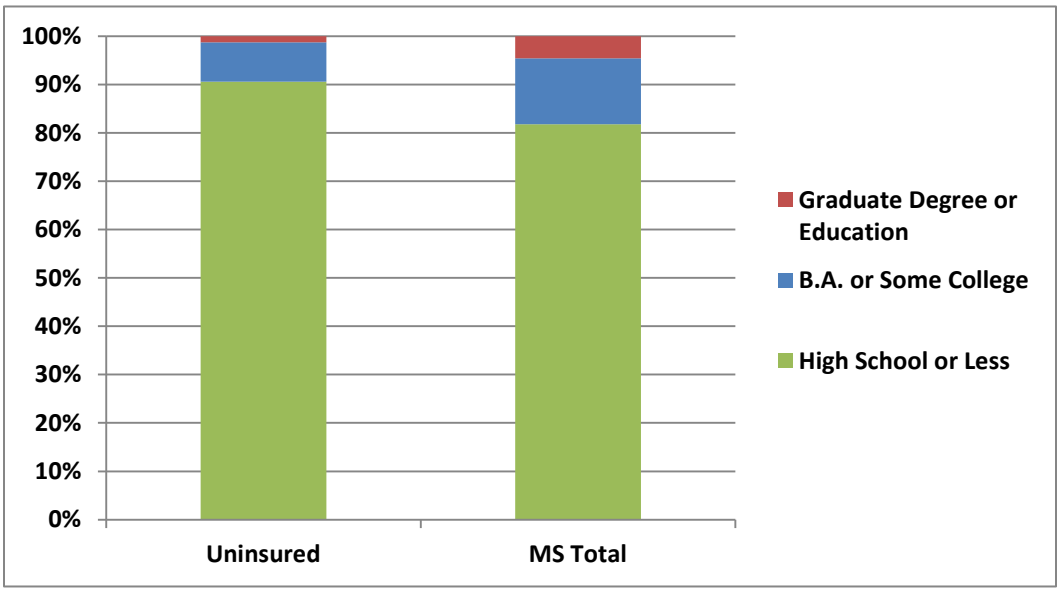


Table 7: Uninsured Population by Marital Status

This table and accompanying chart indicate 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.

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**	

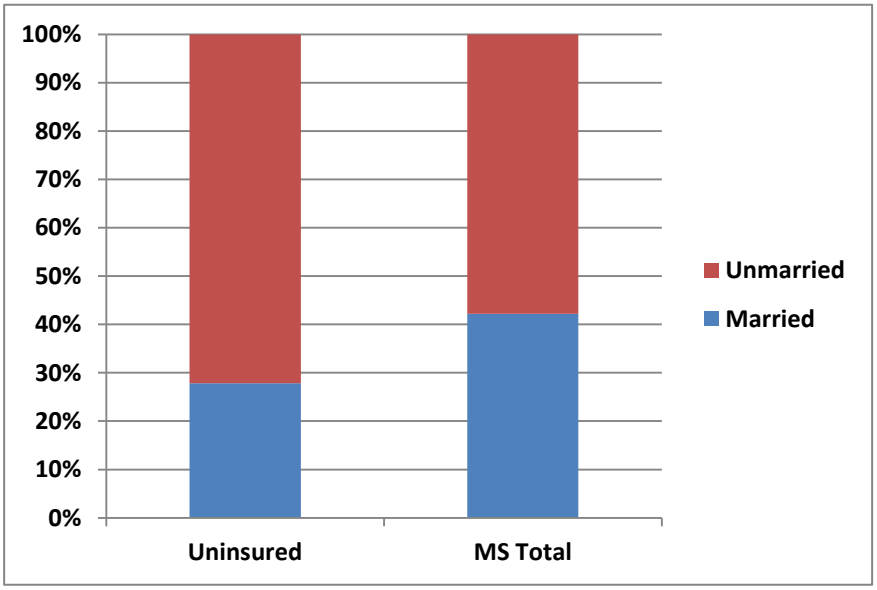


Table 8: Uninsured Population by Household Work Status

This table (see next page) indicates 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 force make 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.

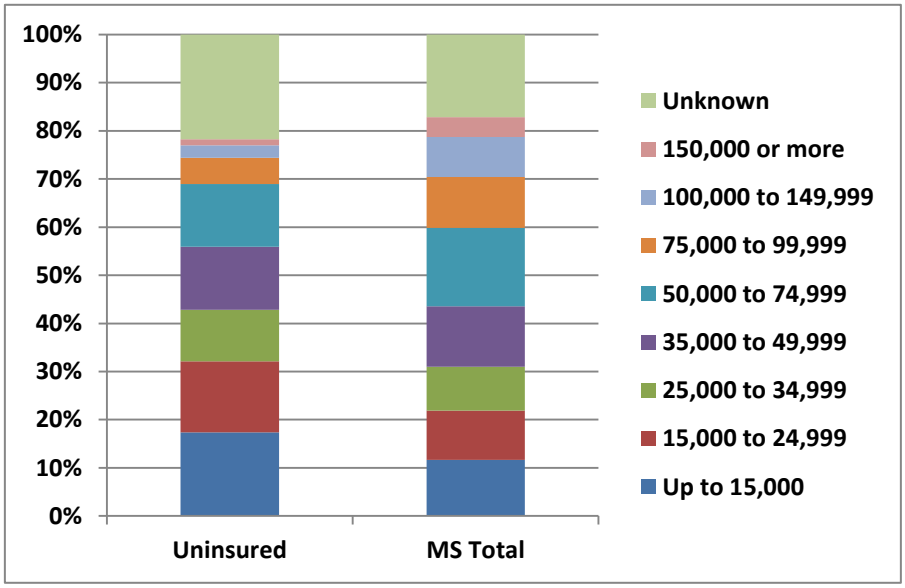
Table 8: Uninsured Population by Household Work Status

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

This table indicates 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 proportions 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.

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**	



Tables 10a-f: House Income Distribution by County

These six tables (see following pages) are designed to show how income is distributed by county. These tables provide a population count by county for annual income in $5k increments (except for the lowest and highest income brackets.) Tables 10a-10c indicate annual household income between 0 and $50K; Tables 10d-10f indicate household income from $50K to in excess of $500K annually. 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 conduct a targeted study that will help decision makers to better understand how to most efficiently and effectively direct outreach efforts.

Table 10a: House Income Distribution by County (0-$50K)

County	Household Income (Number of Households)								
	0-$10K	$10K-$15K	$15K-$20K	$20K-$25K	$25K-$30K	$30K-$35K	$35K-$40K	$40K-$45K	$45K-$50K
Adams	2,394	1,208	1,075	988	930	833	821	546	558
Alcorn	2,332	1,266	1,203	1,046	953	976	904	893	738
Amite	698	390	387	338	322	302	306	251	170
Attala	1,272	715	775	728	609	535	492	405	327
Benton	499	259	254	238	206	181	177	138	156
Bolivar	2,745	1,296	1,135	993	921	834	608	558	641
Calhoun	971	575	571	457	373	356	341	331	280
Carroll	534	261	248	257	221	199	177	153	122
Chickasaw	1,218	719	677	620	548	485	527	482	385
Choctaw	447	255	279	250	158	193	211	199	145
Claiborne	816	356	297	256	237	181	245	185	154
Clarke	1,235	584	529	503	514	410	433	402	320
Clay	1,412	640	598	569	537	520	395	413	359
Coahoma	1,992	917	810	707	602	528	489	405	321
Copiah	1,730	938	977	874	772	743	701	648	541
Covington	1,254	661	655	612	583	564	528	448	346
DeSoto	2,848	1,794	2,153	2,377	2,468	2,885	3,103	3,306	3,387
Forrest	4,439	2,440	2,493	2,227	1,810	1,749	1,616	1,418	1,358
Franklin	578	270	249	257	236	172	172	171	150
George	1,002	493	474	446	519	475	479	562	483
Greene	534	284	323	270	239	206	218	265	208
Grenada	1,398	736	650	625	673	609	576	479	415
Hancock	1,441	815	884	789	683	814	827	830	875
Harrison	6,392	3,708	4,170	4,080	4,674	4,425	4,390	4,306	4,035
Hinds	11,576	6,065	6,033	5,892	5,786	5,556	5,174	4,745	4,660
Holmes	1,757	792	643	466	411	374	361	295	244
Humphreys	809	437	334	274	260	223	165	131	128
Issaquena	100	44	39	43	33	27	21	19	13
Itawamba	1,098	543	562	608	542	532	554	503	487

Table 10b: House Income Distribution by County (0-50K)

County	Household Income (Number of Households)								
	0-$10K	$10K-$15K	$15K-$20K	$20K-$25K	$25K-$30K	$30K-$35K	$35K-$40K	$40K-$45K	$45K-$50K
Jackson	4,010	2,129	2,239	2,351	2,604	2,759	2,831	2,652	2,431
Jasper	1,209	607	590	569	566	478	418	361	351
Jefferson	660	299	262	259	155	133	128	148	96
Jefferson Davis	900	474	472	427	366	295	245	217	215
Jones	3,046	1,825	1,952	1,791	2,036	1,875	1,574	1,424	1,327
Kemper	739	355	323	294	281	246	190	235	195
Lafayette	2,317	1,141	1,119	1,156	998	862	743	709	639
Lamar	2,106	1,212	1,324	1,436	1,505	1,427	1,361	1,382	1,204
Lauderdale	4,971	2,426	2,420	2,109	1,821	1,861	1,988	1,479	1,455
Lawrence	919	500	505	466	348	365	314	290	260
Leake	1,441	675	633	631	672	545	495	498	509
Lee	3,363	1,889	1,951	1,909	2,076	2,139	1,947	1,894	1,632
Leflore	2,881	1,356	1,173	1,009	894	798	674	541	394
Lincoln	1,608	868	956	916	833	778	723	663	545
Lowndes	3,320	1,680	1,546	1,344	1,259	1,413	1,464	1,121	1,179
Madison	2,455	1,243	1,265	1,264	1,490	1,547	1,496	1,600	1,556
Marion	1,416	741	793	814	573	544	516	449	433
Marshall	2,257	1,133	1,081	978	1,076	987	775	854	781
Monroe	2,437	1,186	1,075	1,025	1,072	1,166	1,056	876	859
Montgomery	720	397	401	333	280	217	272	294	241
Neshoba	1,810	914	903	835	742	741	717	634	568
Newton	1,244	726	701	600	605	585	534	462	414
Noxubee	990	468	367	303	292	270	261	235	164
Oktibbeha	3,196	1,581	1,481	1,329	1,132	841	804	750	696
Panola	2,241	1,104	1,039	880	962	790	693	651	700
Pearl River	2,713	1,574	1,707	1,651	1,489	1,527	1,349	1,265	1,181

Table 10c: House Income Distribution by County (0-$50K)

County	Household Income (Number of Households)								
	0-$10K	$10K-$15K	$15K-$20K	$20K-$25K	$25K-$30K	$30K-$35K	$35K-$40K	$40K-$45K	$45K-$50K
Perry	602	323	332	295	314	283	279	273	192
Pike	2,711	1,495	1,506	1,301	1,174	1,027	954	780	680
Pontotoc	1,277	607	602	675	766	639	676	522	542
Prentiss	1,806	855	993	959	843	798	739	743	568
Quitman	619	302	271	229	193	150	149	138	124
Rankin	3,380	2,134	2,388	2,501	3,070	2,688	3,013	2,958	2,890
Scott	1,461	794	793	740	823	667	607	540	469
Sharkey	333	172	177	147	129	105	82	84	73
Simpson	1,554	880	854	661	666	672	675	598	515
Smith	854	468	457	426	462	408	394	363	307
Stone	797	481	573	558	435	404	345	329	387
Sunflower	1,477	757	789	694	557	486	428	383	351
Tallahatchie	937	443	390	306	344	341	288	219	214
Tate	1,118	643	612	591	695	637	575	574	519
Tippah	1,450	818	700	735	697	633	606	563	584
Tishomingo	1,103	696	654	566	571	577	581	458	411
Tunica	745	379	372	321	241	250	212	203	186
Union	1,272	692	701	775	738	683	644	502	484
Walthall	984	511	524	444	374	330	306	267	247
Warren	2,030	1,254	1,294	1,203	1,156	1,040	1,017	1,017	936
Washington	3,821	1,849	1,629	1,443	1,314	1,182	1,030	1,027	831
Wayne	1,085	529	520	500	405	403	416	468	274
Webster	565	332	351	298	245	230	285	230	219
Wilkinson	938	411	341	294	228	210	174	154	154
Winston	1,081	539	521	492	546	401	428	409	353
Yalobusha	983	532	562	552	545	470	392	317	319
Yazoo	1,543	792	770	659	501	495	457	426	417
Total	**113,227**	**59,780**	**59,735**	**56,407**	**55,865**	**52,535**	**49,985**	**46,228**	**42,838**

Table 10d: House Income Distribution by County ($50K-$500K+)

County	Household Income (Number of Households)								
	$50K-$60K	$60K-$75K	$75K-$100K	$100K-$125K	$125K-$150	$150K-$200K	$200K-$250K	$250K-$500K	$500K UP
Adams	793	872	770	445	155	103	101	141	42
Alcorn	1,227	1,372	1,142	551	246	92	71	90	27
Amite	333	377	271	163	51	38	20	16	7
Attala	648	605	552	214	156	68	48	42	17
Benton	201	192	144	76	43	7	8	3	-
Bolivar	836	887	852	444	166	126	82	80	20
Calhoun	494	461	341	149	68	55	27	15	4
Carroll	266	232	295	116	46	54	38	31	12
Chickasaw	602	601	454	214	70	40	23	35	10
Choctaw	280	263	177	86	52	41	23	14	6
Claiborne	227	217	216	135	81	51	15	16	6
Clarke	524	537	542	228	73	61	27	29	8
Clay	550	742	619	291	193	94	61	44	14
Coahoma	558	720	536	333	190	92	68	65	25
Copiah	838	985	983	592	215	157	52	26	14
Covington	520	676	529	267	103	59	60	80	29
DeSoto	6,186	7,836	9,873	6,046	2,212	1,376	744	497	191
Forrest	2,019	2,049	1,901	843	413	262	71	84	25
Franklin	206	318	200	95	29	23	17	11	7
George	850	1,074	1,047	521	191	149	73	20	8
Greene	332	327	386	143	73	43	19	11	7
Grenada	622	721	646	289	135	65	48	32	8
Hancock	1,373	1,568	1,285	937	281	236	131	138	57
Harrison	6,673	8,107	7,929	4,534	1,741	1,398	608	572	265
Hinds	7,242	8,517	8,532	4,537	2,042	1,420	981	1,015	481
Holmes	455	396	379	173	87	82	57	31	18
Humphreys	157	209	181	71	18	17	20	8	4
Issaquena	18	33	26	17	3	4	7	1	-
Itawamba	809	718	658	375	128	93	58	27	9

Table 10e: House Income Distribution by County ($50K-$500K+)

County	Household Income (Number of Households)								
	$50K-$60K	$60K-$75K	$75K-$100K	$100K-$125K	$125K-$150	$150K-$200K	$200K-$250K	$250K-$500K	$500K UP
Jackson	4,377	5,124	5,445	3,031	1,504	853	462	247	105
Jasper	582	608	462	200	96	61	32	32	13
Jefferson	198	184	128	81	38	12	14	2	2
Jefferson Davis	358	334	276	158	49	46	30	19	12
Jones	1,970	2,243	2,007	1,074	446	305	200	162	70
Kemper	298	250	195	91	62	29	12	12	4
Lafayette	982	1,392	1,699	846	472	375	134	177	82
Lamar	2,103	2,687	2,911	1,651	930	773	375	466	212
Lauderdale	2,447	2,659	2,571	1,257	580	330	217	176	71
Lawrence	493	580	594	347	75	66	27	19	8
Leake	760	730	638	351	181	119	33	38	16
Lee	2,814	3,251	3,009	1,530	605	467	258	291	133
Leflore	803	765	751	403	207	141	62	91	24
Lincoln	960	1,093	1,011	497	327	303	63	32	14
Lowndes	1,970	1,883	2,069	1,165	526	324	206	166	51
Madison	2,702	3,506	4,954	2,951	2,083	2,344	937	813	403
Marion	712	702	711	328	131	123	55	39	11
Marshall	1,238	1,529	1,204	524	237	171	119	78	29
Monroe	1,356	1,545	1,244	494	202	112	74	45	11
Montgomery	389	274	335	124	76	87	21	19	6
Neshoba	976	1,106	810	395	208	122	85	64	26
Newton	705	890	769	320	106	93	36	39	16
Noxubee	295	265	202	113	74	28	25	30	8
Oktibbeha	1,260	1,049	1,354	883	552	321	119	117	37
Panola	1,245	1,303	1,012	477	280	181	83	80	33
Pearl River	1,951	2,420	2,061	991	514	301	193	123	46

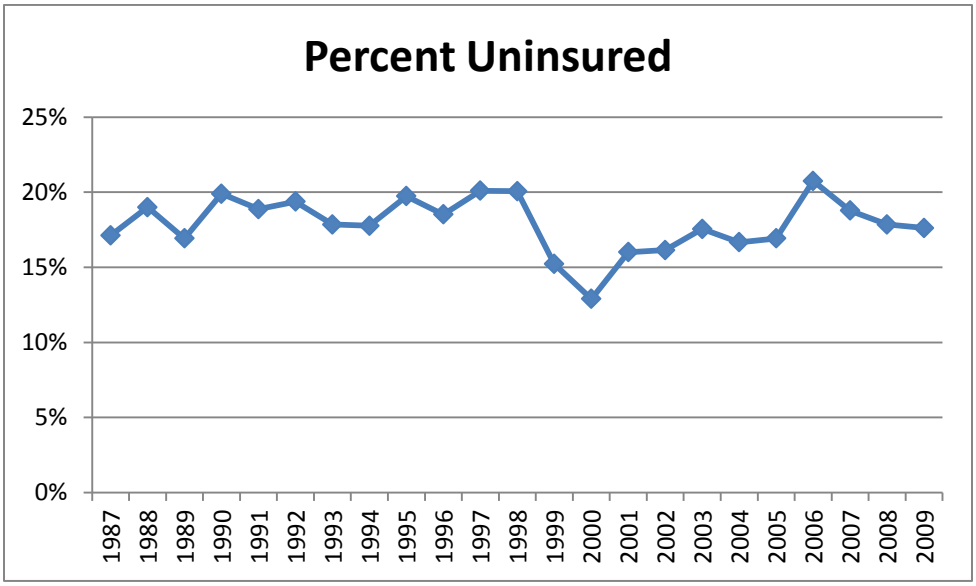
Table 10f: House Income Distribution by County ($50K-$500K+)

County	Household Income (Number of Households)								
	$50K-$60K	$60K-$75K	$75K-$100K	$100K-$125K	$125K-$150	$150K-$200K	$200K-$250K	$250K-$500K	$500K UP
Perry	373	384	336	136	67	52	12	11	7
Pike	1,212	1,189	1,025	564	263	171	135	115	62
Pontotoc	923	1,105	852	416	149	112	67	59	17
Prentiss	881	850	686	324	121	45	25	43	10
Quitman	199	207	126	88	24	18	13	9	4
Rankin	5,266	6,838	7,605	4,449	2,310	1,450	670	500	177
Scott	844	840	800	323	100	82	76	73	36
Sharkey	127	149	154	64	34	17	14	9	5
Simpson	858	919	868	441	144	113	62	47	21
Smith	622	629	444	185	88	57	37	32	10
Stone	575	745	678	348	129	140	67	30	14
Sunflower	477	569	488	203	90	73	46	46	8
Tallahatchie	305	384	242	149	49	35	16	16	6
Tate	879	1,097	1,141	541	251	135	74	44	14
Tippah	719	809	567	218	97	46	28	25	5
Tishomingo	550	591	485	226	104	85	45	38	9
Tunica	175	324	300	149	67	20	23	19	12
Union	1,068	1,042	735	270	87	47	49	72	14
Walthall	423	425	450	173	51	60	45	27	10
Warren	1,456	1,761	1,763	1,165	593	341	164	129	39
Washington	1,394	1,425	1,253	632	290	240	144	131	48
Wayne	534	492	408	225	142	100	45	38	20
Webster	332	306	251	130	39	23	14	20	5
Wilkinson	298	244	215	105	42	14	30	33	17
Winston	594	621	529	286	114	69	41	33	14
Yalobusha	546	546	429	176	100	49	22	35	7
Yazoo	595	609	656	489	107	85	54	43	19
Total	**87,210**	**100,086**	**99,007**	**53,484**	**24,543**	**17,529**	**9,053**	**7,810**	**3,245**

Table 11: Uninsured Population Trend (1987-2009)

This table and corresponding chart indicate the trended uninsured and, 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.

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%



Health Care Cost Data

Table 12: Commercial Cost Characteristics (2008)

This table 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.

	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)

This table (see next page) indicates 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.

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						

Mississippi County Projections

Tables 14a-e: Projected Population by County

Tables 14a-e project 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 14a: Projected Population by County (2010 - 2020)

Projected Mississippi Total Population												
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	Growth
Adams	31,003	30,524	30,069	29,637	29,228	28,840	28,517	28,206	27,905	27,614	27,333	-12%
Alcorn	35,805	35,813	35,829	35,852	35,884	35,923	35,969	36,018	36,070	36,124	36,181	1%
Amite	11,049	10,964	10,884	10,810	10,743	10,680	10,630	10,581	10,536	10,492	10,451	-5%
Atalla	20,890	20,830	20,775	20,726	20,683	20,645	20,635	20,628	20,623	20,620	20,620	-1%
Benton	7,086	7,086	7,088	7,092	7,098	7,106	7,111	7,117	7,124	7,132	7,141	1%
Bolivar	37,339	36,817	36,333	35,881	35,459	35,075	34,728	34,395	34,077	33,772	33,481	-10%
Calhoun	14,275	14,170	14,070	13,976	13,887	13,804	13,734	13,665	13,599	13,534	13,471	-6%
Carroll	8,439	8,391	8,348	8,311	8,277	8,249	8,218	8,189	8,162	8,137	8,113	-4%
Chickasaw	20,151	20,008	19,873	19,744	19,621	19,505	19,413	19,323	19,237	19,153	19,072	-5%
Choctaw	7,845	7,759	7,676	7,597	7,521	7,449	7,387	7,328	7,270	7,215	7,161	-9%
Claiborne	11,104	10,965	10,832	10,707	10,588	10,476	10,381	10,289	10,200	10,113	10,028	-10%
Clark	17,356	17,250	17,150	17,057	16,970	16,889	16,822	16,758	16,697	16,638	16,582	-4%
Clay	20,809	20,610	20,422	20,242	20,073	19,912	19,784	19,660	19,541	19,426	19,315	-7%
Coahoma	26,715	26,229	25,764	25,320	24,894	24,488	24,167	23,855	23,553	23,260	22,976	-14%
Copiah	32,381	32,350	32,332	32,326	32,333	32,353	32,370	32,392	32,419	32,452	32,490	0%
Covington	20,934	20,976	21,023	21,074	21,131	21,192	21,256	21,323	21,392	21,465	21,540	3%

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

	Projected Mississippi Total Population											
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Growth**
DeSoto	160,114	164,469	169,006	173,735	178,664	183,803	188,897	194,170	199,631	205,286	211,144	32%
Forrest	73,211	73,686	74,188	74,717	75,273	75,858	76,436	77,030	77,641	78,268	78,912	8%
Franklin	8,166	8,124	8,088	8,059	8,036	8,019	7,995	7,973	7,953	7,935	7,920	-3%
George	25,079	25,387	25,704	26,030	26,365	26,710	27,040	27,377	27,719	28,068	28,424	13%
Greene	12,925	12,939	12,958	12,983	13,013	13,048	13,076	13,107	13,140	13,176	13,215	2%
Granada	22,137	22,038	21,946	21,860	21,781	21,708	21,655	21,605	21,558	21,512	21,470	-3%
Hancock	33,937	34,009	34,117	34,260	34,439	34,654	34,757	34,882	35,027	35,194	35,383	4%
Harrison	189,808	191,904	194,117	196,447	198,898	201,476	203,076	204,749	206,496	208,318	210,218	11%
Hinds	246,769	245,207	243,787	242,502	241,351	240,344	239,657	239,048	238,514	238,057	237,677	-4%
Holmes	20,838	20,713	20,599	20,496	20,402	20,319	20,245	20,176	20,110	20,049	19,991	-4%
Humphreys	10,024	9,887	9,760	9,642	9,534	9,434	9,343	9,257	9,174	9,094	9,019	-10%
Issaquena	1,460	1,426	1,395	1,367	1,341	1,317	1,291	1,267	1,244	1,222	1,201	-18%
Ittawamba	21,297	21,262	21,233	21,211	21,195	21,186	21,182	21,180	21,181	21,184	21,189	-1%
Jackson	121,156	121,250	121,412	121,642	121,941	122,310	122,514	122,758	123,045	123,373	123,744	2%
Jasper	18,915	18,862	18,818	18,784	18,759	18,743	18,721	18,702	18,685	18,672	18,662	-1%
Jefferson	7,971	7,858	7,753	7,655	7,564	7,480	7,407	7,338	7,271	7,208	7,148	-10%
J. Davis	12,561	12,379	12,203	12,035	11,874	11,719	11,592	11,469	11,349	11,232	11,118	-11%

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

Projected Mississippi Total Population												
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Growth**
Jones	65,744	65,833	65,937	66,054	66,185	66,331	66,473	66,622	66,777	66,939	67,108	2%
Kemper	10,025	9,923	9,826	9,735	9,649	9,568	9,502	9,438	9,375	9,315	9,256	-8%
Lafayette	41,826	42,211	42,618	43,047	43,500	43,980	44,439	44,911	45,396	45,895	46,407	11%
Lamar	65,383	66,491	67,636	68,818	70,038	71,299	72,526	73,784	75,073	76,393	77,747	19%
Lauderdale	79,321	79,115	78,939	78,791	78,671	78,583	78,530	78,492	78,468	78,457	78,460	-1%
Lawrence	15,871	15,829	15,794	15,767	15,747	15,734	15,717	15,704	15,693	15,684	15,679	-1%
Leake	25,545	25,642	25,744	25,853	25,968	26,090	26,237	26,387	26,541	26,697	26,857	5%
Lee	80,260	80,593	80,951	81,334	81,744	82,179	82,585	83,007	83,445	83,900	84,373	5%
Leflore	37,133	36,755	36,398	36,059	35,737	35,431	35,185	34,947	34,718	34,498	34,286	-8%
Lincoln	31,546	31,634	31,728	31,829	31,935	32,047	32,157	32,269	32,384	32,501	32,621	3%
Lowndes	59,754	59,288	58,854	58,450	58,074	57,730	57,434	57,156	56,894	56,650	56,422	-6%
Madison	92,502	93,910	95,405	96,993	98,678	100,464	102,158	103,918	105,746	107,646	109,621	19%
Marion	24,464	24,436	24,416	24,403	24,397	24,399	24,397	24,398	24,402	24,408	24,418	0%
Marshall	41,600	41,837	42,087	42,349	42,625	42,914	43,193	43,478	43,771	44,071	44,379	7%
Monroe	39,979	39,838	39,709	39,591	39,484	39,389	39,320	39,256	39,197	39,143	39,093	-2%
Montgomery	11,363	11,204	11,054	10,911	10,777	10,649	10,552	10,459	10,369	10,281	10,197	-10%
Neshoba	30,306	30,431	30,560	30,693	30,830	30,971	31,111	31,253	31,398	31,545	31,695	5%

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

	Projected Mississippi Total Population											
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Growth**
Newton	22,925	22,912	22,908	22,910	22,921	22,939	22,958	22,979	23,003	23,029	23,058	1%
Noxoubee	11,698	11,580	11,469	11,367	11,273	11,186	11,107	11,030	10,956	10,886	10,818	-8%
Oktibbeha	44,700	44,696	44,709	44,740	44,789	44,855	44,946	45,046	45,157	45,277	45,407	2%
Panola	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	60,480	61,280	62,101	62,945	63,812	64,703	65,582	66,482	67,401	68,342	69,304	15%
Perry	11,255	11,223	11,197	11,175	11,158	11,147	11,135	11,125	11,116	11,110	11,105	-1%
Pike	41,913	41,907	41,912	41,927	41,952	41,988	42,032	42,081	42,134	42,192	42,254	1%
Pontotoc	26,281	26,406	26,538	26,677	26,824	26,978	27,124	27,275	27,429	27,587	27,750	6%
Prentiss	28,675	28,624	28,577	28,535	28,498	28,466	28,452	28,440	28,430	28,421	28,414	-1%
Quitman	7,895	7,791	7,699	7,613	7,533	7,460	7,379	7,301	7,226	7,154	7,084	-10%
Rankin	144,047	146,209	148,453	150,783	153,203	155,716	158,240	160,834	163,501	166,243	169,063	17%
Scott	27,647	27,598	27,558	27,525	27,501	27,484	27,480	27,480	27,484	27,492	27,503	-1%
Sharkey	5,392	5,320	5,254	5,195	5,142	5,095	5,036	4,981	4,928	4,877	4,830	-10%
Simpson	28,208	28,188	28,177	28,176	28,185	28,204	28,221	28,242	28,266	28,295	28,327	0%
Smith	16,416	16,320	16,229	16,142	16,060	15,982	15,921	15,863	15,807	15,754	15,704	-4%
Stone	19,777	20,055	20,343	20,642	20,951	21,272	21,573	21,881	22,198	22,523	22,856	16%
Sunflower	28,581	28,096	27,631	27,183	26,754	26,343	26,012	25,689	25,375	25,070	24,772	-13%

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

	Projected Mississippi Total Population											
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Growth**
Tallahatchie	12,794	12,648	12,511	12,383	12,263	12,152	12,033	11,918	11,807	11,701	11,598	-9%
Tata	27,969	28,092	28,222	28,359	28,504	28,656	28,799	28,947	29,099	29,257	29,420	5%
Tippah	23,017	22,987	22,963	22,947	22,938	22,936	22,935	22,937	22,942	22,950	22,962	0%
Tishomingo	18,345	18,260	18,182	18,110	18,046	17,989	17,942	17,898	17,855	17,815	17,777	-3%
Tunica	10,584	10,635	10,694	10,763	10,842	10,931	11,024	11,122	11,227	11,337	11,454	8%
Union	25,233	25,328	25,433	25,546	25,669	25,802	25,921	26,044	26,170	26,300	26,434	5%
Walthall	14,704	14,697	14,694	14,692	14,694	14,698	14,704	14,712	14,722	14,733	14,746	0%
Warren	47,493	47,063	46,660	46,281	45,926	45,596	45,332	45,081	44,843	44,618	44,406	-6%
Washington	54,127	53,045	52,020	51,041	50,107	49,215	48,514	47,835	47,177	46,541	45,924	-15%
Wayne	17,243	17,116	16,995	16,881	16,771	16,668	16,591	16,516	16,443	16,373	16,305	-5%
Webster	10,059	9,995	9,935	9,880	9,828	9,781	9,736	9,693	9,652	9,613	9,575	-5%
Wilkinson	10,784	10,728	10,678	10,636	10,600	10,570	10,539	10,511	10,485	10,462	10,442	-3%
Winston	18,315	18,189	18,068	17,952	17,840	17,733	17,651	17,571	17,492	17,415	17,339	-5%
Yalobusha	15,939	15,951	15,968	15,992	16,021	16,057	16,090	16,127	16,166	16,208	16,253	2%
Yazoo	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**	

Tables 15a-e: Projected Medicaid Covered Lives by County (2010-2020)

These tables show 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 15a: 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	9,151	8,675	8,354	7,915	10,331	10,786	10,727	10,344	10,214	10,062	9,941
Alcorn	7,347	7,036	6,859	6,553	8,451	8,907	9,253	9,063	9,050	9,036	9,041
Amite	2,613	2,485	2,403	2,282	2,891	3,019	3,108	3,028	3,007	2,984	2,967
Atalla	5,400	5,187	5,063	4,855	6,091	6,376	6,570	6,451	6,449	6,441	6,448
Benton	2,038	1,958	1,911	1,834	2,310	2,420	2,472	2,423	2,418	2,411	2,410
Bolivar	14,018	13,327	12,863	12,238	15,763	16,415	16,132	15,569	15,383	15,151	14,970
Calhoun	3,640	3,477	3,375	3,219	3,995	4,154	4,266	4,169	4,143	4,116	4,098
Carroll	1,840	1,747	1,688	1,600	1,996	2,081	2,169	2,120	2,107	2,095	2,086
Chickasaw	4,804	4,583	4,446	4,231	5,339	5,574	5,738	5,597	5,560	5,522	5,496
Choctaw	2,109	1,996	1,918	1,811	2,233	2,305	2,353	2,289	2,266	2,241	2,221
Claiborne	3,624	3,435	3,311	3,141	4,197	4,415	4,390	4,237	4,197	4,142	4,101
Clarke	3,572	3,400	3,296	3,132	4,179	4,425	4,558	4,429	4,403	4,374	4,355
Clay	5,676	5,398	5,218	4,958	6,358	6,644	6,724	6,528	6,472	6,406	6,357
Coahoma	12,083	11,468	11,026	10,465	12,951	13,306	12,991	12,529	12,337	12,108	11,920
Copiah	8,113	7,797	7,620	7,309	9,222	9,668	9,940	9,760	9,757	9,750	9,765
Covington	4,786	4,595	4,491	4,306	5,684	6,038	6,243	6,112	6,115	6,112	6,123

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

	Estimated Medicaid Covered Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Forrest	14,347	13,802	13,554	13,034	19,183	20,929	21,616	21,117	21,241	21,328	21,477
Franklin	2,150	2,058	2,003	1,918	2,522	2,665	2,706	2,635	2,624	2,610	2,603
George	4,405	4,254	4,186	4,026	4,942	5,196	5,565	5,544	5,597	5,660	5,733
Greene	2,489	2,365	2,291	2,171	2,833	2,994	3,130	3,059	3,051	3,043	3,041
Grenada	5,071	4,833	4,687	4,458	5,814	6,120	6,276	6,111	6,078	6,040	6,017
Hancock	5,860	5,582	5,416	5,148	6,588	6,943	7,269	7,125	7,115	7,107	7,116
Harrison	33,519	32,381	31,850	30,661	37,745	39,693	42,173	41,780	41,974	42,209	42,523
Hinds	54,389	51,663	49,938	47,393	61,094	64,012	65,497	63,647	63,182	62,625	62,234
Holmes	9,053	8,703	8,484	8,161	10,600	11,131	10,915	10,600	10,547	10,453	10,395
Humphreys	4,499	4,298	4,164	3,985	5,136	5,358	5,219	5,038	4,983	4,909	4,853
Issaquena	541	504	478	446	571	591	583	559	549	538	529
Itawamba	3,243	3,081	2,983	2,825	3,599	3,793	4,098	4,022	4,012	4,007	4,007
Jackson	17,570	16,697	16,172	15,314	19,049	19,910	21,212	20,805	20,725	20,667	20,647
Jasper	4,828	4,626	4,505	4,309	5,437	5,697	5,864	5,743	5,729	5,712	5,707
Jefferson	2,886	2,734	2,633	2,497	3,357	3,526	3,451	3,314	3,270	3,216	3,173
J. Davis	4,112	3,896	3,747	3,550	4,508	4,677	4,670	4,516	4,460	4,395	4,343
Jones	14,047	13,532	13,262	12,743	15,806	16,571	17,408	17,182	17,225	17,272	17,353

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

	Estimated Medicaid Covered Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Kemper	2,519	2,386	2,300	2,178	2,930	3,095	3,142	3,042	3,018	2,988	2,966
Lafayette	4,115	3,920	3,826	3,640	6,538	7,440	8,032	7,809	7,869	7,923	7,994
Lamar	7,633	7,386	7,292	7,032	9,316	10,069	11,210	11,193	11,372	11,566	11,780
Lauderdale	17,505	16,734	16,281	15,548	20,507	21,696	22,250	21,689	21,624	21,528	21,487
Lawrence	3,474	3,326	3,241	3,094	3,962	4,159	4,262	4,163	4,144	4,127	4,119
Leake	5,563	5,352	5,241	5,032	6,423	6,793	7,133	7,032	7,062	7,090	7,134
Lee	12,890	12,356	12,074	11,529	14,508	15,279	16,343	16,115	16,142	16,190	16,267
Leflore	14,190	13,539	13,114	12,522	16,503	17,318	17,008	16,429	16,281	16,071	15,917
Lincoln	6,493	6,233	6,089	5,831	7,436	7,845	8,236	8,102	8,117	8,130	8,158
Lowndes	12,872	12,226	11,822	11,214	14,657	15,402	15,720	15,256	15,138	15,003	14,907
Madison	11,274	10,870	10,686	10,271	12,911	13,707	14,933	14,878	15,050	15,241	15,461
Marion	6,591	6,347	6,210	5,970	7,491	7,848	8,051	7,904	7,900	7,889	7,896
Marshall	9,051	8,710	8,531	8,192	10,558	11,180	11,674	11,493	11,534	11,570	11,632
Monroe	8,171	7,797	7,573	7,210	9,184	9,640	10,046	9,828	9,793	9,757	9,741
Montgomery	3,297	3,124	3,007	2,845	3,489	3,591	3,623	3,521	3,482	3,442	3,410
Neshoba	6,529	6,293	6,173	5,940	7,736	8,226	8,648	8,513	8,550	8,578	8,625
Newton	4,651	4,466	4,366	4,180	5,328	5,610	5,841	5,736	5,735	5,736	5,750
Noxoubee	4,561	4,367	4,243	4,065	5,317	5,575	5,466	5,286	5,239	5,174	5,126

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

	Estimated Medicaid Covered Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Oktibbeha	6,933	6,610	6,450	6,154	10,119	11,241	11,628	11,240	11,260	11,254	11,280
Panola	10,448	10,055	9,831	9,446	11,864	12,433	12,732	12,506	12,509	12,499	12,518
Pearl River	9,744	9,397	9,240	8,885	11,861	12,745	13,667	13,526	13,659	13,798	13,964
Perry	2,691	2,560	2,477	2,352	2,943	3,068	3,169	3,096	3,078	3,061	3,049
Pike	11,980	11,550	11,311	10,892	13,987	14,736	14,983	14,678	14,677	14,652	14,664
Ponotoc	3,689	3,537	3,459	3,304	4,242	4,509	4,936	4,874	4,892	4,916	4,947
Prentiss	5,401	5,147	4,996	4,745	6,171	6,511	6,832	6,675	6,648	6,625	6,615
Quitman	3,567	3,394	3,272	3,114	3,884	4,014	3,926	3,796	3,748	3,690	3,644
Rankin	13,607	13,091	12,862	12,314	15,377	16,354	18,550	18,549	18,773	19,049	19,352
Scott	6,771	6,501	6,346	6,080	7,564	7,907	8,206	8,063	8,056	8,047	8,055
Sharkey	2,690	2,568	2,482	2,369	2,855	2,926	2,862	2,775	2,737	2,693	2,657
Simpson	6,435	6,153	5,988	5,717	7,340	7,726	7,988	7,818	7,805	7,787	7,786
Smith	3,349	3,178	3,068	2,904	3,598	3,744	3,933	3,844	3,818	3,794	3,776
Stone	3,659	3,543	3,495	3,373	4,349	4,630	4,907	4,865	4,910	4,959	5,018
Sunflower	10,287	9,720	9,329	8,815	11,163	11,553	11,472	11,070	10,918	10,738	10,592
Tallahatchie	4,872	4,640	4,482	4,271	5,381	5,586	5,521	5,344	5,283	5,208	5,150
Tate	4,569	4,380	4,279	4,086	5,062	5,316	5,718	5,651	5,665	5,687	5,718

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

	Estimated Medicaid Covered Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Tippah	5,349	5,138	5,019	4,809	6,085	6,380	6,587	6,459	6,445	6,433	6,435
Tishomingo	3,361	3,202	3,107	2,950	3,805	3,997	4,165	4,063	4,039	4,017	4,004
Tunica	3,207	3,093	3,033	2,928	3,868	4,112	4,168	4,080	4,092	4,093	4,106
Union	3,865	3,704	3,619	3,457	4,410	4,674	5,075	5,003	5,013	5,030	5,055
Walthall	4,143	3,971	3,867	3,704	4,845	5,119	5,206	5,084	5,079	5,062	5,059
Warren	10,580	10,045	9,701	9,186	11,226	11,606	11,996	11,708	11,609	11,513	11,440
Washington	22,811	21,603	20,735	19,631	24,159	24,754	24,237	23,358	22,962	22,508	22,129
Wayne	4,331	4,112	3,972	3,768	4,918	5,166	5,270	5,116	5,079	5,034	5,002
Webster	2,536	2,424	2,354	2,243	2,774	2,879	2,944	2,875	2,854	2,833	2,819
Wilkinson	3,399	3,258	3,175	3,047	4,181	4,455	4,433	4,300	4,289	4,262	4,250
Winston	4,536	4,324	4,189	3,986	4,977	5,181	5,321	5,197	5,169	5,136	5,114
Yalobusha	3,875	3,730	3,650	3,505	4,419	4,637	4,777	4,694	4,693	4,694	4,705
Yazoo	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**

Tables 16a-e: Projected Uninsured Lives by County (2010 – 2020)

Tables 16a-e show 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 16a: Projected Uninsured Lives by County (2010-2020)

	Estimated Uninsured Lives										
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Adams	8,558	8,605	8,628	8,664	4,881	3,765	3,260	3,286	3,204	3,132	3,120
Alcorn	6,971	7,075	7,183	7,276	4,158	3,245	2,741	2,758	2,723	2,687	2,718
Amite	2,197	2,221	2,244	2,269	1,270	983	834	838	823	807	810
Atalla	4,181	4,263	4,342	4,421	2,472	1,918	1,635	1,654	1,633	1,614	1,631
Benton	1,515	1,557	1,595	1,634	910	706	606	617	610	604	611
Bolivar	11,819	11,919	12,016	12,138	6,732	5,146	4,390	4,420	4,312	4,206	4,192
Calhoun	2,727	2,769	2,806	2,842	1,571	1,211	1,029	1,037	1,019	1,001	1,007
Carroll	1,393	1,415	1,440	1,466	807	621	519	520	511	501	505
Chickasaw	4,146	4,198	4,248	4,289	2,427	1,882	1,585	1,588	1,560	1,531	1,540
Choctaw	1,541	1,564	1,584	1,607	893	692	582	581	569	556	557
Claiborne	3,525	3,542	3,563	3,598	2,000	1,527	1,312	1,329	1,302	1,276	1,276
Clarke	3,882	3,913	3,944	3,969	2,281	1,775	1,519	1,530	1,503	1,479	1,486
Clay	5,050	5,097	5,144	5,199	2,940	2,280	1,940	1,950	1,914	1,877	1,882
Coahoma	8,211	8,325	8,401	8,506	4,684	3,591	3,105	3,132	3,048	2,971	2,950
Copiah	6,846	6,962	7,092	7,212	4,098	3,199	2,685	2,694	2,657	2,618	2,645
Covington	4,849	4,930	5,015	5,099	2,941	2,303	1,965	1,989	1,970	1,951	1,978
DeSoto	10,611	10,872	11,246	11,598	7,154	5,871	4,766	4,730	4,801	4,817	5,019

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

	Estimated Uninsured Lives										
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Forrest	20,772	21,025	21,413	21,751	12,519	9,707	8,249	8,400	8,360	8,309	8,472
Franklin	2,031	2,056	2,080	2,107	1,193	927	802	815	804	794	801
George	3,624	3,716	3,832	3,937	2,293	1,825	1,484	1,473	1,471	1,458	1,494
Greene	2,672	2,691	2,736	2,782	1,578	1,213	939	915	905	879	893
Grenada	4,981	5,042	5,104	5,159	2,945	2,289	1,939	1,949	1,918	1,887	1,901
Hancock	5,664	5,759	5,857	5,963	3,511	2,801	2,345	2,333	2,305	2,268	2,294
Harrison	26,520	27,280	28,117	28,942	16,879	13,510	11,144	11,070	10,992	10,853	11,046
Hinds	50,971	51,326	51,746	52,249	29,727	23,091	19,494	19,521	19,173	18,793	18,870
Holmes	7,195	7,359	7,513	7,686	4,292	3,310	2,896	2,963	2,917	2,877	2,891
Humphreys	3,502	3,555	3,595	3,648	2,019	1,548	1,366	1,397	1,368	1,345	1,344
Issaquena	404	409	413	419	221	165	137	137	133	129	128
Itawamba	2,936	2,968	3,011	3,053	1,722	1,338	1,109	1,107	1,094	1,076	1,089
Jackson	16,148	16,320	16,546	16,758	9,789	7,758	6,350	6,249	6,157	6,028	6,085
Jasper	3,860	3,934	4,006	4,079	2,292	1,781	1,518	1,534	1,514	1,495	1,509
Jefferson	2,879	2,893	2,909	2,930	1,626	1,235	1,057	1,067	1,043	1,018	1,016
J. Davis	3,254	3,285	3,307	3,339	1,834	1,401	1,205	1,217	1,188	1,162	1,158
Jones	11,154	11,369	11,609	11,841	6,731	5,279	4,396	4,400	4,355	4,298	4,358

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

	Estimated Uninsured Lives										
County	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Kemper	2,624	2,637	2,652	2,674	1,494	1,142	970	977	958	939	941
Lafayette	9,999	9,975	10,072	10,163	5,802	4,435	3,707	3,768	3,760	3,736	3,824
Lamar	8,442	8,616	8,850	9,086	5,400	4,335	3,629	3,653	3,674	3,674	3,783
Lauderdale	17,969	18,176	18,401	18,630	10,740	8,390	7,129	7,173	7,073	6,963	7,020
Lawrence	3,239	3,288	3,345	3,386	1,933	1,507	1,263	1,266	1,246	1,226	1,238
Leake	5,044	5,142	5,259	5,377	3,105	2,440	2,035	2,044	2,032	2,010	2,046
Lee	12,044	12,247	12,480	12,676	7,389	5,852	4,847	4,825	4,780	4,719	4,795
Leflore	12,746	12,906	13,055	13,233	7,394	5,670	4,907	4,980	4,881	4,784	4,785
Lincoln	5,768	5,874	5,987	6,101	3,494	2,743	2,317	2,334	2,314	2,289	2,322
Lowndes	13,284	13,363	13,449	13,536	7,820	6,111	5,178	5,178	5,081	4,979	4,995
Madison	10,080	10,322	10,628	10,937	6,486	5,230	4,375	4,394	4,411	4,406	4,530
Marion	5,297	5,398	5,502	5,605	3,184	2,490	2,109	2,123	2,095	2,066	2,087
Marshall	8,284	8,453	8,644	8,834	5,060	3,966	3,336	3,364	3,341	3,309	3,366
Monroe	7,459	7,550	7,644	7,734	4,418	3,450	2,902	2,908	2,866	2,821	2,846
Montgomery	2,344	2,377	2,403	2,428	1,335	1,025	865	866	846	827	826
Neshoba	6,284	6,394	6,508	6,634	3,851	3,044	2,614	2,650	2,635	2,617	2,658
Newton	4,327	4,399	4,483	4,550	2,618	2,052	1,712	1,713	1,691	1,666	1,687
Noxoubee	4,001	4,056	4,103	4,157	2,335	1,799	1,561	1,584	1,552	1,522	1,523

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

	Estimated Uninsured Lives										
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Oktibbeha	14,253	14,118	14,177	14,232	8,112	6,182	5,141	5,185	5,136	5,063	5,138
Panola	8,214	8,399	8,587	8,781	4,986	3,906	3,319	3,352	3,317	3,280	3,321
Pearl River	10,826	11,062	11,338	11,602	6,824	5,416	4,554	4,595	4,594	4,575	4,686
Perry	2,220	2,255	2,291	2,327	1,318	1,027	858	858	846	832	840
Pike	10,306	10,523	10,731	10,940	6,251	4,893	4,208	4,266	4,214	4,165	4,206
Ponotoc	3,622	3,673	3,734	3,790	2,196	1,732	1,449	1,453	1,443	1,430	1,456
Prentiss	5,285	5,355	5,435	5,495	3,101	2,394	2,000	2,008	1,979	1,948	1,970
Quitman	2,319	2,382	2,433	2,493	1,359	1,042	898	910	889	869	867
Rankin	12,700	12,950	13,299	13,627	8,049	6,465	5,254	5,204	5,218	5,186	5,335
Scott	5,385	5,477	5,571	5,663	3,212	2,511	2,113	2,121	2,093	2,063	2,084
Sharkey	1,470	1,514	1,549	1,591	863	667	569	571	555	540	536
Simpson	6,012	6,098	6,192	6,287	3,620	2,839	2,395	2,405	2,376	2,344	2,370
Smith	2,663	2,696	2,733	2,771	1,552	1,204	1,000	996	980	962	969
Stone	3,449	3,540	3,647	3,744	2,168	1,713	1,429	1,441	1,439	1,432	1,467
Sunflower	8,327	8,384	8,443	8,528	4,670	3,539	2,934	2,927	2,855	2,774	2,767
Tallahatchie	3,550	3,616	3,670	3,737	2,060	1,585	1,360	1,373	1,341	1,312	1,309
Tate	3,819	3,883	3,969	4,050	2,318	1,823	1,494	1,485	1,472	1,452	1,477

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

	Estimated Uninsured Lives										
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**
Tippah	4,603	4,678	4,757	4,819	2,714	2,105	1,764	1,772	1,747	1,723	1,742
Tishomingo	3,264	3,300	3,336	3,356	1,900	1,471	1,234	1,237	1,215	1,194	1,203
Tunica	2,995	3,058	3,120	3,189	1,843	1,451	1,275	1,307	1,300	1,294	1,314
Union	3,619	3,673	3,738	3,796	2,184	1,718	1,438	1,444	1,434	1,420	1,446
Walthall	3,773	3,844	3,915	3,994	2,272	1,770	1,523	1,547	1,531	1,514	1,530
Warren	8,390	8,471	8,556	8,642	4,936	3,871	3,226	3,197	3,133	3,062	3,070
Washington	15,695	15,871	15,972	16,117	8,871	6,801	5,820	5,834	5,665	5,506	5,459
Wayne	4,249	4,281	4,313	4,351	2,482	1,929	1,641	1,650	1,623	1,595	1,604
Webster	1,949	1,982	2,014	2,043	1,143	886	739	738	724	710	714
Wilkinson	3,692	3,725	3,767	3,820	2,165	1,669	1,433	1,453	1,432	1,409	1,418
Winston	3,633	3,681	3,730	3,784	2,129	1,654	1,389	1,390	1,366	1,340	1,348
Yalobusha	3,151	3,226	3,301	3,364	1,898	1,479	1,248	1,258	1,242	1,227	1,242
Yazoo	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**

Table 17: Projected Payor Composition (2010 – 2020)

This table and accompanying chart (next page) indicate how Mississippi's population obtains health care coverage 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.

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**

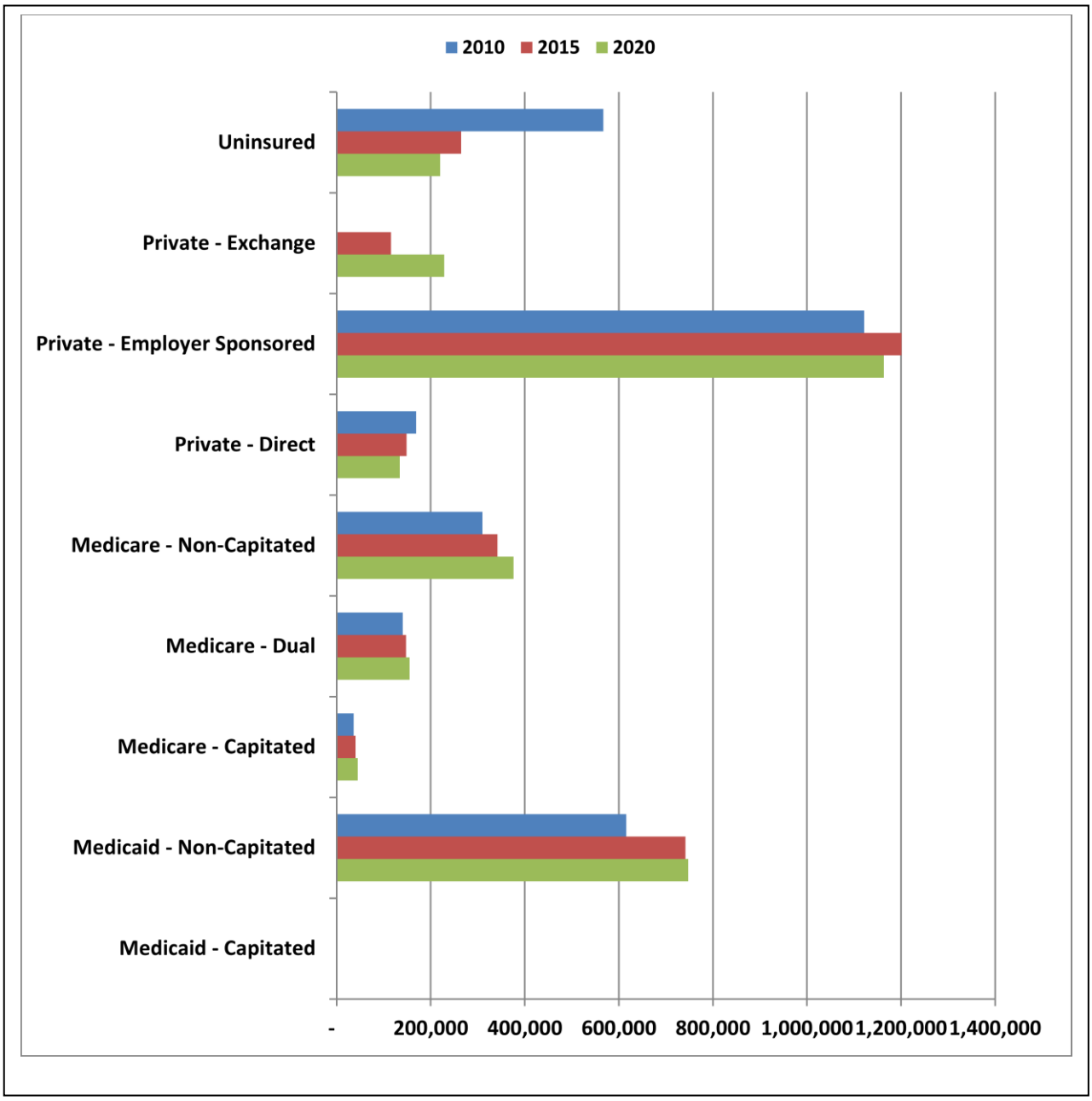

2010
2015
2020
Uninsured
Private - Exchange
Private - Employer Sponsored
Private - Direct
Medicare - Non-Capitated
Medicare - Dual
Medicare - Capitated
Medicaid - Non-Capitated
Medicaid - Capitated
-
200,000
400,000
600,000
800,000
1,000,000
1,200,000
1,400,000

Chart 1: Mississippi Historic Unemployment Rate (Trended)

This chart 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.

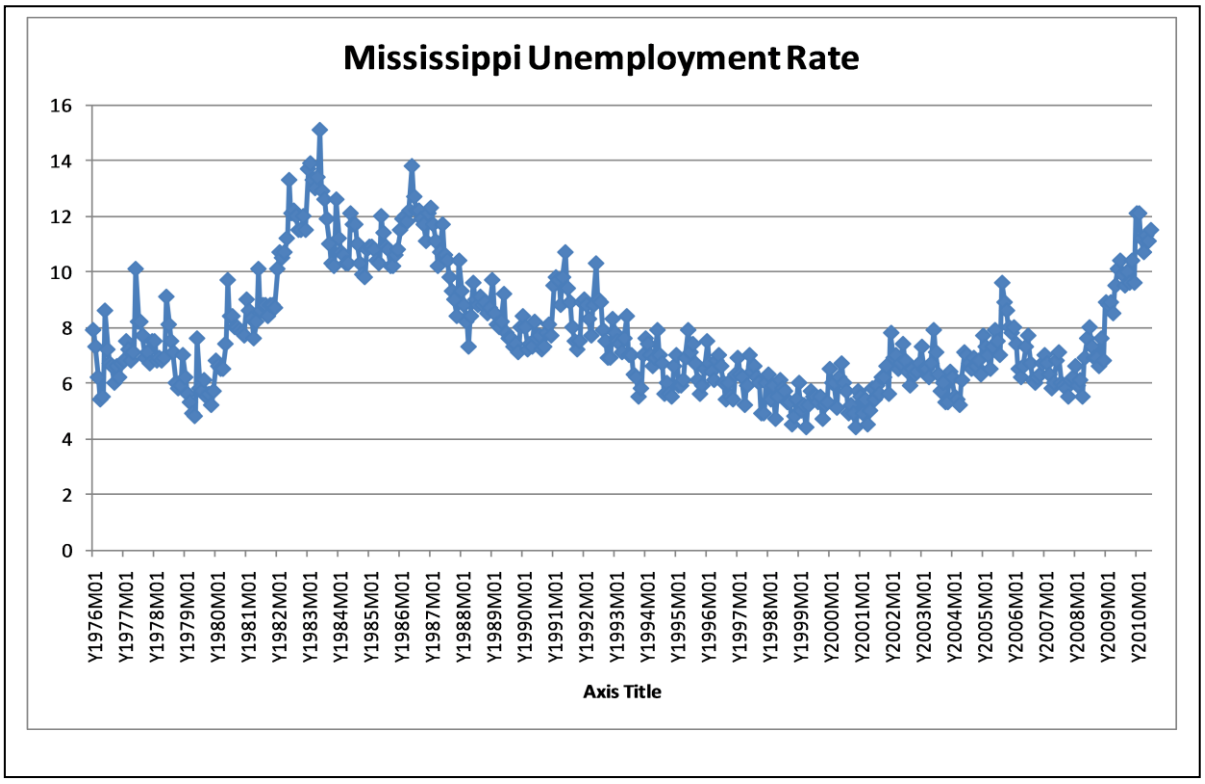


Chart 2: 10 Year Change in Uninsured & Medicaid by Number of Lives (2010-2020)

This chart is 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.

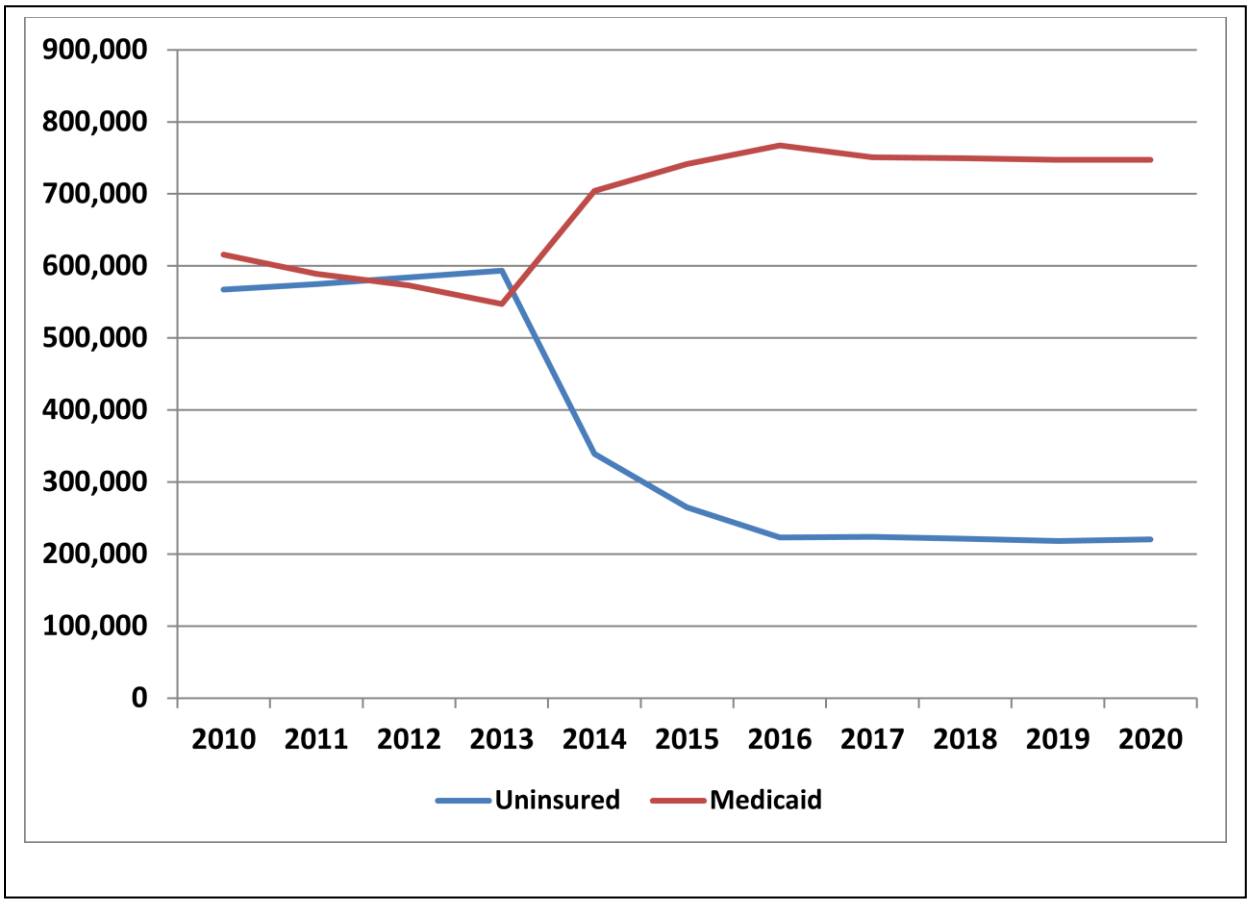
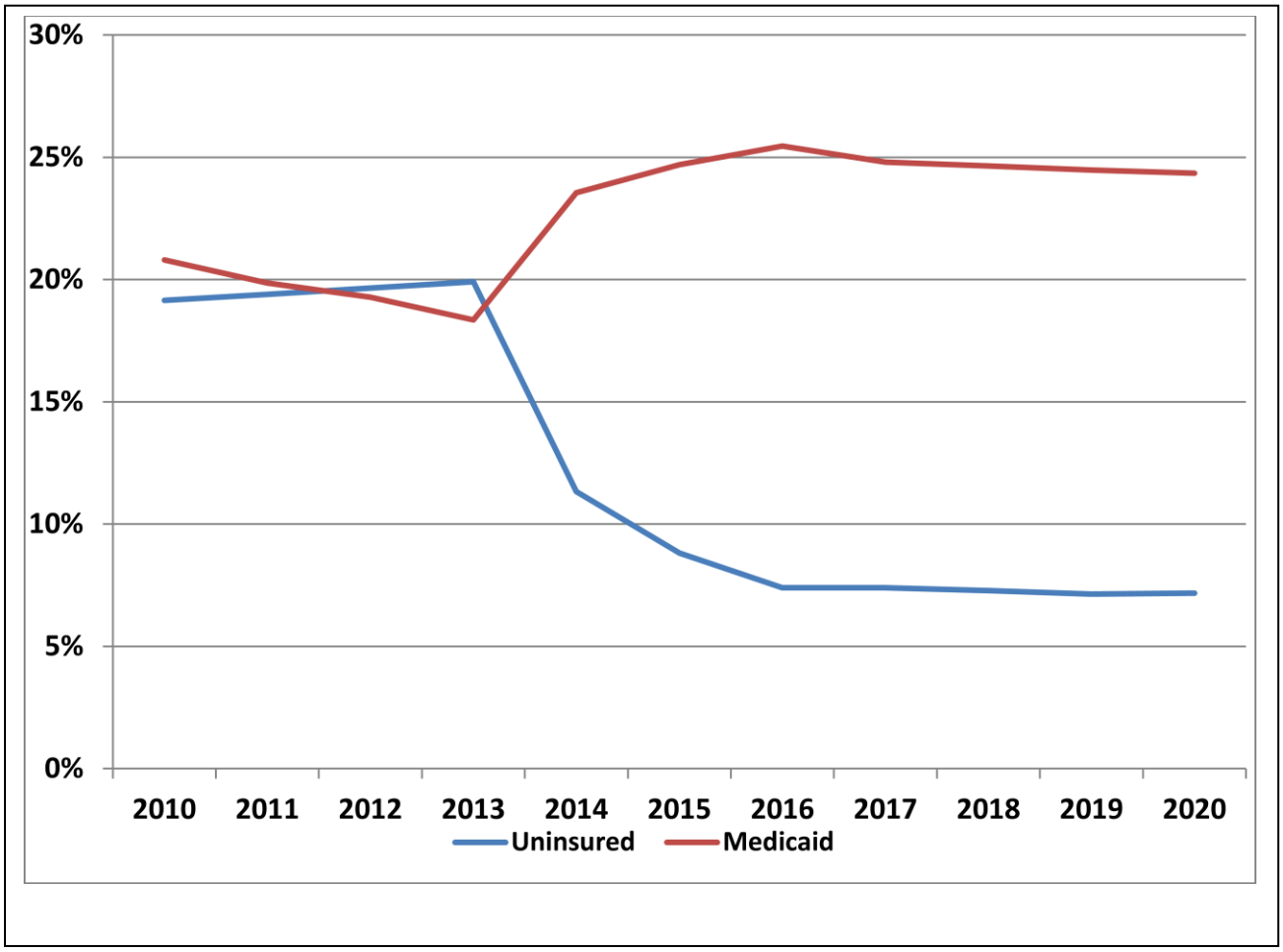


Chart 3: 10 Year Change in Uninsured & Medicaid by Percentage of Population (2010-2020)

This chart is 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.



PHASE I MARKET RESEARCH REPORT

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 unique challenges 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 the overall 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 plan options 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 premiums will 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 will increase 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.[2] Mississippi ranks last [nationally] in the percentage of public high school students who graduate.[3] The state ranks last in the percentage of people who use the Internet inside or outside the home.[4] 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.[5] These challenges reinforce the need for an exchange built by Mississippians, for Mississippians.

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[2] United States Department of Agriculture. *United States Department of Agriculture.* http://www.ers.usda.gov/statefacts/ms.htm (accessed March 7, 2011).
[3] 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).
[4]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).
[5]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).

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 be carried 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[6] to assist in designing an effective exchange for the state.

This report includes results from more than sixty in-depth interviews[7] 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 foundation for future qualitative and quantitative research that will be necessary to create the optimal exchange for the State of Mississippi.

[6] Company profiles of Leavitt Partners and Cicero Group are located in the "Methodology" section of this report.
[7] Notes from interviews and small business and broker mini focus groups are an overview of the discussion, not a transcription.

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 an online 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 viewed as 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 it is 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 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. 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 that Mississippi 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 computer in rural areas and 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 that a 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 employers do 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 as created "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 a defined contribution model, the ability to offer benefits to part-time employees, and a digitally simple 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?

> *"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*

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.

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?

> *"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*

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.

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?

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.

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

How many products should be available in the exchange?

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.

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

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 will likely 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 in 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 cited the 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 supply navigators [an individual who provides information about the exchange] with the ability to enroll individuals in the 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 believed that 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 TennCare program?

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-risk must 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 to be 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.

State of Mississippi House of Representatives 1
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 group is 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 manage 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.

- Brokers should 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 made as 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 many young individuals 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 deductible, 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 deductible and one low. The younger typically take the high deductible, 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 deductible, low premium plan with an HSA to a low deductible, 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 deductible low premium plan with an HSA to a low deductible, 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 them in 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 is really 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.

Functions of a Health Exchange

The implementation of state-based health insurance exchanges are the centerpiece of the health reforms within the 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 a qualified 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. 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 are key 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 may increase 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 exchange's 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 viability 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 includes a number of provisions intended to make and keep exchanges viable. The so-called "individual mandate" goes into effect in 2014, requiring that all individuals purchase health insurance. The hope is that those individuals who do not currently carry health insurance will purchase their policies through an exchange. In addition, the federal government will provide financial incentives to qualified individuals who fall below 400 percent of the federal poverty line (FPL). As an incentive to employers, the federal government will make available a small-employer tax credit during the first two years after an exchange goes online. Current research suggests that 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*. An exchange that is attractive to business and individuals will incent adoption and expand risk pools, thereby mitigating adverse selection. 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 a government agency, a quasi-governmental entity, 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 percent federal 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

PHASES II & III MARKET RESEARCH

Section 1: Report Introduction

A key feature of the Patient Protection Affordable and 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 unique needs of 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 an exchange in the State of Mississippi.

One goal of an exchange is to increase the overall 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 plan options 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 premiums will 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 will increase 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.[8] Mississippi ranks last [nationally] in the percentage of public high school students who graduate.[9] The state ranks last in the percentage of people who use the Internet inside or outside the home.[10] 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, and second in infant mortality. [11] 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

[8] United States Department of Agriculture. http://www.ers.usda.gov/statefacts/ms.htm (accessed March 7, 2011).
[9] National Center 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).
[10]National Telecommunications and Information 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).
[11]United States Department of Health and Human Services – Centers for Disease Control and Prevention (CDC). National Center for Health Statistics, Mississippi 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).

be carried 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[12] to assist in designing an effective exchange for the state.

This report details the results of a survey in which over a thousand Mississippi employers, employees, advocacy groups, health care providers, and insurance brokers participated. Additionally, the report contains findings from informational town hall meetings about the exchange held in thirteen cities throughout Mississippi.

[12] Company profiles of Leavitt Partners and Cicero Group are located in Appendix I of this report.

Section 2: Phases II and III Research Introduction

It is relevant to briefly summarize the findings from Phase I of the research before introducing Phases II and III. Phase I of the Mississippi Health Benefit Exchange research entailed an amalgamation of in-depth interviews with Mississippi legislators, business associations, economic development leaders, consumer advocates, health care providers, insurance carriers, broker representatives, small businesses, and health policy analysts. The purpose of this expansive approach was to develop a foundation of qualitative conclusions upon which quantitative research—particularly of Phase II—could build.

Five key insights from the Phase I report showed that Mississippians:

- **Demonstrate Confusion about the PPACA and a Health Benefits Exchange.** Participants showed a general lack of information and/or significant misinformation surrounding the Patient Protection Affordable Care Act and health insurance exchanges. Lack of information and broad misinformation has generated frustration and fear among stakeholders in Mississippi.

- **Prefer an Exchange Designed for Mississippians, by Mississippians.** Mississippians repeatedly stated that the health benefit exchange should be designed and operated by the state, rather than by the federal government. Mississippians recognize how the diversity of their state creates unique needs and challenges.

- **Value Simplicity.** Participants stressed the importance of simplicity in the outreach, design, and operation of a health insurance exchange. For example, participants recommended an exchange design that would condense health insurance plans down to two or three options. Additionally, employers emphasized the importance of creating an exchange that reduced the administrative burden of offering insurance.

- **Require Effective Outreach.** All respondents addressed the challenges of educating the general public and business community about health insurance and the health benefit exchange. However, participants also addressed the importance of leveraging the strong social and professional networks that already exist in Mississippi.

- **Request Exchange Assistance.** Almost all participants—including employers, industry groups, insurance carriers, and consumer advocate groups—stressed the importance of assistance in using the health benefit exchange. From information to enrollment to management of the exchange, assistance in multiple forms for both small businesses and employees will be critical to the success of the exchange.

To confirm and quantify the findings from Phase I, Leavitt Partners and Cicero designed a survey for Phase II of the research process. People were recruited for participation by telephone, mail, and online. Over 1,000 Mississippians participated in the survey, and most of

the findings align directly with the insights gleaned from the first phase. Additionally, the survey revealed user preferences that are important to designing various logistical aspects of the exchange (e.g. outreach methods, educational formats, enrollment preferences, and plan administration).

Through town hall meetings, Phase III of the research process sought to confirm and expand upon the findings from Phases I and II. These meetings provided an environment for state officials and researchers to present the findings of the research to the residents of Mississippi and to seek feedback. The town hall meetings also laid an important foundation upon which state officials can build an effective outreach campaign for the Mississippi health benefit exchange.

Section 3: Phases II and III Research Executive Summary

Ten key issues emerged in Phases II and III of the research. They are summarized in the following list:

11. **Opposition to the Patient Protection and Affordable Care Act (PPACA).** The vast majority of Mississippians objected to the PPACA. Survey participants reported strong opposition to this act, and this resistance toward the PPACA resonated throughout the town hall meetings, particularly because of negative connotations associated with "Obamacare." To ensure acceptance and successful implementation of any PPACA mandate (i.e. a health benefit exchange), an active brand disassociation with the PPACA and the federal government will need to take place, most notably in the Gulf Coast region, where opposition was most strong.
12. **Mississippians Support a State Health Solution.** Mississippians expressed concern about the inefficiencies of the health care system in Mississippi, noting that it is too expensive, confusing, and often unfriendly. Although many individuals lack general comprehension of the health care market, the notion of a state-run health insurance exchange (as opposed to a federal-run exchange) is preferred by the majority. The vast approval is derived from the belief that a state-run exchange will decrease confusion and improve access to health care, while catering to the unique health needs of Mississippians.

13. **Affordable Health Care in Mississippi.** The primary factor that has prevented or discouraged employers from offering health insurance to their employees is cost. Small employers have listed the mitigation of insurance costs as the primary factor in their acceptance of a health benefit exchange, whether through direct (e.g. reduced premiums) or indirect (e.g. reducing time-consuming health benefit management tasks) implementations.

14. **Quality Health Care in Mississippi.** Along with the affordability of health care, Mississippians are particularly concerned about the quality of health care available to them. They expressed an unwillingness to sacrifice quality in favor of lower administrative costs. This standpoint likely stems from their recognition of the pressing health challenges present in many households in the state.

15. **Knowledge about Health Care and a Health Insurance Exchange.** Mississippi's small employers were more informed about the insurance market than were their employees. Yet, collectively, understanding of a health insurance exchange was low, indicating the need for a broad and systematic outreach campaign. Although the mediums for outreach will vary among demographic and socioeconomic groups, there was unanimous agreement that direct education and enrollment assistance are essential to properly informing Mississippians about the role and function of the state's health benefit exchange.

16. **Simplicity in Exchange Education, Design, and Administration.** Real understanding about the health benefit exchange and the health insurance market is minimal, as survey respondents and town hall participants both expressed the need for greater clarity regarding these issues. In order to obtain widespread participation rates, the state will have to implement a simple, easy-to-understand education process. Participants defined "simplicity" in education as straight-forward marketing and informational online and offline collateral.
    a. Employers and employees both reported a need for simplifying the process of comparing and selecting plan options. They recommended a system that filters the number of plan options from many-to-few based on the unique criteria of the individual seeking insurance. Both employers and employees requested health plans be comparable on an "apples to apples" basis.

    b. Employers were particularly emphatic about health insurance not becoming or remaining "their problem" as a result of the health benefit exchange. Small businesses want to run their affairs without spending time dealing with health insurance. Therefore, information about adding and dropping employees, selecting plans, looking up coverage, answering health insurance-related questions, and so forth must be presented in a simple, user-friendly manner. The exchange must decrease the current administrative burden of offering health insurance benefits if it is to garner the support of small businesses.

17. **The Value of Health Benefits.** Both employers and employees reported health insurance as one of the most important benefits a company can offer to attract and retain quality employees. However, employers placed less weight than employees did on the degree to which health insurance influences an employee's likelihood to choose an employer. And while employees currently trust the system of employers selecting a plan for them, many employees reported a strong interest in having more control over their health plans (i.e. selection and management).

18. **The Necessity of Broad Outreach.** In the process of soliciting participation in the survey and town hall meetings, it became evident that the state's outreach will have to go beyond traditional methods to reach the citizens of Mississippi. For instance, e-mail, telephone, direct mail, online advertising, television, radio, newspaper, and in-person invitations were widely utilized to encourage participation in both the survey and town hall meetings. Despite these efforts, response rates were proportionately low (when compared to the fielding of similar studies in other states)—particularly considering the critical nature of this discussion, and the importance of health insurance in the lives of Mississippians. If an exchange is to be successfully implemented in Mississippi, outreach efforts will need to be extensive.

The survey also discovered what outreach methods might best suit employers and employees. Employers recommend business organizations, insurance brokers, and fellow business owners as the best channels for outreach. Employees and individuals suggested employers, health providers, television, friends, family, and colleagues as being the best sources for outreach.

19. **The Importance of Individualized Assistance.** Both survey and town hall participants articulated a desire for assistance in understanding and navigating the health benefit exchange. Employers, in particular, initially expressed interest in in-person assistance, from either an insurance broker or a health exchange expert, without taking into account the potential cost to either the employer or the employee of such assistance. When potential costs, either to the employer or employee, were added, all respondents generally expressed greater interest in lower-cost forms of assistance, particularly a dedicated and interactive website with information and enrollment assistance. Regardless, the range of preferences expressed by both employers and employees indicates the importance of providing a number of different options for information about, enrollment in, and assistance with the exchange.

20. **Defined Contribution Plans.** Defined contribution plans were introduced as a potential component of the health benefit exchange at the town hall meetings. These plans allow employers to contribute a specified amount of money toward individual employee health benefits; employees then use this amount to select the coverage that is best suited to them. Employers and employees who participated in the town hall meetings expressed interest in learning more about defined contribution plans, particularly with respect to the flexibility and choice they offer both employers and employees.

Section 4(a): Survey Methodology

Survey Introduction and Methodology

Mississippi's health benefit exchange must effectively address and serve the needs of the state's diverse population. Further, it is imperative that the exchange maximize impact in a cost-effective manner. Therefore, a multi-phased research approach was designed to solicit the insights of Mississippians in order to properly construct and implement the exchange.

The in-depth interviews and exhaustive secondary research from Phase I created a foundation for research conducted in Phases II and III.

In Phase II, the initial respondents for the survey were (1) employers with two to 100 full-time employees, and (2) full- and part-time employees. However, health care providers, insurance brokers, and advocacy groups also expressed interest in contributing to the survey. Therefore, separate surveys were created for employers, employees, insurance brokers, health care providers, and advocacy groups to capture feedback from an array of Mississippians. While tailored to each audience, the survey questions were kept as similar as possible to allow for accurate comparison between employer and employee responses. Via the survey, each of these groups had the opportunity to express their own concerns, needs, and insights.

Phase I also revealed potential challenges to conducting Phase II, as well as future research. A methodology analysis determined that an online survey would be the best medium for seeking input about something as complex as health insurance and the exchange. However, this medium was utilized with the recognition that online surveys may exclude feedback from individuals in various socioeconomic groups and rural areas who lack broadband connectivity, personal computers, and proper outreach networks.

In order to maximize survey participation among all interest groups, the following strategies were implemented:

- Over four hundred senior-level phone calls to chambers of commerce, business organizations, consumer advocates, policy analysts, state, county, and local leaders, economic development representatives, health care provider groups, and insurance agent representatives
- 5,000 personalized direct mail pieces sent to a random sample of businesses and employees
- 6,000 telephone calls made to a random set of businesses throughout the state
- 10,000 telephone calls made by professional call center interviewers asking employers to participate in the survey
- 29,000 e-mail invitations sent to employers and employees through an online panel

Survey responses were gathered from June 1st to July 15th 2011.

Analysis

Upon completion of the survey timeframe, all results were categorized into their respective groups (i.e. employer, employee, etc.). As a quality assurance process, each response was analyzed to ensure there were no inaccuracies in verbal responses and selections. Respondents who completed the survey too quickly or who seemed to have randomly clicked on answers without reading questions were excluded from the final data set.

Section 4(b): Town Hall Methodology

Introduction and Methodology

In addition to the 80+ in-depth interviews conducted in Phase I and the 1,000+ survey responses collected during Phase II, Mississippi conducted town hall meetings throughout the state to ensure all citizens had an opportunity to learn about and comment on the exchange. A survey was fielded in each town hall meeting, allowing for an additional 287 responses to be captured. As this sampling methodology was not random, the responses were not amalgamated with the 1000+ random survey responses. However, the results from the town hall meetings are informative, and can be found in Appendix G. It should be noted that the town hall responses generally mirrored the random survey responses.

Thirteen different sites were selected for town hall meetings on the basis of population density, geographic location, demographic representation, and socioeconomic diversity. Seven of the ten largest counties in Mississippi were represented, and each major geographic region of the state was visited. Town hall meetings were held in the following communities:

- Meridian
- Starkville
- Tupelo
- Olive Branch
- Oxford
- Clarksdale
- Cleveland
- Greenville
- Jackson
- Pearl
- Clinton
- Hattiesburg
- Gulfport/Biloxi

To ensure the participation of Mississippians, specific contact information was obtained for a broad spectrum of groups and organizations. Invited groups included:

- Small businesses
- Trade groups and associations
- Business organizations and industry groups
- Economic development organizations
- Consumer advocacy groups
- Community clubs and organizations
- State agencies and legislators
- Insurance representatives
- City and town elected officials, representatives and governments
- Chambers of commerce
- Churches and religious organizations
- Community health organizations
- Health care providers and professional networks

In addition to the personal invitations that were sent via e-mail, telephone, and direct mail, advertisements were placed in major newspapers one week and then again one day prior to each town hall meeting. Press releases informed both local and regional media outlets about these meetings. Finally, all survey participants who expressed interest in attending were invited.

It is important to note that the primary purpose for issuing extensive invitations was to elicit broad participation from as many stakeholders as possible, and to make certain that Mississippians had the opportunity to shape this important policy.

Press coverage of these town hall meetings was widespread, and included reports from at least seven broadcast news stations and eleven printed media outlets.

Section 5: Overview of Phase II Survey Results

Confusion about the Health Benefit Exchange

Health insurance and health benefit exchanges are complicated for even the most seasoned health policy analysts. It should come as little surprise that Mississippians—including employers and employees—had little understanding of health benefit exchanges.

Who understands a health insurance exchange?

A key element of the survey was designed to gauge Mississippians' understanding of a health benefit exchange. Respondents were asked, unaided, to describe a health benefit exchange. The overwhelming majority were unable to produce a generally accurate definition. Only eleven percent of employers and seven percent of employees were able to provide a generally accurate definition of a health benefit exchange.

While employers had a slightly better understanding of the purpose and functionality of a health insurance exchange than employees, employer responses were often laced with negative undertones (e.g. that it was 'forced' and 'unnecessary'), underscoring the need for outreach and education to ensure their understanding of—and participation in—the exchange.

> *"It's a government program with restrictions that are unacceptable."*
> *- Small Business Owner*

A State-Sponsored Solution

Mississippians recognize that health care is broken, and believe that fixing health care in the state is critical to economic growth in Mississippi – as reported by seventy three percent of businesses. In addition, seventy percent of businesses indicated that they support a solution sponsored by the state of Mississippi to improve access to health insurance. Despite a lack of understanding about health benefit exchanges, Mississippians broadly voiced their desire for a state-sponsored policy as opposed to one operated by the federal government. Similar opinions came to light in the in-depth interviews and town hall meetings that were conducted as a part of this research: Mississippians believe a state-level policy would be better tailored to the unique needs of the state, having the ability to more effectively allocate resources, and the capacity to operate with lower administrative costs.

Mississippians and the Patient Protection and Affordable Care Act

Employers in Mississippi were clear in their opposition to the Patient Protection and Affordable Care Act, with seventy-one percent of surveyed employers indicating they oppose the PPACA, and only fifteen percent voicing support for the act. Fourteen percent of employers indicated that they were undecided regarding their support for or opposition to the act. Though in smaller numbers, employees also voiced opposition to the PPACA, with forty-two percent opposing and twenty-seven percent supporting the act. Thirty-one percent of employees remain undecided.

State vs. federal health insurance exchange

In order to gauge preferences as to who should operate the health benefit exchange in Mississippi, survey respondents were informed about exchanges generally, and were told that an exchange must be operational by 2014. Mississippians were then asked whether they would prefer the health insurance exchange to be operated by the state or the federal government.

A state-operated health benefit exchange was preferred by seventy-seven percent of employers and fifty-three percent of employees. Only a small percentage of employers and employees—five percent and nineteen percent respectively—favored a health benefit exchange operated by the federal government. Among employers, eighteen percent were undecided as to their preference for operation of a health benefit exchange, and among individuals, twenty-nine percent were undecided. This suggests that many Mississippians are sufficiently unfamiliar with health care policy, or uncertain enough about the role that a health benefit exchange may play in their lives to be willing to register a specific opinion.

Mississippians are interested in a health benefit exchange as a solution

The majority of small businesses and individuals reported interest in learning more about a health benefit exchange as a solution in Mississippi. Seventy-three percent of employer respondents and sixty-four percent of employee respondents indicated a strong interest in learning more about a health benefit exchange. Both groups were motivated to understand how an exchange would help them provide and obtain better access to affordable care.

Employers and employees expressed a range of different responses when asked which ways of hearing about the exchange would most increase their interest. Given the opportunity to select up to three options from a lengthy, detailed list of ways to increase their interest in the exchange, a range of different ways of hearing about the exchange were preferred by employers:

1. Insurance agents or brokers	41 percent
2. Direct mail	35 percent
3. Business and community organizations	27 percent
4. Fellow business owners	27 percent
5. Health providers	19 percent
6. Online advertising and e-mails	18 percent
7. Television advertisement	17 percent
8. Article or special report in the news	17 percent
9. State, county, and local leaders	14 percent
10. Family, friends, and colleagues	12 percent

Among employees, who were similarly given the opportunity to select up to three options, the following ways of hearing about the exchange would most increase their interest:

1. Employer	46 percent
2. Health providers	35 percent
3. Family, friends, and colleagues	29 percent
4. Television advertisement	27 percent
5. Article or special report in the news	24 percent
6. Direct mail	18 percent
7. Print advertisement	16 percent
8. State, county, and local leaders	15 percent
9. Online advertising and e-mails	14 percent
10. Insurance agents or brokers	12 percent

The diversity of responses in these lists indicates the importance of utilizing a broad range of different methods across a number of different mediums to increase interest in the exchange. In addition, the importance of fostering interest in the exchange among employers is clearly emphasized by the large percentage of employees who indicated that their interest in the exchange would increase most upon hearing about it through their employers.

Affordable Health Care in Mississippi

When Mississippians think about health care, they often envision high premiums and unpredictable costs—both of which can significantly deter small businesses from offering health benefits. Responses from both employers and employees indicated that costs play a substantial role in their decisions about health insurance.

Employer-provided health insurance

Thirty-seven percent of employers surveyed do not currently offer health insurance to any type of employee, while fifty-six percent of employers offer health insurance only to full-time employees. Only seven percent of employers surveyed indicated that they offer insurance to part-time employees. Among those who currently do not offer health insurance, twenty-three percent indicated that they have never offered insurance to any employees, and fourteen percent offered health insurance in the past but have since stopped.

Concerns about the current costs of providing and obtaining health insurance

When asked why they do not currently provide health benefits, sixty-one percent of non-providing employers indicated cost as the primary factor for not offering health insurance. Adding the nine percent of employers who cited uncertainty in predicting increases in future health insurance costs as the primary factor for not offering health insurance, this represents seventy percent of the responding employers who do not offer health insurance. This underscores the often substantial burden that the cost of providing health insurance can place on employers. And while many agree that the costs associated with providing employee health

benefits are significant, thirty-two percent of employers agreed that sick, unhealthy, or injured employees cost their businesses more than offering health insurance.

Individuals who were surveyed echoed employer concerns about the cost of health insurance. When those who indicated that they do not currently have health insurance were asked why, the two largest reasons cited were the cost of insurance and the lack of employer-provided insurance. The emphasis placed on cost among survey respondents clearly demonstrates that it is a matter of critical concern to many Mississippians as they think about health insurance in specific and health care in general.

The Importance of Quality Health Care

As discussed in the previous section, while costs are a consistent concern for both small businesses and individuals, the quality and services offered through health care plans are also of great importance to both employers and employees.

What matters most when comparing health insurance plans?

When asked to select the top two characteristics they consider when comparing health insurance plans, employers and employees ranked the same characteristics first and second. Employers indicated monthly premium cost (seventy-five percent) and services covered by the plan (forty-three percent) as their two most important characteristics. Similarly, employees indicated monthly premium cost (fifty-nine percent) and services covered by the plan (forty-seven percent) as most important. For both employers and employees, while cost is obviously a primary point of focus, the services covered by a health insurance plan are of significant importance, and were noted by seventeen percent more employers and nineteen percent more employees than the next most important characteristic.

What outcomes do Mississippians want to see from a health benefit exchange?

Given their expressed concerns about cost, it is not surprising that employers indicated a potential decrease in monthly premiums as the best possible outcome that they believed could result from a health insurance exchange. Employees, on the other hand, expressed a stronger preference for high quality health insurance. The list of potential outcomes from which employees could select included;

- More easily compare health insurance plans
- A 10 percent decrease in health insurance premiums
- Simplify health insurance enrollment
- High quality health insurance
- Increased access to health insurance
- Other

> *"I live in a community with a lot of Native Americans who are diabetic. Please have programs available that can support the specific needs of Mississippians."*
> *- Individual*

Employee respondents ranked "High quality health insurance" as the top outcome that could result from a health exchange. After their preference for reducing costs, employers ranked the opportunity to provide health benefits to attract and

retain employees next in terms of optimal outcomes from the exchange. Acknowledging that price reductions may or may not result from a health benefit exchange, employers and employees in Mississippi are clearly interested in the provision and maintenance of high quality health insurance. As the health benefit exchange is being created, it is important to Mississippians that the providers participating in the health insurance exchange offer the same level of quality health insurance plans that they would find in the outside market.

Health Insurance Simplicity

One of the primary challenges for any health benefit exchange is simplifying the overwhelming complexities of health insurance. In Phase I of the research, it was clear that Mississippians wanted the health insurance exchange to be centered on the concept of simplicity. Successful implementation hinges on having straightforward education, enrollment, and management of benefits in the exchange. Survey participants reiterated this concept when they expressed preference for a simple presentation of plan options, simple education platforms, simple enrollment mediums, and simple administration.

Comparing health plan options in Mississippi

One of the primary components of a health insurance exchange is to provide transparency in the insurance market. The ability to easily compare the details of competing plan options is an important facet of that process. Currently in Mississippi, very few employer respondents (twenty-seven percent) believe it is easy to compare health plan options. Furthermore, the employers who do not currently offer health benefits to their employees perceive it to be far more difficult to compare plans in Mississippi than do those who currently offer health plans.

> *"I am interested in the simplification of comparing policies and benefits."*
> *- Small Business Owner*

Small business owners in Mississippi spend their days balancing a variety of managerial tasks (e.g. payroll, logistics, operations, health care, etc.), while employees carry out the important work of their companies. Given these responsibilities, managing health benefits can be difficult for both employers and employees due of the general complexities, time consumption, repetitiveness, and details often associated with health insurance. Interviews conducted in Phase I of the research indicated that designing an exchange with simple enrollment and administration, and straight-forward plan comparisons is likely to best meet the needs of small businesses and employees in Mississippi.

How many plan options should be available?

Many stakeholder groups have debated the number of plan options that should be available. Some believe that providing the maximum number of options would ensure better customization. Others assert, once again, that simplicity is fundamental to the success of the exchange, and feel that offering fewer plan options would minimize complexity and management hassles.

The survey sought to gauge the number of plan options employers and employees wanted based on the level of complexity/simplicity associated with that quantity. Participants were given four tiers from which to choose: most simple (3 or fewer plan options), moderately simple (4 to 8 plan options), moderately complex (9 to 12 plan options), and most complex (all plan options). The results showed that Mississippians generally preferred being presented with fewer plan options rather than more.

Employers

- 43 percent preferred to choose among three or fewer plan options (Most Simple)
- 36 percent preferred to choose among four to eight plan options (Moderately Simple)

Employees

- 27 percent preferred to choose among three or fewer plan options (Most Simple)
- 42 percent preferred to choose among four to eight plan options (Moderately Simple)

In total, seventy-nine percent of employers and sixty-nine percent of employees prefer to choose from among eight or fewer plans. Of note, in spite of the potential complexity, thirteen percent of employers and seventeen percent of employees indicated interest in choosing from among all potential plan options.

How do small business owners currently cope with health insurance complexities?

Many small business owners rely on the assistance of a third party to navigate the insurance market. In Mississippi, small businesses receive much of their direction from insurance brokers. Fifty percent of small business owners stated that they are currently unable to understand the complexities of health insurance without the assistance of a broker.

It will be imperative that the state health benefit exchange remain conscious of the issue of complexity in health insurance. During the development of the exchange, many of the general idiosyncrasies of health insurance must be simplified to appeal to the employers who do not enlist the assistance of either a broker or an exchange expert.

It should be noted that emphasizing simplicity may also help to reduce perceived barriers to entry for employers who do not currently provide health benefits. While costs were cited as the greatest concern for employers who do not currently provide health insurance, some reported concern with the complexity associated with choosing plans or the time and resources required to administer and manage health insurance as a factor in their decision not to offer health benefits to their employees. A simpler platform, with easy to use tools and access to comprehensive assistance may help reduce some of the concerns among employers who do not currently offer health insurance.

The Value of Health Benefits to Employees

Survey results showed that in Mississippi health care plays a critical role in an individual's employer selection process. Next to wage compensation, health benefits are often the main

reason employees choose one employer over another: eight out of ten (eighty-two percent) employees rated health care as a leading factor when making their employment decision.

When assigning a ranking to the degree to which employees valued certain aspects of a job, health benefits were second, behind salary/wages, and ahead of other factors such as company policies (including paid vacation), company reputation, geographic location, company culture, and type of clients with whom the company works. Interestingly, employers did not seem to understand the value employees placed upon health benefits at a job—employers rated health benefits as only the fourth most important factor in attracting and retaining employees, behind salary/wages, company reputation, and company culture. Additionally, some employers who do not currently offer health insurance to their employees indicated that they do not offer these benefits at least in small part because they believe that their organization can attract and retain quality employees without offering health insurance. Helping employers understand the degree to which health benefits are a priority for their employees may drive demand for and participation in an exchange.

Who is making the health insurance decisions?

Like most states, employers in Mississippi make the health insurance decisions for their employees. This is relatively common since the majority of individuals receive health insurance through their employer or their spouse's employer. When participants were asked how they decided on their health plan, the majority (sixty-four percent) responded that they chose whatever their employer was offering.

> *"I am interested in the ability to find health care suited to me."*
> *-Individual*

Health insurance is an important safety net in one's life that requires a large degree of trust when placed in the hands of a secondary party (e.g. employer or broker). Seventy-two percent of employees surveyed indicated that they currently trust their employer's health plan. However, sixty percent indicated that they would like more control in choosing their own plan. If they were to choose their own plan, fifty-eight percent indicated that they would need some form of assistance to enroll in a plan.

Allowing employees to choose their health insurance permits them to tailor a plan to their unique health needs. It also better informs them about the options, the level of quality, and most importantly, the things that would not be covered in the case of an emergency. In the survey, sixty-four percent of Mississippi employees agreed with the statement that they believed they would have a better understanding of health insurance if they were to select their own health plans.

Outreach and Education

Mississippians' opposition to the PPACA, as well as confusion regarding the role and function of health benefit exchanges both illustrate the need for significant outreach. If Mississippi is to create a successful exchange, the state must engage in an effective outreach program. Due to the demographic and socioeconomic diversity of Mississippi residents, various outreach

methods should be undertaken to ensure that employers and employees across the state have the ability to learn about and enroll in the health insurance exchange. For maximum impact, each element of the outreach campaign should be tailored to the education preferences of the target group.

How do employers prefer to be informed and educated?

For some small businesses, the role of brokers will be important as they attempt to learn more about the exchange. Forty percent of employers stated they would prefer to use a broker to obtain information and education about the health exchange over other means. For other small businesses, the cost of meeting with a broker can be prohibitive, or they may simply prefer to utilize other means to learn about the exchange. Below is the list (in order of preference) of how small businesses would prefer to be educated about the health benefit exchange:

1. Insurance brokers (40 percent)
2. Health insurance exchange website (36 percent)
3. Toll-free telephone support (10 percent)
4. E-mail/chat support (7 percent)
5. Town hall meetings (3 percent)

How do employees prefer to be informed and educated?

Thirty-nine percent of employees reported they would prefer to receive information and education about the exchange through a website. Below is the list in order of preference for how employees prefer to be educated about the health benefit exchange:

1. Health insurance exchange website (39 percent)
2. Insurance brokers (24 percent)
3. Toll-free telephone support (16 percent)
4. E-mail/chat support (8 percent)
5. Town hall meetings (5 percent)

Enrollment in the Exchange

Research conducted throughout Phases I, II, and III suggests that while businesses understand the generalities of health insurance, they would rather spend their time conducting business than dealing with the complexities of health insurance.

Convenience matters, but lower administrative costs matter more

With the implementation of a health benefit exchange, when asked how they would prefer to enroll annually in a health insurance plan through the exchange, fifty-three percent of employers and twenty-seven percent of employees indicated they would prefer enrollment through a broker or health insurance exchange expert who will travel to their place of business to assist them with enrollment. Others— twenty-eight percent of small businesses and forty-four percent of employees—said they would prefer a website with online tutorials and

educational videos to guide the enrollment process. Employer preferences for exchange enrollment assistance for their employees are listed below:

1. Insurance agent or broker who travels to your business and assists employees with enrollment	37 percent
2. Health insurance exchange website enrolment process that has online tutorials and education videos	28 percent
3. Health insurance exchange experts who travel to your business and assist employees with enrollment	16 percent
4. Paper enrolment application that is filled out individually and returned by mail	7 percent
5. E-mail/chat with a health insurance exchange expert who assists employees with enrollment	6 percent
6. Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment	4 percent
7. Other	3 percent

Thinking about their expressed preferences in a different way, note that that seventy-one percent of enrollment options preferred by employees involve completing the process of enrollment without in-person assistance, either using the web, paper applications, telephone, or email. This contrasts the stated preference for in-person enrollment assistance among fifty-three percent of employers. Employee preferences for exchange enrollment assistance are listed below:

1. Website enrollment process that has online tutorials and education videos	44 percent
2. Insurance agent or broker who travels to assist with enrollment	17 percent
3. Paper enrollment application that is filled out individually and returned by mail	15 percent
4. Health exchange experts who travel to assist with enrollment	10 percent
5. Toll-free telephone call with a health insurance exchange expert who assists with enrollment	6 percent
6. E-mail/chat with a health insurance exchange expert who assists with enrollment	6 percent
7. Other	2 percent

The responses in the above scenario were not weighted by cost, but were likely selected by employers and employees on the basis of the convenience and effectiveness they would ostensibly provide employers and employees as they enroll in and manage their health insurance plans.

To measure these preferences in conjunction with cost, participants were asked the same question and provided the same options but with an associated price tag. This time, fifty-eight percent of small businesses and seventy percent of employees preferred a health exchange website (the least expensive option) for use in enrolling in and managing their health insurance plans. In this cost-weighted scenario, the enrollment assistance of brokers and health exchange experts was preferred by a combined total of only twenty-one percent of small businesses and five percent of employees. The complete list of employer preferences, after weighting for cost, is below:

1. Health insurance exchange website enrollment process that has online tutorials and education videos (free)	58 percent
2. Insurance agent or broker who travels to your business and assist employees with enrollment ($500 annual fee)	15 percent
3. E-mail/chat with a health insurance exchange expert who assists employees with enrollment ($100 annual fee)	7 percent
4. Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment ($150 annual fee)	7 percent
5. Paper enrollment application that is filled out individually and returned by mail ($100 annual fee)	7 percent
6. Health insurance exchange experts who travel to your business and assist employees with enrolment ($400 annual fee)	6 percent

Recall that without weighting for cost, seventy-one percent of employees expressed preference for options that would allow them to complete the for enrollment process on their own, using the web, paper applications, telephone, or email. After taking potential costs into consideration, employee preference for options that did not involve in-person assistance increased to a rate of ninety percent. The complete list of employee preferences, after weighting for cost, follows:

1. Health insurance exchange website enrollment process that has online tutorials and education videos (free)	70 percent

2. Paper enrollment application that is filled out individually and returned by mail ($100 annual fee)	9 percent
3. E-mail/chat with a health insurance exchange expert who assists with enrollment ($100 annual fee)	6 percent
4. None of the above	5 percent
5. Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment ($150 annual fee)	5 percent
6. Insurance agent or broker who travels and assists with enrollment ($500 annual fee)	3 percent
7. Health insurance exchange experts who travel to your business and assist employees with enrollment ($400 annual fee)	2 percent

Most respondents, both employers and employees, indicated a clear preference for less expensive enrollment and assistance solutions, particularly a comprehensive, dedicated website, even if it means that they may lack the convenience of having in-person assistance from brokers or exchange experts. In other words, while convenience is obviously important, as noted above, lower administrative costs are clearly of greater import to both employees and employers.

Where should questions about health benefit plans be directed?

Many organizations want someone to whom their employees or HR manager can turn with questions about their health care plan. Employers were asked to select their preferred option for such assistance. This time, provided options from which employers could choose were weighted initially by anticipated cost in an effort to gauge realistic interest on the basis of both convenience and cost. Once again, employers preferred the options that represented the lowest administrative costs, as noted below.

1. Health insurance exchange website with easy to understand FAQs (FREE)	46 percent
2. Support from a health exchange expert by 24/7 e-mail/chat ($2.50 per employee per month)	16 percent
3. Support from a health exchange expert by 24/7 telephone ($5 per employee per month)	11 percent
4. Support from a health exchange expert by 24/7 e-mail/chat and telephone ($6 per employee per month)	10 percent
5. Support from an in-person insurance broker ($25 per employee per month)	9 percent
6. Other	5 percent

7. Support from an in-person health exchange expert ($20 per employee per month)	2 percent

Enrollment and assistance options according to the needs of each business

Small businesses of different types and sizes have different needs. In spite of the generally expressed preferences among employers for exchange enrollment and assistance options that offer the lowest administrative costs, more costly options should not be excluded. These options, while more expensive, may be a better fit for some small businesses in Mississippi, as noted by employers who indicated their preference for more hands-on assistance in spite of the potential costs.

The role of brokers

Employers often rely on insurance brokers to educate employees, enroll them in health plans, and manage health benefits. Health insurance includes at least two fundamentally different parts: transactional and consultative. According to small business owners in Mississippi, the insurance market can be intimidating and often provides little direction. While the exchange will be designed to provide a more streamlined experience for the transactional aspect of working with health benefits, brokers are likely to continue to play an important role in the consultative aspects for some small businesses.

In addition to helping employers navigate the complexities of health insurance, brokers can provide education to both employers and employees. As mentioned previously, without weighting for cost, forty percent of employers and twenty-four percent of employees said they would prefer to be educated about the state exchange through an insurance broker than through alternative method, indicating an existing level of trust in brokers that should certainly be leveraged in developing the framework for the exchange.

The survey additionally revealed that those employers who do not currently offer insurance to their employees would rather receive education about an exchange via a website, while those who currently offer insurance would prefer broker assistance. Given the number of employers who currently offer insurance to their employees, and who either rely on brokers or anticipate receiving broker assistance in working with the exchange, brokers should be utilized as an important bridge between employers and the exchange.

To whom will small businesses turn to manage health insurance challenges if brokers are not utilized?

When asked to whom they would turn for answers about health insurance questions if a broker were not available, due to cost, availability, or other concerns, small businesses said they would likely contact a dedicated exchange expert on the phone or contact their insurance carriers directly, in virtually equal measure. Given this scenario, some respondents indicated that they would be willing to pay slightly more for ongoing support from a broker. The range of different responses to this question illustrates the different types of interaction the exchange should be prepared for as it is developed and implanted. The complete list of responses is below:

1. The health exchange must provide dedicated 24/7 telephone support with an exchange expert	18 percent
2. I will contact the health insurance carrier for assistance	18 percent
3. The health exchange must provide dedicated 24/7 email/chat support with an exchange expert	17 percent
4. I would be willing to pay slightly more for on-going support from an insurance broker	11 percent
5. Employees will deal with health insurance issues on their own	11 percent
6. I will manage our organization's health insurance challenges and questions on my own	10 percent
7. I will have a human resources employee manage all health insurance challenges and questions	9 percent
8. Other	4 percent
9. Friend, family, or colleague will provide assistance	2 percent

Section 6: Overview of Phase III Town Hall Meetings

The Purpose of the Town Hall Meetings

Town hall meetings were conducted throughout the state to provide Mississippians with information regarding the state's planned health benefit exchange, while allowing stakeholders to share their concerns and feedback. The gatherings represent a coordinated effort between the Mississippi Insurance Department, Leavitt Partners, and the Cicero Group to initiate the state's outreach campaign surrounding the Mississippi Health Benefit Exchange. The meetings were held throughout the state during the week of June 20–24, 2011.

These town hall meetings were designed to reach Mississippians in their communities, allowing them the opportunity to participate in the process of working toward a solution that will increase access to health insurance for Mississippi employers and employees. These meetings featured an interactive presentation that broadly discussed topics surrounding health insurance in the state of Mississippi, as well as a discussion regarding the implementation of a health benefit exchange.

Town Hall Presentation and Content

The town hall presentation was designed to provide an overview of the purpose and function of a health benefit exchange in the State of Mississippi. In addition, the presentation was crafted to educate and inform participants sufficiently about the exchange.

Due to the complexities and emerging political ramifications of health benefit exchanges, the scope of the town hall presentation was necessarily limited. Participants were presented with general information about the PPACA, its impact in Mississippi, the administration and function of a health benefit exchange, and the directions and challenges of an exchange in the State of Mississippi.

Town hall meetings were designed to provide Mississippians the opportunity to ask questions and provide feedback. Attendees used these forums to express a range of questions and comments, which were noted for the purpose of further informing the development of an optimal exchange, and they are catalogued in the appendix (p. 26) of this report.

Who participated in the town hall meetings?

A broad mix of small business owners, employees, health care providers, business advocates, local government officials, state legislators, advocacy groups, brokers and agents, as well as many other stakeholders attended these meetings. The following is a short list of attendees:*

- Mississippi Health Advocacy Program
- Center for MS Health Policy
- Children's Defense Fund
- Clinton Chamber of Commerce
- Fisher Brown Bottrell
- MS American Academy of Pediatrics

- Office of U.S. Senator Wicker
- Olive Branch Chamber of Commerce
- Pioneer Health Services
- Tupelo Holy Apostolic Temple Church
- United Healthcare
- University of Mississippi Medical Center
- Cleveland Bolivar County Greater Chamber of Commerce
- Hattiesburg Clinic
- Jackson Public Schools
- Plaza Pharmacy
- Self-employed Small Business Owners
- BlueCross BlueShield of Mississippi
- Tupelo Mfg. Co.

**A full list of groups who identified themselves at these meetings is included in the appendix (p.24) of this report.*

Section 7: Key Findings from Town Hall Meetings

Introduction

The range of questions and comments shared by Mississippians at the town hall meetings reflects a diverse set of suggestions and concerns. The following is a summary of the findings that emerged from those questions and comments.

Uncertainty among Mississippians

Mississippians want to know how the PPACA will affect them

Echoing Phases I and II of the research, these meetings further demonstrated that throughout the state there is a considerable amount of confusion and fear surrounding the Patient Protection Affordable Care Act (PPACA). Many town hall participants expressed either misinformation or confusion about why a health insurance exchange is proposed for implementation in Mississippi and what impact it might have.

> *"I think it has to be Mississippi doing this, based on what we know, what we've heard today."*
> *-Town Hall Participant*

There is a complex relationship between the PPACA, the state of Mississippi, insurance carriers, and the residents. Given the number of questions about the PPACA that were addressed at the town meetings, it is evident that an ongoing outreach and information campaign will be critical in helping Mississippians understand how their health benefits will change via an exchange, what these changes will mean for them, and what role a state-implemented exchange will have. The state will need to continue to emphasize that while a health benefit exchange has considerable promise, it is only part of the solution to the current challenges.

Mississippians and the Patient Protection and Affordable Care Act (PPACA)

In an effort to provide town hall participants with context for why the state is designing a health insurance exchange, the PPACA was briefly discussed. In each of the thirteen cities visited, Mississippians demonstrated a general shared resistance toward the act. The term "Obamacare" was often mentioned with frustration, apprehension, and even vitriol among participants, particularly in the Gulf Coast.

For Mississippians, By Mississippians

Comments and questions from participants in the town hall meetings demonstrated that Mississippians want the mandated health benefit exchange to be designed and implemented for Mississippians, by Mississippians, and administered from within their state. Mississippians were clear that a state health insurance exchange should be operated by the state and not the federal government.

> *"We want to know that this is really for Mississippians, that it is in the hands of Mississippians."*

Mississippians also want to make certain that the economic benefits of the exchange are realized by companies and consumers in the state. A concern that was repeated at many of the meetings involved the influx of out-of-state carriers who may seek to participate in the exchange, and their lack of knowledge about or concern for the specific needs of Mississippians.

Mississippians Want Simple Forms of Assistance

At the town hall meetings, Mississippians broadly expressed a desire for a health benefit exchange to be simple to understand—easy to see how and why it benefits them, and how to utilize it either as an employer or employee.

Many employers, employees, advocates, and brokers expressed the resounding need for simplicity and clarity in comparing and understanding plans. Participants talked at length about how important it will be for them to have different forms of easy-to-understand and unbiased assistance in working with the exchange.

> *"As someone who recently got health insurance . . . [I can say] it is a very complicated process."*
> *-Town Hall Participant*

Town hall moderators consistently emphasized that a health benefit exchange will not directly reduce the cost of health care. In response, employers felt that the real benefit of an exchange will be realized if it can simplify their efforts to provide health benefits, thereby reducing their administrative burdens.

Small business owners are too busy to manage insurance questions

Small business owners expressed the virtually universal issue that health care management was too time-consuming. Business owners stated that they were too busy to allocate their time and resources toward managing health benefits for their employees. Many small businesses are fearful an exchange will increase the amount they will need to be involved in helping employees select a plan most appropriate for them.

> *"I'm tired of the HR portion of dealing with insurance for my employees; would this help them with that?"*

Addressing this significant issue, the health benefit exchange will need to devote resources toward mitigating health care management on behalf of the employer. Both qualitative and quantitative research clearly show that alleviating management responsibility on behalf of the business owner will be of particular importance in the success of the Mississippi health benefit exchange.

The enrollment and management process needs to be quick and efficient

Small business owners are particularly uninterested in dealing with insurance processes that are lengthy, confusing, and/or cumbersome. They have spoken out in favor of a

clear, simplistic, and decisive method for describing how the exchange will work, how it will benefit them, how the pooling of risk will impact their premiums, and ultimately how to use and interact with the system. Furthermore, small businesses require exchange assistance to be just as clear, simple, and decisive. Employees similarly expressed a desire that this system be easy to use, particularly as they compare, enroll in, and utilize plans. The mediums of assistance will need to be tailored to employers and employees.

Mississippians Want Enhanced Access to Health Care

What are their health care concerns?

Beyond keeping processes simple, employers talked about how important it is to be able to provide greater access to health care through the exchange. Employees spoke about the issue of portability, as they move between jobs, if they live and/or work across state lines, or if they were unemployed, and questioned how the exchange would benefit them in each of these circumstances.

Defined contribution plans

The presentation at the town hall meetings briefly introduced the concept of a defined contribution model, in which employers contribute a specified amount of money toward employee health benefits and employees use that amount to select the coverage that best meets their needs. After this presentation, questions and comments indicated a high level of interest in learning more about how such a model might benefit both employers and employees as they seek to enhance access to health care.

Some brokers expressed concern about the defined contribution model, worrying that this solution will significantly increase their administrative burden of educating, enrolling, and administering plans for their clients, without concomitant compensation. Therefore, the exchange must be designed in such a way that it provides brokers with appropriate support and resources through online and offline mediums (e.g. e-mail / chat, phone, direct mail, web tutorials, and videos).

Government subsidy programs and the health benefit exchange

The need for seamless integration between the health benefit exchange and federal government subsidy programs (e.g. Medicare, Medicaid, and CHIP) was repeated by various stakeholders in attendance at the town hall meetings. Because uncertainty exists among individuals regarding the types of plans and/or programs for which they qualify, it is critical that PPACA programs work seamlessly with the exchange. In other words, the health insurance exchange program must ensure that an individual receives proper direction and ultimately appropriate coverage in conjunction with federal subsidy programs.

Mississippians Need Broad Outreach

Mississippians are concerned about outreach

Perhaps the most critical finding from the town hall meetings is the importance of outreach in effectively creating, implementing, and managing a successful health benefit exchange in the State of Mississippi.

> *"There are a lot of people in Mississippi who are not employed —will those people be educated about the exchange?"*
> *-Town Hall Participant*

Thousands of invitations to participate in the survey and town hall meetings were sent via e-mail, direct mail, and phone calls. Additionally, the meetings were advertised locally and regionally on television, on the radio, and in newspapers.

While participation at the meetings was active, and many demographics were represented, there are many more Mississippians who will be affected by the implementation of a health insurance exchange but who remain unaware and unengaged. These residents will need to be consulted and involved in research, development, and implementation of the exchange to ensure that the needs of employers and employees in Mississippi are being properly considered and met by the exchange.

Small businesses and employees often simply do not have time to attend town hall meetings. Therefore, extensive networking among Mississippians will be essential to disseminate information about the exchange, as well as to convince employers and employees to participate in the exchange.

What types of outreach are needed?

Throughout the research phases, it was evident that vital online tools—including communication, e-mail, and enrollment tools, such as an online portal to the exchange—may not be enough to reach all Mississippians, particularly those in rural areas of the state.

Considering that more than half of Mississippi's population resides in rural areas, educating this substantial group will be a critical part to the success of the health insurance exchange. Also, understanding the needs and constraints of Mississippi's rural population will be crucial in the implementation of an exchange. Word of mouth and traditional networks—such as churches and religious affiliations, neighborhoods, community organizations—along with traditional media such as television, radio, and newspapers will be essential in educating and informing these groups.

Alternate forms of outreach

The exchange must be available to people who do not have Internet access, or who do not wish to use the Internet to enroll in or manage their benefits. Access to personal support and assistance, whether in person or by telephone will be crucial in this regard.

Beyond issues regarding access to the Internet, many participants, including employers and employees, indicated strong preference for working with people who can assist them in understanding and working with the exchange.

Mississippians Want a Voice in the Creation of the Health Benefit Exchange

How did Mississippians respond to the town hall meetings?

A common theme among participants in the town hall meetings was the need for a voice in the development of an exchange unique to Mississippi. Many participants expressed gratitude for the opportunity to receive information and provide feedback. Furthermore, attendees expressed a strong interest in participating further in the development of the health insurance exchange.

What did small businesses and individuals say?

> *"I really appreciate what you're doing, giving us a chance to participate. This has been great."*
> *-Town Hall Participant*

Different constituents offered compelling reasons for incorporating their voices in the development process. For instance, small business owners want to dialogue how an exchange will be most beneficial for their business, and how it will impact the benefits they can offer their employees without adding cost or risk. These small business owners have dealt with managing and administering health benefits for many years, and they are willing to apply their insights to developing an exchange that works for them.

Employees and individuals expressed concerns about their current access to affordable health insurance, and want to ensure that the exchange will genuinely enhance their access to good options for themselves and their families. Both employers and employees commented that health benefits are often complicated, and yet are critical to them. They expressed the overwhelming need for simpler processes and better understanding of their health care options.

What did health care providers say?

> *"As a provider in a rural area, I'm concerned about my patients, about the care they receive."*
> *-Health Care Provider*

Health care providers expressed a desire to apply their insight and expertise to the development of an exchange that will increase residents' access to high quality health care. In particular, rural providers expressed the importance of looking out for the needs of rural Mississippians, and understanding their unique constraints, including lack of proximity to specialists. They also voiced concerns about the specificity of current network options, discussed the need for more patient options in choosing providers, and expressed the hope that the exchange will help meet some of these needs.

What did advocacy groups say?

Advocacy groups want to ensure that the needs of employees, consumers, and specific populations are being properly considered and protected in the process of designing and implementing an exchange. Many of these advocacy groups were adamant that the exchange ensure individuals have proper access in spite of constraints, such as lack of internet access or limited experience in working with or accessing health insurance plans.

> *"We've got a huge hurdle in front of us in terms of education and outreach. There are just so many myths."*
> *-Town Hall Participant*

What did health insurance brokers say?

Insurance brokers had extensive representation at the meetings. Brokers expressed concern that they will be marginalized in the process of implementing an exchange, and emphatically asserted the importance of their role in explaining insurance to consumers, both employers and employees.

Many brokers expressed understanding that their roles might change with the implementation of the PPACA, but articulated uncertainty about the impact it would have on their roles and livelihoods. They also clearly wanted a seat at the table in the design and implementation of the health benefit exchange in Mississippi. They were willing to apply their expertise in working with health insurance to the implementation and management of an effective exchange.

Brokers were also concerned that a defined contribution plan would increase their administrative load when assisting clients. However, survey data confirm that Mississippians want the exchange to include e-mail/chat, web tutorials, and telephone support aspects. These assistance channels should be designed to reduce the administrative burden that a defined contribution plan could impose on brokers.

Appendix A – Organizations Represented at Town Hall Meetings

Names of Organizations	
AARP	Mobley Insurance
AEB	Morgan White
Aflac Insurance	MPHCA
Aflac/NAHU	MS American Academy of Pediatrics
American Cancer Society	MS Center for Justice
Amite County Medical Services	MS Hospital Association
BancorpSouth Insurance	MS Human Services Coalition
Baptist Memorial Health Care	MS Human Services Coalition
Benefit Resource LLC	MS Life and Health
Blue Cross Blue Shield of Mississippi	MS Nurses Association
Bolivar Commercial	MS Optometric Association
Bottrell Insurance	MS Psychiatric Association
Bounds and Assoc.	MS Section ACOG (OBGYN)
Candidate	MS Senate
Candidate - Jackson County Supervisor	MSA Services
Candidate for state office	MSPH
Capital Resources	MWC
Center for MS Health Policy	NAMI - MS
Chamber Plus	National Tree Preservation & Fulgham, Inc.
Children's Clinic	Nems Entertainment, Inc.
Children's Defense Fund	Nettleton
City of Amory	NMMC
City of Jackson	Northeast MS Health Care
Cleveland Bolivar County Greater Chamber of Commerce	Office of State Senator Billy Hewes
Cleveland Collision Center	Office of Steven M. Palazzo, Member of Congress
Cleveland Current	Office of U.S. Senator Wicker
Clinton Chamber of Commerce	Olive Branch Chamber of Commerce
Coastal Family Health	Orchard Healthcare
Coastal Family Health Care	Owen Insurance
Collum & Associates, LLC	Oxford Eagle
Colonial	Pakmail
Communicare	PDS/Burchfield's, Inc.
CPS	Philip Moran for Senate
Crisis Resources	Pioneer Health Services
Daily Journal, Inc.	Planned Parenthood Southeast
Delta Health Alliance	Plastic Surgery of RIMS
Delta State University	Plaza Pharmacy

Desoto Appeal	PPCMS
Desoto Co. Board of Supervisors	Public Policy Center of MS
Faith Answers	Rankin Co. Citizen
Family Health Care Clinic	Reese Eyecare
FEMA	Renasant Insurance, Inc.
First Choice	Richard L. Maddox PA
First National Realty	SBEC
Fisher Brown Bottrell	SE Mississippi Rural Health
Forrest General Hospital	Self-employed Small Business Owner
Fox-Everett, Inc.	SFBLI
Gary Smith Agency	Smith & Associates, Inc.
Gulfport NAACP	Smith and Co., Inc.
Hattiesburg American	SMPDD
Hattiesburg Clinic	South Group
Holly Springs Eyecare	South Mississippi AIDS Task Force
Hunt Insurance	St. Dom. Hospital
J. Russell Persons II CPA PC	Stan White Assoc., Inc.
Jackie's International	Stewart Sneed Hewes
Jackson Public Schools	Tupelo Holy Apostolic Church
KLLM Transport Services	The Dog's Day (small business)
LeBonheur Comm. HIV Network	Tupelo Mfg. Co. (small employer)
Mattejevich Insurance	United Healthcare
McDonald Insurance LTD	United Healthcare MS
Mississippi Attorney General's Office	Univ. of MS Health Care
Mississippi Health Advocacy Program	University of Mississippi Medical Center
Mississippi House of Representatives	Watkins Ludlam Winter & Stennis
Moore Community House	Wellington Associates, Inc.

Appendix B – Town Hall Comments

WHAT MISSISSIPPIANS HAD TO SAY ABOUT THE TOWN HALL MEETINGS

- "This makes me feel a whole lot better (to know my voice is being heard)." *Meridian*
- "I think your effort is great." *Meridian*
- "We've been tough on you, but I want to thank you. I participated in similar forums in Tennessee, and this is just a much better approach. I really appreciate what you're doing, giving us a chance to participate. This has been great." *Olive Branch*
- "In terms of how we do it, I think we're going to have to do what we're doing here. We need to go out into the communities and ask what works best for them." *Clarksdale*
- "These kinds of discussions are helpful; we're on the right path." *Clarksdale*

COMMENTS ABOUT THE WORKINGS OF A DEFINED CONTRIBUTION PLAN

- "Who would be responsible for the record keeping on a defined contribution plan?" *Hattiesburg*
- "By definition, how is defined contribution different from an insurance bank?" *Gulfport*
- "Are small business employees paying taxes on the money they receive in defined contribution plans? Is it pre-tax?" *Jackson*
- "Employees think that health benefits are very important to them, but employers less so. Many companies provide insurance. Would we see a shift with a defined contribution model to include part-time employees, maybe with just a contribution to part-time employees or something? Will it be up to the employee to then go out and get their own insurance?" *Pearl*
- "With defined contribution, would a broker sit down with employees and decide on two or three companies to offer to their employees? How would that work?" *Starkville*
- "I'm an employer—what are the company subsidies that would be paid in the scenario of the defined contribution?" *Tupelo*
- "Is this health insurance exchange defined contribution plan a required thing? Does it have to be put in place? So, when we say this is a requirement of the ACA, could we come up with something else, something better? Could we do a single payer plan? Everybody has access to health insurance now; we just can't afford it." *Clinton*

COMMENTS ABOUT THE WORKINGS OF A HEALTH INSURANCE EXCHANGE

- "If you're going to have companies that allow part-time employees to purchase through the exchange, how are you going to reconcile when some companies allow their employees to go in the exchange, but others don't?" *Meridian*
- "One of the mistakes that Massachusetts has said that they've made has to do with the open enrollment period. Can you opt in, have a surgery, and then opt back out? Because that was a problem there. How are you going to avoid that?" *Meridian*
- "Would open enrollment be for individuals as well as for businesses?" *Meridian*
- "Is there going to be a high risk pool for people who are already in poor health?" *Meridian*

> *"What does the exchange offer that's not already in existence?"*
> *-Tupelo*

- "Are businesses that have smoke-free workplaces and healthy workplace plans going to be lumped in with those that don't? Are they going to be penalized?" *Meridian*
- "How are agents and brokers going to be involved in the exchange?" *Starkville*
- "Federal law will have zero compensation for agents, and Mississippi law will have compensation for agents (3–5%)—is this correct?" *Starkville*
- "I understand the federal requirement, but you say the exchange could be more efficient here, could be more administratively efficient and lower cost. Why?" *Starkville*
- "We offer credits to our employees for wellness in bringing their deductible down. Will that still be around?" *Tupelo*
- "What does the exchange offer that's not already in existence?" *Tupelo*
- "This state requires automobile insurance, but everyone doesn't have automobile insurance. Who is going to enforce health insurance in this state?" *Tupelo*
- "This is going to be different from the insurance risk pool?" *Olive Branch*
- "Did you say that the employees can go into the exchange? Employers can do what they're doing now and offer health insurance? And the employees can go right in there and choose now? It is still a group plan?" *Olive Branch*
- "Mississippi has one major insurance company. Great company, but they are king in Mississippi. So one of the things that was discussed early on with exchanges was allowing carriers to sell across state lines. Mississippi is very unique. Memphis is just up the road. Arkansas is nearby. Lots of people who live in Mississippi and work in Tennessee, or vice versa. Would a carrier that is established in TN be portable to Mississippi with this?" *Olive Branch*
- "Is this going to work at all for small businesses? Are there penalties?" *Olive Branch*
- "As an individual, may I go online, or how do I choose?" *Olive Branch*
- "What about an individual who works for an employer that does not provide health insurance, or will not participate in the exchange? Can they participate in an exchange?" *Olive Branch*
- "If you fell within a category with government subsidies, is the only way to take advantage of the subsidy to use the exchange? I like the idea of the exchange, if this!" *Olive Branch*
- "When it comes to the individuals, if you don't take insurance, you're going to be penalized, but $95 is a drop in the bucket. What else is going to be the penalty?" *Olive Branch*
- "You said initially that any business with more than 100 employees wouldn't be able to participate in the exchange. Is that full-time employees?" *Olive Branch*
- "What about subsidies? How does that work?" *Olive Branch*
- "Does it have to be delivered through the employer?" *Oxford*
- "Explain the role of a navigator. What are the qualifications that are going to be involved?" *Oxford*
- "On the employer-based exchange, how will age rating and composite group scores be calculated? Will it utilize an individual-based rate?" *Oxford*

> *"I would like to see Mississippi step up and do it before we have to do it! Not have the federal government step in and tell us how to do it!"*
> *-Greenville*

- "If an employer opts to be in the exchange, do employees have to participate in the exchange? If an employer opts not to be in the exchange then can their employees get insurance through the exchange?" *Oxford*
- "The insurance commissioner is going to design this? How does this work?" *Oxford*
- "With the exchange, the employer is no longer in charge of picking the plan?" *Oxford*
- "Would this be applicable to employees of both public and private sector? How would it apply to state retirees?" *Cleveland*
- "What is going to entice carriers to participate in the exchange?" *Cleveland*
- "Have the processes been set up for how an underwriter joins the exchange?" *Cleveland*
- "What sort of provisions will be in place for me to compare policy to policy to policy?" *Cleveland*
- "For the person who has experience dealing with this, I can tell you that there needs to be simplicity and consistency so that people can understand this. I mean, one word differences can make all the differences between policies, and so people need something that is clear, simple, and understandable for them to use for this to really work." *Cleveland*
- "Will insurance companies have a screening process, or will they all be invited to participate in the exchange?" *Greenville*
- "You don't have to participate in the exchange, you can stay with your carrier, but you have to have some kind of coverage, right?" *Greenville*
- "I kept flashing back to Medicare prescription drugs and how confusing that was, trying to figure that out. With this, I'm worried that this will be the same. Will the plans in the exchange literally be laid out to compare, in an easy-to-understand way?" *Greenville*
- "One of the biggest problems we've had here in the delta is networks. Hospitals don't communicate well. Doctors seem to understand you, but hospitals don't. Access to networks is a problem. Understanding how to deal with all of this is difficult. Will this help with that?" *Greenville*
- "Medicare, Medicaid, CHIP, state employees are not in this, right? This is just for private business?" *Greenville*
- "Would it be portable? Could I keep my plan from one job to the next, even if the employers work with different plans?" *Greenville*
- "On the exchange, the target market seems to be small groups and individuals—if we have a 70-year-old who's eligible for our small group plan, is that still going to be the case on the exchange, or are they going to be bumped off for Medicare because they're over 65?" *Jackson*
- "You're referencing a small business model; what about other groups—are they eligible to participate?" *Jackson*
- "I have a very rudimentary understanding of insurance, but would it not be better for adverse selection to have just one exchange?" *Jackson*
- "The plans should have a prevention aspect. Will our plans have preventative health care?" *Jackson*
- "I'm tired of the HR portion of dealing with insurance for my employees, would this help with that?" *Pearl*

> *"There needs to be simplicity and consistency so that people can understand this."*
> *-Cleveland*

- "What do you all anticipate in terms of broker involvement? My concern is that there are so few carriers to work with, how is this going to attract more carriers to the market? What will the exchange do to handle the lack of competition? You have a broker, you have to pay him. What percentage of the exchange dollar is going to pay him?" *Clinton*
- "With that part-time situation, is there a mechanism where if I give the money to an employee, can I be certain that that money will be used to buy health insurance?" *Clinton*
- "How does the HR person communicate all this to the employees? Do they just go to the web themselves to help the employees? It just needs to be laid out properly." *Clinton*
- "One thing I can't wrap my head around: an individual exchange makes sense to me, but a small employer exchange doesn't make sense to me. Different employees doing different things, and they all have different options? I just can't get my mind around that. My ten employees could go to four different carriers, I just make my contribution, and it goes into the exchange, then?" *Clinton*
- "How is the pricing going to work? How will the ratings work?" *Clinton*
- "What about state employees? Will they be eligible to enter the exchange?" *Clinton*
- "Who pays to administer the exchange?" *Hattiesburg*
- "Have you had a discussion about provider networks and who will be able to participate?" *Hattiesburg*
- "How many carriers are you going to have in the exchange?" *Gulfport*
- "Is the individual going to be able to use the exchange, too?" *Gulfport*
- "What protections will be put in place to ensure that insurance companies don't unfairly influence the type of plans that will be offered in the exchange?" *Gulfport*
- "Is this only through employers? What happens to people when they lose their jobs?" *Gulfport*

WHAT MISSISSIPPIANS WANT TO SEE FROM THE HEALTH BENEFIT EXCHANGE AND HEALTH REFORM IN GENERAL

- "Make it honest. So many of the things I receive on the television, on the internet, and on the phone . . . are mostly scams." *Meridian*
- "I don't want it to be confusing, for it to get lost in the small print." *Meridian*
- "We want to know that this is really for Mississippians. That it is in the hands of Mississippians, not a company that is set up here but based in Illinois or something." *Meridian*
- "I want to get back to any willing provider—if you are licensed to provide a service, you will be able to do it, and you will be compensated the same as any provider providing that service. This is what we want." *Meridian*
- "You've got to make people realize it affects their pocketbooks." *Meridian*
- "You talk about Mississippians saying they want health exchange designed by Mississippians—it's because they don't want the bureaucracy of the federal government coming in, and that's because the assumption is that Mississippians will have a voice in the implementation of this. That hasn't always been the case with Mississippi, but in this

"I'm tired of the HR portion of dealing with insurance for my employees, would this help with that?"

case, it's really important. Consumers need to be represented on the governing board for this exchange. Open meetings for the governing board. Consumers need to have an active role in the design and implementation of this." *Starkville*

- "You should allow users to rate quality in an effort to increase transparency. Don't exclude a smaller company that may not be as well known. Continue this process online, in the exchange." *Oxford*
- "I like to be able to go online, but it does take a lot of time." *Clarksdale*
- "I would like future presentations to focus on the quality of products available in the insurance exchange. I hope that Mississippi will really look at and focus on this, what Mississippi needs." *Jackson*
- "You need to publicize this! This needs to be covered so Mississippians know what's happening with this." *Jackson*
- "I was looking at your statement that marketing needs to reach out to everyone, but I want to say that people at the table need to be diverse. Diversity is not a simple thing to achieve. As you are planning, make sure that you don't have only foxes at the table, guarding the henhouse. Particularly in your design." *Jackson*
- "It makes sense; it just needs to make sure that information is on the web 24/7." *Clinton*
- "Maybe I'm confused—so the main thing is either Mississippi does it by 2014, or the federal government does it for us, right? So it comes down to, who do you want to do it—who would be better to do it? I think it has to be Mississippi doing this, based on what we know, what we've heard today." *Gulfport*

CONCERNS AND COMMENTS STAKEHOLDERS HAVE ABOUT THE HEALTH BENEFIT EXCHANGE AND HEALTH CARE REFORM

- "I'm concerned that special interest groups will influence this plan. That's one of my major concerns." *Meridian*
- "I own a small business and this morning my only employee called in sick . . . we can only do so much if we are a REALLY small business." *Meridian*
- "When you consider age, right now, as you go up, premiums go up. How are you going to deal with the age problem?" *Meridian*
- "How do you get the engagement of small businesses?" *Meridian*
- "I'm a small business owner and also an insurance provider—through the exchange will you be concerned with insurance companies coming in to influence what will be offered? How will who is involved and what is offered be determined? Will it be just the cheapest, or will it be those who provide and care best for the people? How will that be decided?" *Meridian*
- "How are you going to ensure that once we decide on an exchange, how can we be sure that what we decide we will have will continue?" *Meridian*
- "A big concern for all people: I want to see the doctor I want to see! I've paid out of pocket to see a doctor I trust. How are you going to address that?" *Meridian*
- "Is there some consideration to strong-arming insurance companies to make this decision easier for consumers?" *Starkville*
- "It's sounding as though a lot of the administrative costs are

"I'm concerned that special interest groups will influence this plan. That's one of my major concerns."
-Meridian

savings to the employer. From the broker's side, does the monthly meeting now take place between the broker and 20 employees, rather than the broker and the one employer? This breaks my model. How does my compensation make sense with this new model?" *Starkville*

- "How do you get employees time off the assembly line to assimilate this process, to make choices about health benefits?" *Starkville*
- "Assuming the Supreme Court moves forward, will the MID consider stripping a lot of the mandates that go along with the law?" *Starkville*
- "Does the federal mandate insist that everyone be insured?" *Tupelo*
- "I think everyone appreciates this open forum. I see some inherent good and some inherent bad with the exchange. While I understand that you are putting brokers at the table, I think there is a risk with eliminating broker services. Let's say that some people opt out of my pool, there is inherent risk for the people who remain with me, or in a plan I sponsor? Doesn't that introduce the possibility of adverse selection for those who remain with me?" *Tupelo*
- "What's being done in the legislature to ensure that our borders are being opened to other carriers?" *Tupelo*
- "What does this do for an individual— an entrepreneur— who is neither an employer nor an employee?" *Tupelo*
- "You can go on the internet and select and purchase insurance. I'm just saying it's already in place and we don't need it." *Tupelo*
- "I know that Mississippi is a right-to-work state, but how will that affect Mississippi where Medicare and Medicaid are so pervasive?" *Tupelo*
- "How are people going to get access and participate when they're working three jobs and they can't pay premiums?" *Tupelo*
- "We're going to treat them regardless, but if the mindset is to sell everyone insurance, and they're all insured with a high deductible, then the costs aren't going to go down for anyone." *Olive Branch*
- "The law says insurance companies are not going to be able to claim people. When you say you can't decline, if I'm healthy, I'll just wait until I get sick. But that won't work well. I think forcing people to buy from a private company is un-American." *Olive Branch*
- "There are a lot of people in Mississippi who are not employed—will those people be educated about this? And old folks, too? We all need to know the difference in what we are going to get!" *Olive Branch*
- "Will this affect the risk pool? We're insured in the risk pool due to pre-existing conditions. Will the companies penalize me because of something I was born with? Will the risk pool still be available?" *Tupelo*
- "I just want a clarification on the fact that we are not forced to participate in an exchange, correct?" *Olive Branch*
- "What if someone loses their job and doesn't have any insurance?" *Oxford*
- "Can this be portable with an individual exchange; would you be able to stay on the same plan?" *Oxford*
- "Was there any thought given to making it not employer-driven? Anything separate from employers at all?" *Oxford*

- "One of the things I worry about is what the Affordable Care Act will do to Nurse Practitioners like myself." *Clarksdale*
- "Just going around the state, there's so much misinformation out there. People have these fears about things like the individual mandate. I'm just underscoring the need for education on things like the ACA and exchanges through the state. The education outreach just isn't there right now. We've got a huge hurdle in front of us in terms of education and outreach. There are just so many myths." *Clarksdale*

> *"We don't want it to go under like Massachusetts!"* -Greenville

- "MS is not the healthiest state in the nation; what impact does that have on our ability to develop and maintain an exchange?" *Cleveland*
- "Are you going to be doing focus groups on the website, putting together groups and research to find out how to make this all work? How can I be involved?" *Greenville*
- "We don't want it to go under like Massachusetts!" *Greenville*
- "What do you expect to be covered by this? With only part of the state involved, will it be large enough to make it buyable?" *Greenville*
- "Having run a business for years, and having been a leader in Greenville, it's important for the leaders of communities to get together. I'd love the insurance commissioner to gather these leaders together." *Greenville*
- "Can you talk about mandatory participation? Who is going to enforce it and how? Who is going to pay?" *Greenville*
- "Are you describing a health benefit package or plan? How is a consumer going to make it happen; how can a consumer understand this?" *Jackson*
- "I'm also wondering what kind of insurance brokers we're talking about—the kind that just push the plan that makes the most money for them, or the kind that represent different kinds of plans and help people know which plan is really best for them?" *Jackson*
- "You have been talking specifically about the small business exchange. We also have to implement the individual exchange, which will be very important for Mississippi. My biggest concern is how we are going to build what the federal law calls "navigators." Who are the navigators, how are they trained, and will there be bias there? I appreciate your comment about doing both simultaneously—make sure that one is informed by the other. There are a lot of things you're learning as you put one together that can be applied to the other that can increase access and make it more affordable." *Jackson*
- "Mississippi has a high rate of uninsured: the need is concentrated in this area, so it seems to be that we're not focusing on a big problem that will affect many Mississippians—the unemployed and people working part-time without insurance. The individual exchange seems so necessary for this." *Jackson*
- "Here's a scenario that's real-life for my company. We've got a major medical plan that is lesser than others because we can't afford a better plan. Still, it's very expensive. We're charging our employees too much. The mandates of the ACA will force us to raise our benefits, and yet we're barely surviving. It's almost easier to think about paying the annual fine. I'm hoping that what you talked about provides a fix for this, for us. I'm curious from the company's standpoint—I mean, we're almost tempted to pay

> *"How would we as agents get trained to sit down and be able to have an intelligent conversation with people about it?"* -Gulfport

the fine, because we aren't going to be able to bear the cost of the new mandate." *Pearl*

- "I think it's a great idea; it will do a lot of positive things. What are you going to do to attract more carriers into the system? How do we expect the exchange will help solve the problem of the lack of competition? Because that is a big issue right now; it's a real problem, and probably an unintended consequence of the ACA." *Clinton*
- "How many members are coded under this in Utah right now? Did agents participate there? Because from what I've read about Massachusetts, it was a fiasco." *Clinton*
- "Has any thought been given to having a health reimbursement or savings account with an unlimited duration rather than expiring?" *Hattiesburg*
- "Going back to the broker issue—for people who don't already have insurance, how will they access the exchange? Will brokers reach out to those people?" *Hattiesburg*
- "How are you going to address this paper wise? How's it going to manage all that? Isn't that just a pipe dream?" *Gulfport*
- "I'm just curious with the risk pool—how involved will you allow the agents to still be? If everyone leaves the high risk pool to join the exchange, I'm out of a job, am I not?" *Gulfport*
- "How would we as agents get trained to sit down and be able to have an intelligent conversation with people about it?" *Gulfport*

STAKEHOLDER QUESTIONS REGARDING GENERAL INSURANCE CONCERNS

- "Do you see more insurance companies coming back into the state, to participate with this after tort reform?" *Starkville*
- "There is an exchange already, a big group. I can go on the internet and look at insurance." *Olive Branch*
- "Small businesses already offer insurance; if employees don't like that insurance, they can opt out and go with something from the exchange?" *Olive Branch*
- "Well I know Mississippi has one of the highest poverty levels in the U.S. and a lot of people use Medicaid. How will this impact that?" *Olive Branch*
- "As someone who recently got health insurance for myself, every time you go to a different health insurance company, you have to fill out their form, you have to go through their system. It is a very complicated process." *Oxford*
- "I just came out because I saw it in the paper. I'm trying to find out how I can get coverage now. My son and daughter are both insulin-dependent. Before I changed jobs three years ago, I asked an agent how much insurance would cost if I lost my CHIP. They've got to have coverage; what if they lose it? And when I asked a private agent, I found out that it would cost twice my salary. If I didn't do anything, I could get CHIP, but that would put me further behind." *Clarksdale*
- "Where is the leadership coming from in Mississippi to drive medical costs down? Are business leaders willing to get together? Pharmaceutical industry? How can we get together and quit being greedy, create an affordable medical environment? We have just got to quit charging what we are." *Greenville*

Appendix C – Online Small Group Survey

Preliminary Questions [Heading text will not appear in survey]

Before we begin, please answer the questions below.

1. How important are the following for your organization in attracting and retaining quality employees?

Options/Scales

	Not Important At All (1)	(2)	(3)	(4)	Very Important (5)
❑ Health insurance benefits	❍	❍	❍	❍	❍
❑ Company culture	❍	❍	❍	❍	❍
❑ Salary / wages	❍	❍	❍	❍	❍
❑ The types of clients with whom your company works	❍	❍	❍	❍	❍
❑ Geographic location	❍	❍	❍	❍	❍
❑ Company policies (e.g. paid vacation, sick leave, paid tuition, etc)	❍	❍	❍	❍	❍
❑ Company reputation	❍	❍	❍	❍	❍
❑ Other, please specify: [text entry]	❍	❍	❍	❍	❍

[Randomize]
[Required]

---------- Page Break ----------

2. To what degree do you support the Patient Protection and Affordable Care Act, sometimes referred to as "ObamaCare"?

Options/Scales

Single select:

❑ Strongly Oppose
❑ Oppose

- ❑ Neither Oppose nor Support
- ❑ Support
- ❑ Strongly Support

[Required]

The State of Mississippi is considering a solution to improve access to health insurance. The Mississippi Insurance Department wants to build a solution that maximizes the benefit for small businesses and organizations. Your feedback is critical in designing this health insurance solution. Please take 10-12 minutes to honestly and openly answer this survey. Your responses will be aggregated with others and kept completely anonymous.

Screener Questions [Heading text will not appear in survey]

S3. In which state is your company primarily located?

Options/Scales

Single Select

- ❑ Alabama [terminate]
- ❑ Arkansas [terminate]
- ❑ Florida [terminate]
- ❑ Georgia [terminate]
- ❑ Louisiana [terminate]
- ❑ Mississippi
- ❑ North Carolina [terminate]
- ❑ South Carolina [terminate]
- ❑ Tennessee [terminate]
- ❑ Other [terminate]

[Required]

---------- Page Break ----------

S4. In which region of Mississippi do you live (see map)?

Options/Scales

Single Select

- ❑ Northeast (Purple – Olive Branch, Tupelo, Starkville)
- ❑ Northwest (Orange – Clarksdale, Tunica, Greenville)
- ❑ Southwest (Green – Jackson, Vicksburg, Brandon)
- ❑ Southeast (Blue – Hattiesburg, Biloxi, Gulfport)
- ❑ Other [terminate]

[Randomize]
[Required]

S5. What role do you play in your organization's health insurance decisions?

Options/Scales

Single Select

- ❑ 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 [terminate to question S5a]
- ❑ An outside party makes the health insurance decisions for our organization [terminate]
- ❑ We do not offer health insurance to our employees or members

[Required]

---------- Page Break ----------

S5a. Unfortunately, you do not qualify for this survey. However, we would still like input from your organization. Please share the contact information of the individual who makes the health insurance decisions for your organization.

Options/Scales

Open Ended

- ❑ First name: [text entry]
- ❑ Last name: [text entry]
- ❑ Contact telephone number: [text entry]
- ❑ Contact e-mail address: [not required]

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S6. Including you, how many employees are in your organization?

Options/Scales

Single Select

- ❑ Full-time employees
  - ○ None
  - ○ 1-9
  - ○ 10-19
  - ○ 20-29
  - ○ 30-39
  - ○ 40-49
  - ○ 50-99
  - ○ 100 or more [terminate]
- ❑ Part-time employees
  - ○ None
  - ○ 1-9
  - ○ 10-19
  - ○ 20-29
  - ○ 30-39
  - ○ 40-49
  - ○ 50-99
  - ○ 100 or more [terminate]

[If full-time and part-time are both equal to "none," terminate]
[If the "50-99" option is selected on BOTH the full-time and part-time category then terminate]

[Required]

---------- Page Break ----------

Current Health Insurance Situation [Heading text will not appear in survey]

7. Which of the following best describes the health insurance your organization offers?

Options/Scales

Single Select

- ❑ Health insurance offered to full-time and part-time employees [skip to question 9]

- ❑ Health insurance offered only to full-time employees [skip to question 9]
- ❑ Health insurance has never been offered to any employees [skip to question 8]
- ❑ Health insurance is not currently being offered to any employees, but was offered in the past [skip to question 8]

[Randomize options 1 and 2 as a group and randomize 3 and 4 as a group]
[Required]

8. **Suppose you had 100 points of value to distribute to reflect the reasons that best describe your decision NOT to offer health insurance to employees. A reason that most reflects your decision will receive the most points. A reason that least reflects your decision may receive fewer or no points.**

   Please distribute 100 points among the reasons below to describe why you do not offer health insurance. You can give all 100 points to one reason if that is the sole reason you do NOT offer health insurance.
   Your total must sum to 100.

Options/Scales	Total Points
❑ Uncertainty in predicting increases in future health insurance costs	
❑ Complexity in choosing the right health insurance plan for my group	
❑ The financial cost of offering health insurance to our employees	
❑ The time and resources necessary to administer health insurance (e.g. selecting a plan, managing employee concerns, paperwork, etc)	
❑ Our organization can attract and retain quality employees without offering health insurance	
❑ There are liabilities to our organization associated with offering health insurance	
❑ Other, please specify: [text entry]	

[Auto sum column]
[Ask question if respondent does not offer insurance]
[Randomize]
[Required]

---------- Page Break ----------

9. To what extent do you agree or disagree with the following statements?

Options/Scales

	Strongly Disagree (1)	Somewhat Disagree (2)	Neither Agree nor Disagree (3)	Somewhat Agree (4)	Strongly Agree (5)
❑ Sick, unhealthy, or injured employees cost my business more than offering health insurance.	❍	❍	❍	❍	❍
❑ I could not understand the complexities of health insurance without an insurance broker	❍	❍	❍	❍	❍
❑ I support any 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.	❍	❍	❍	❍	❍
❑ The most important characteristic to increasing access to health care is to decrease premium costs	❍	❍	❍	❍	❍

[Randomize]
[Required]

Exchange Specific Questions [Heading text will not appear in survey]

Thank you for your responses. Now we would like to ask you some questions about the health insurance solution the State of Mississippi is considering.

10. Briefly describe your understanding of a health insurance exchange:

Options/Scales

Open Ended

[Open ended text]

[Required]

---------- Page Break ----------

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**

---------- Page Break ----------

11. 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

Options/Scales

	Total Points
❑ More easily compare health insurance plan options	
❑ A 10% decrease in health insurance premiums	
❑ Simplify health insurance enrolment and administration	
❑ Attract and retain the best employees by offering health benefits	

❑ Reduce business costs associated with sick, unhealthy, or injured employees	
❑ Other, please specify: [text entry]	

[Auto sum column]
[Randomize]
[Required]

12. Through which of the following ways would hearing about the Mississippi health insurance exchange <u>most increase</u> your interest?

<u>Select up to 3 options</u>

Options/Scales

<u>Select Three</u>

- ❑ Fellow business owners
- ❑ Health providers (e.g. physicians and nurses)
- ❑ Business and community organizations (e.g. chambers of commerce, Elks Lodge, trade associations, etc)
- ❑ Family, friends, and colleagues
- ❑ Insurance agents or brokers
- ❑ Church, religious group, or pastor
- ❑ State, county, and local leaders
- ❑ Online advertising and e-mails
- ❑ Television advertisement
- ❑ Radio advertisement
- ❑ Direct mail-piece to my office
- ❑ Billboard
- ❑ 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: [text entry]

[Select three]
[Randomize]
[Required]

13. 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?

Options/Scales

Single select:

- ❑ The State of Mississippi should operate the state health insurance exchange
- ❑ The federal government should operate the state health insurance exchange
- ❑ Don't know/undecided

[Randomize]
[Required]

14. 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 plans would you like to see presented in the enrollment process?

Options/Scales

Select Three

- ❑ 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 plans options (most complex)
- ❑ Don't know

[Required]

15. In which of the following ways would your organization most prefer to receive education and information about the health insurance exchange?

Options/Scales

Single Select

- ❑ Website with information tutorials and education videos
- ❑ Town hall meeting conducted by a health exchange expert
- ❑ In-person presentation by an insurance broker or agent
- ❑ Dedicated 24/7 toll-free telephone support and questions answered by an exchange expert

- ❑ Dedicated 24/7 e-mail/chat support and questions answered by an exchange expert
- ❑ Would not utilize any of the above options to learn more about the health insurance exchange
- ❑ Other, please specify: [text entry]

[Randomize – do not randomize the last 2 options]
[Required]

16. How would you <u>most</u> prefer for your organization to <u>enroll annually</u> in a health insurance plan?

Options/Scales

<u>Multiple Select</u>

- ❑ Website enrollment process that has online tutorials and education videos
- ❑ Toll-free telephone call with a health exchange expert who assists employees with enrollment
- ❑ E-mail/chat with a health exchange expert who assists employees with enrollment
- ❑ Paper enrollment application that is filled out individually and returned by mail
- ❑ Health insurance exchange experts who travel to your business and assists employees with enrollment
- ❑ Insurance agent or broker who travels to your business and assists employees with enrollment
- ❑ Other, please specify: [text entry]

[Randomize]
[Required]

17. Individuals vary in the amount they pay attention to these kinds of surveys. Some take them seriously and read each question, while others go very quickly and barely read the questions at all. If you have read this question carefully, please write the word "yes" in the "Other, please specify" box below.

Options/Scales

<u>Single select:</u>

- ❑ Strongly Disagree
- ❑ Disagree
- ❑ Neither Agree nor Disagree
- ❑ Agree
- ❑ Strongly Agree
- ❑ Other, please specify: [text entry]

[Terminate if the respondent does not enter something in the text entry box]

[Randomize]
[Required]

---------- Page Break ----------

18. 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

Options/Scales

Multiple Select

- ❑ Website enrollment process that has online tutorials and education videos (free)
- ❑ Toll-free telephone call with a health exchange expert who assists employees with enrollment ($150 annual fee)
- ❑ E-mail/chat with a health exchange expert who assists employees with enrollment ($100 annual fee)
- ❑ Paper enrollment application that is filled out individually and returned by mail ($100 annual fee)
- ❑ Health insurance exchange experts who travel to your business and assists employees with enrollment ($400 annual fee)
- ❑ Insurance agent or broker who travels to your business and assists employees with enrollment ($500 annual fee)

[Randomize]
[Required]

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19. When comparing health insurance plan options, what are the top two characteristics most important to your organization?

Options/Scales

Top 2 Options:

- ❑ Deductible amount
- ❑ What your plan covers (e.g. the amount your plan covers and what services are covered)
- ❑ Co-pay amount
- ❑ Prescription benefits
- ❑ Monthly premium cost
- ❑ Availability of specialized benefits (e.g. maternity, psychiatric care, eye care, etc)

- ❑ Physician, nurse, or hospital network
- ❑ Customer service quality and availability
- ❑ Other, please specify: [text entry]

[Top 2 Select]
[Randomize]
[Required]

---------- Page Break ----------

Health insurance can be complicated. Many organizations want someone to whom their employees and HR manager can go to with health insurance questions.

20. Which of the following would you select for your group or organization (added to the cost of the monthly premium)?

Select all that apply

Options/Scales

Multiple Select

- ❑ Support from an in-person health insurance exchange expert ($20 per employee per month)
- ❑ Support from an in-person insurance broker ($25 per employee per month)
- ❑ Support from a health insurance exchange expert by 24/7 telephone ($5 per employee per month)
- ❑ Support from a health insurance exchange expert by 24/7 e-mail/chat ($2.50 per employee per month)
- ❑ Support from a health insurance exchange expert by 24/7 e-mail/chat and telephone ($6 per employee per month)
- ❑ Health insurance exchange website with easy to understand FAQs (free)
- ❑ Other, please specify: [text entry]

[Randomize]
[Required]

21. If you were not to utilize an insurance broker, how would you manage health insurance challenges for your small business or organization?

Select all that apply

Options/Scales

Multiple Select

- ❑ Friend, family, or colleague will provide assistance
- ❑ I will contact the health insurance carriers (e.g. BlueCross BlueShield, United Healthcare) for assistance
- ❑ Employees will deal with health insurance issues on their own
- ❑ I will have a human resources employee manage all health insurance challenges and questions
- ❑ I will manage our organization's health insurance challenges and questions on my own
- ❑ The health exchange must provide dedicated 24/7 telephone support with an exchange expert
- ❑ The health exchange must provide dedicated 24/7 e-mail/chat support with an exchange expert
- ❑ Other, please specify: [text entry]
- ❑ I would be willing to pay slightly more for on-going support from an insurance broker

[Randomize]
[Required]

---------- Page Break ----------

22. How interested are you in learning more about Mississippi's health insurance exchange?

Options/Scales

Single Select

- ❑ Not all interested
- ❑ Not interested at all
- ❑ Neither interested nor disinterested
- ❑ Interested
- ❑ Very interested

[Required]

22a. You suggested you were not interested in learning more about Mississippi's health insurance exchange. Which aspects of the health insurance exchange disinterested you and why?

Options/Scales

Open Ended

[Open ended text]

[Required]

22b. You suggested you were interested in learning more about Mississippi's health insurance exchange. Which aspects of the health insurance exchange caused you interest and why?

Options/Scales

Open Ended

[Open ended text]

[Required]

23. In which of the following industries does your business or organization fall?

Options/Scales

Single Select:

- ❑ Agriculture
- ❑ Mining
- ❑ Construction
- ❑ Manufacturing
- ❑ Transportation
- ❑ Wholesale trade
- ❑ Retail Trade
- ❑ Arts, Entertainment, and Recreation
- ❑ Accommodation and Food Services
- ❑ Finance, Insurance, and Real Estate
- ❑ Services
- ❑ Non-Profit Organization
- ❑ Other, please specify: [text entry]

[Randomize]
[Required]

24. How many years has your business been in operation?

Options/Scales

Single Select

- ❑ Less than a year
- ❑ 1-2 years
- ❑ 3-6 years
- ❑ 7-12 years
- ❑ More than 12 years

[Required]

---------- Page Break ----------

25. Join us for a meeting near you!

We will be holding town hall meetings to share more information about the Mississippi health insurance exchange the week of June 20th – 24th. During these meetings, we will share the findings of this and other studies to seek further public feedback about the health insurance exchange.

Please share your contact information below so that we may send you an invitation to a meeting near you.

Options/Scales

Single-Select:

- ❑ First name: [text entry]
- ❑ Last name: [text entry]
- ❑ Street address: [text entry] [not required]
- ❑ City: [text entry] [not required]
- ❑ State: [text entry] [not required]
- ❑ Zip code: [text entry] [not required]
- ❑ Preferred telephone number: [text entry]
- ❑ Preferred e-mail address: [text entry] [not required]

[Required]

Appendix D – Online Individual Survey

Preliminary Questions [Heading text will not appear in survey]

Before we begin, please answer the questions below.

3. How important are the following in <u>your decision to work for an employer</u>?

Options/Scales

	Not Important At All (1)	(2)	(3)	(4)	Very Important (5)
❑ Health insurance benefits	❍	❍	❍	❍	❍
❑ Company culture	❍	❍	❍	❍	❍
❑ Salary / wages	❍	❍	❍	❍	❍
❑ The types of clients with whom the company works	❍	❍	❍	❍	❍
❑ Geographic location	❍	❍	❍	❍	❍
❑ Company policies (e.g. paid vacation, sick leave, paid tuition, etc)	❍	❍	❍	❍	❍
❑ Company reputation	❍	❍	❍	❍	❍
❑ Other, please specify: [text entry]	❍	❍	❍	❍	❍

[Randomize]
[Required]

4. To what degree do you support the Patient Protection and Affordable Care Act, sometimes referred to as "ObamaCare"?

Options/Scales

<u>Single select:</u>

- ❑ Strongly oppose
- ❑ Oppose
- ❑ Neither oppose nor support
- ❑ Support
- ❑ Strongly support

[Required]

---------- Page Break ----------

Screener Questions [Heading text will not appear in survey]

S3. In which state do you reside?
Options/Scales
Single Select ❑ Alabama [terminate] ❑ Arkansas [terminate] ❑ Florida [terminate] ❑ Georgia [terminate] ❑ Louisiana [terminate] ❑ Mississippi ❑ North Carolina [terminate] ❑ South Carolina [terminate] ❑ Tennessee [terminate] ❑ Other [terminate] [Required]

---------- Page Break ----------

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 employees and 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.

---------- Page Break ----------

S4. In which region of Mississippi do you live (see map)?
Options/Scales

Single Select

- ❑ Northeast (Purple – Olive Branch, Tupelo, Starkville)
- ❑ Northwest (Orange – Clarksdale, Tunica, Greenville)
- ❑ Southwest (Green – Jackson, Vicksburg, Brandon)
- ❑ Southeast (Blue – Hattiesburg, Biloxi, Gulfport)
- ❑ Other [terminate]

[Randomize]
[Required]

S5. In which city do you live?
Please spell the full name of the city

Options/Scales

Open-ended

[Open ended text]

[Required]

S6. Which of the following best describes your current employment status?

Options/Scales

Single-select

- ❑ Employed full-time
- ❑ Employed part-time
- ❑ Not employed
- ❑ Retired
- ❑ Other, please specify: [text entry]

[Required]

S7. Are you:

Options/Scales

Single-select

- ❑ Male
- ❑ Female
- ❑ Prefer not to answer

[Required]

S8. What is your age?

Options/Scales

Single-select

- ❑ Under 18 [terminate]
- ❑ 18-24
- ❑ 25-29
- ❑ 30-34
- ❑ 35-44
- ❑ 45-54
- ❑ 55-64
- ❑ 65 and older [terminate]

[Required]

S9. Which of the following best describes your ethnicity?

Options/Scales

Single-select

- ❑ White
- ❑ Black or African American
- ❑ Asian
- ❑ American Indian or Alaskan Native
- ❑ Native Hawaiian or Other Pacific Islander
- ❑ Hispanic or Latino
- ❑ Other, please specify: [text entry]
- ❑ Prefer not to answer

[Randomize]
[Required]

S10. In 2010, what was your household income before taxes?

Options/Scales

Single-select

- ❑ $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

[Required]

---------- Page Break ----------

Current Health Insurance Situation [Heading text will not appear in survey]

9. Do you currently have health insurance?

Options/Scales

Single-select

- ❑ Yes, I currently have health insurance [skip to question 11]
- ❑ No, I do not currently have health insurance [skip to question 13]

[Required]

---------- Page Break ----------

10. How did you decide on your health insurance plan?

Options/Scales

Single select:

- ❑ I alone made the decision
- ❑ I made the decision with my spouse or partner
- ❑ I took whatever my employer was offering
- ❑ An outside party (insurer, broker, etc) made the decision for me
- ❑ I signed up for whatever my family was currently on
- ❑ I receive government health care (e.g. Medicaid, Medicare) [skip to question 13]
- ❑ Other, please specify: [text entry]

[Ask if respondent has health insurance]
[Randomize]
[Required]

11. How much do you agree with the following statements?

Options/Scales

	Strongly Disagree (1)	Somewhat Disagree (2)	Neutral (3)	Somewhat Agree (4)	Strongly Agree (5)	Not Applicable (6)
❑ I trust the health insurance plan my employer offers	❍	❍	❍	❍	❍	❍
❑ I wish I was in charge of choosing my own health insurance plan	❍	❍	❍	❍	❍	❍
❑ I would need assistance if I were to choose my own health insurance (e.g. broker, online tutorials, etc)	❍	❍	❍	❍	❍	❍
❑ An insurance broker would enrol me in the best possible plan that met my needs	❍	❍	❍	❍	❍	❍
❑ If I needed help in enrolling in a health insurance plan, I would prefer an online tutorial to telephone support	❍	❍	❍	❍	❍	❍
❑ I would have a better understanding of my health insurance plan if I chose it	❍	❍	❍	❍	❍	❍

[Randomize]
[Required]

---------- Page Break ----------
-

12. Suppose you had 100 points to distribute among the reasons that describe <u>why you do not currently have health insurance</u>. A reason that was a larger factor in why you don't have insurance would receive more points. A reason that was a smaller factor would receive fewer or no points.

<u>Please distribute 100 points among the reasons below to describe why you do not currently have health insurance.</u>

Your total must sum to 100

Options/Scales	
	Total Points
❑ Too expensive	
❑ Complicated enrolment process	
❑ I do not qualify for insurance	
❑ Lack of quality health plans	
❑ I'm in perfect health	
❑ My employer does not offer health insurance	
❑ Other, please specify: [text entry]	

[Auto sum column]
[Ask if respondent DOES NOT have health insurance]
[Randomize]
[Required]

---------- Page Break ----------

Exchange Specific Questions [Heading text will not appear in survey]

13. Briefly describe your understanding of a health insurance exchange?

Options/Scales

<u>Open Ended</u>

[Open ended text]
[Required]

---------- Page Break ----------

A health insurance exchange is a marketplace where individuals can compare and purchase a variety of plans from different insurance companies.

The goals of a health insurance exchange are to:

- **Increase the accessibility of health insurance to individuals**
- **Reduce the number of individuals without health insurance**
- **Increase transparency in the health insurance market**
- **Increase competition among insurers**

14. 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

Options/Scales	Total Points
❑ More easily compare health insurance plans	
❑ A 10% decrease in health insurance premiums	
❑ Simplify health insurance enrolment	
❑ High quality health insurance	
❑ Increased access to health insurance	
❑ Other, please specify: [text entry]	

[Auto sum column]
[Randomize]
[Required]

---------- Page Break ----------

15. Through which of the following ways would hearing about the Mississippi health insurance exchange most increase your interest?

Select up to 3 options

Options/Scales

Select Three

- ❑ Employer
- ❑ Health providers (e.g. physicians and nurses)
- ❑ Community organizations (e.g. community health center, YMCA/YWCA, local non-profits, etc)
- ❑ Family, friends, and colleagues
- ❑ Insurance agents or brokers
- ❑ Church, religious group, or pastor
- ❑ State, county, and local leaders
- ❑ Online advertising and e-mails
- ❑ Television advertisement
- ❑ Radio advertisement
- ❑ Direct mail-piece to my office
- ❑ Billboard
- ❑ 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: [text entry]

[Select three]
[Randomize]
[Required]

---------- Page Break ----------

16. 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?

Options/Scales

Single select:

- ❑ The State of Mississippi should operate the state health insurance exchange
- ❑ The federal government should operate the state health insurance exchange
- ❑ Don't know/undecided

[Randomize]
[Required]

17. 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 you, how many plan options would you like to see presented in the enrollment process?

Options/Scales

Select Three

- ❑ 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

[Required]

18. In which of the following ways would you most prefer to receive education and information about the health insurance exchange?

Options/Scales

Single-select

- ❑ Website with information tutorials and education videos
- ❑ Town hall meeting conducted by a health exchange expert
- ❑ In-person presentation by an insurance broker or agent
- ❑ Dedicated 24/7 toll-free telephone support with questions answered by an exchange expert
- ❑ Dedicated 24/7 e-mail/chat support with questions answered by an exchange expert
- ❑ Would not utilize any of the above options to learn more about the health insurance exchange
- ❑ Other, please specify: [text entry]

[Required]
[Randomized]

19. How would you <u>most prefer</u> to <u>enroll annually</u> in a health insurance plan?

Options/Scales

<u>Single Select</u>

- ❑ Website enrollment process that has online tutorials and education videos
- ❑ Toll-free telephone call with a health exchange expert who assists with enrollment
- ❑ E-mail/chat with a health exchange expert who assists with enrollment
- ❑ Paper enrollment application that is filled out and returned by mail
- ❑ Health exchange experts who travel to assists with enrollment
- ❑ Insurance agent or broker who travels to assist with enrollment
- ❑ Other, please specify: [text entry]

[Randomize]
[Required]

20. Individuals vary in the amount they pay attention to these kinds of surveys. Some take them seriously and read each question, while others go very quickly and barely read the questions at all. If you have read this question carefully, please write the word "yes" in the "Other, please specify" box below.

Options/Scales

<u>Single select:</u>

- ❑ Strongly Disagree
- ❑ Disagree
- ❑ Neither Agree nor Disagree
- ❑ Agree
- ❑ Strongly Agree
- ❑ Other, please specify: [text entry]

[Terminate if the respondent does not enter something in the text entry box]
[Randomize]
[Required]

---------- Page Break ----------

21. 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

Options/Scales

Single Select

- ❑ Website enrollment process that has online tutorials and education videos (free)
- ❑ Toll-free telephone call with a health exchange expert who assists with enrollment ($150 annual fee)
- ❑ E-mail/chat with a health exchange expert who assists with enrollment ($100 annual fee)
- ❑ Paper enrollment application that is filled out and returned by mail ($100 annual fee)
- ❑ Health insurance exchange expert who travel and assists with enrollment ($400 annual fee)
- ❑ Insurance agent or broker who travels and assists with enrollment ($500 annual fee)

[Randomize]
[Required]

22. When comparing health insurance plans, what are the top two characteristics you consider?

Options/Scales

Top 2 Options:

- ❑ Deductible amount
- ❑ What your plan covers (e.g. what services are covered)
- ❑ Co-pay amount
- ❑ Prescription benefits
- ❑ Monthly premium cost
- ❑ Availability of specialized benefits (e.g. maternity, psychiatric care, eye care, etc)
- ❑ Physician, nurse, or hospital network
- ❑ Customer service quality and availability
- ❑ Other, please specify: [text entry]

[Top 2 Select]
[Randomize]
[Required]

Health insurance can be complicated. Many individuals want someone to whom they can go to with health insurance questions.

23. Which of the following would you select (added to the cost of the monthly premium)?

Select all that apply

Options/Scales

Multiple Select

- ❑ Support from an in-person health exchange expert ($20 per employee per month)
- ❑ Support from an in-person insurance broker ($25 per employee per month)
- ❑ Support from a health exchange expert by 24/7 telephone ($5 per employee per month)
- ❑ Support from a health exchange expert by 24/7 e-mail/chat ($2.50 per employee per month)
- ❑ Support from a health exchange expert by 24/7 e-mail/chat and telephone ($6 per employee per month)
- ❑ Health exchange website with easy to understand FAQs (free)
- ❑ Other, please specify: [text entry]

[Randomize]
[Required]

24. If you were not to utilize an insurance broker, how would you manage health insurance challenges?

Select all that apply

Options/Scales

Multiple Select

- ❑ Friend, family, or colleague will provide assistance
- ❑ I will contact the health insurance carriers (e.g. BlueCross BlueShield, United Healthcare) for assistance
- ❑ I would speak directly to my employer with questions
- ❑ My company has a human resources department I would contact
- ❑ The health exchange must provide dedicated 24/7 telephone support with an exchange expert
- ❑ The health exchange must provide dedicated 24/7 e-mail/chat support with an exchange expert
- ❑ Other, please specify: [text entry]
- ❑ I would be willing to pay slightly more for on-going support from an insurance broker

[Randomize]
[Required]

25. How interested are you in learning more about Mississippi's health insurance exchange?

Options/Scales

Single Select

- ❑ Not interested at all
- ❑ Disinterested
- ❑ Neither interested nor disinterested
- ❑ Interested
- ❑ Very interested

[Required]

25a. You suggested you were not interested in learning more about Mississippi's health insurance exchange. Which aspects of the health insurance exchange disinterested you and why?

Options/Scales

Open Ended

[Open ended text]

[Required]

25b. You suggested you were interested in learning more about Mississippi's health insurance exchange. Which aspects of the health insurance exchange caused you interest and why?

Options/Scales

Open Ended

[Open ended text]

[Required]

Appendix E –Small Group Online Survey Results

Mississippi Health Insurance Exchange Survey (Small Business Owners)	Total Column % (& others)
Q1. How important are the following for your organization in attracting and retaining quality employees?	
Top Box Scores (4-5)	
Sample Size	**399**
Salary / wages	88%
Company reputation	87%
Company culture	72%
Health insurance benefits	70%
Company policies (e.g. paid vacation, sick leave, paid tuition, etc)	68%
The types of clients with whom the company works	60%
Geographic location	57%
Q1. How important are the following for your organization in attracting and retaining quality employees?	
Health insurance benefits	
Sample Size	**399**
Not At All Important - 1	7%
2	8%
3	16%
4	31%
Very Important - 5	39%
Mean	**3.88**
Company culture	
Sample Size	**399**
Not At All Important - 1	4%
2	5%
3	19%
4	40%
Very Important - 5	32%
Mean	**3.92**
Salary / wages	
Sample Size	**399**
Not At All Important - 1	1%
2	2%

3	9%
4	37%
Very Important - 5	51%
Mean	**4.34**
The types of clients with whom the company works	
Sample Size	**399**
Not At All Important - 1	6%
2	12%
3	22%
4	33%
Very Important - 5	27%
Mean	**3.63**
Geographic location	
Sample Size	**399**
Not At All Important - 1	6%
2	9%
3	28%
4	33%
Very Important - 5	24%
Mean	**3.61**
Company policies (e.g. paid vacation, sick leave, paid tuition, etc.)	
Sample Size	**399**
Not At All Important - 1	6%
2	6%
3	20%
4	38%
Very Important - 5	31%
Mean	**3.82**
Company reputation	
Sample Size	**399**
Not At All Important - 1	2%
2	2%
3	9%
4	30%
Very Important - 5	57%
Mean	**4.37**
Q2. To what degree do you support the Patient Protection and Affordable Care Act?	
Top Box Scores	
Sample Size	**399**
Support (4-5)	15%

Oppose (1-2)	71%
Q2. To what degree do you support the Patient Protection and Affordable Care Act?	
Sample Size	**399**
Strongly Oppose-1	56%
Oppose-2	15%
Undecided-3	14%
Support-4	8%
Strongly Support-5	7%
Mean	**1.95**
Q9. What role do you play in your organization's health insurance decisions?	
Sample: Excludes Advocates, Health Providers, Insurance Agents | Phone survey participants were not asked this question	
Sample Size	**332**
I alone make the health insurance decisions for our organization	32%
I, along with a small group of other leaders in our organization, make the health insurance decisions for our organization	27%
We do not offer health insurance to our employees or members	24%
Others within the organization present health insurance options, but I make the final health insurance decisions	11%
Another individual(s) within our organization makes the health insurance decisions	4%
An outside party makes the health insurance decisions for our organization	1%
Q10. Including you, how many employees are in your organization?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Full-Time Employees	
Sample Size	**380**
None	0%
1-9	52%
10-19	20%
20-29	9%
30-39	3%
40-49	2%
50-99	14%
100 or more	0%
Part-Time Employees	
Sample Size	**380**
None	32%
1-9	56%
10-19	5%

20-29	2%
30-39	1%
40-49	1%
50-99	1%
100 or more	1%
Q11. Which of the following best describes the health insurance your organization offers?	
Sample Size	399
Health insurance is offered to full-time and part-time employees	7%
Health insurance is offered only to full-time employees	56%
Health insurance has never been offered to any employees	23%
Health insurance is not currently being offered to any employees, but was offered in the past	14%
Q12. Suppose you had 100 points of value to distribute to reflect the reasons that best describe your decision NOT to offer health insurance to employees. A reason that most reflects your decision will receive the most points. A reason that least reflects your decision may receive fewer or no points.	
Sample: Includes Advocates, Health Providers, Insurance Agents, Non-Health Insurance Offering Businesses	
Sample Size	160
The financial cost of offering health insurance to our employees	61.11
Other	9.31
Uncertainty in predicting increases in future health insurance costs	9.24
Our organization can attract and retain quality employees without offering health insurance	8.74
The time and resources necessary to administer health insurance (e.g. selecting a plan, managing	4.73
Complexity in choosing the right health insurance plan for my group	3.84
There are liabilities to our organization associated with offering health insurance	3.06
Q13. To what extent do you agree or disagree with the following statements?	
Top Box Scores (4-5)	
Sample Size	399
The most important characteristic to increasing access to health care is to decrease premium costs	81%
Increasing access to health insurance is critical to economic growth in Mississippi	73%
I support a solution sponsored by Mississippi to improve access to health insurance	70%
I could not understand the complexities of health insurance without an insurance broker	50%
Sick, unhealthy, or injured employees cost my business more than offering health insurance	32%

It is currently easy to compare the different health plan options available to Mississippians	27%
Q13. To what extent do you agree or disagree with the following statements?	
Sick, unhealthy, or injured employees cost my business more than offering health insurance	
Sample Size	**399**
Strongly Disagree-1	20%
Somewhat Disagree-2	18%
Neither Agree nor Disagree-3	31%
Somewhat Agree-4	20%
Strongly Agree-5	12%
Mean	**2.87**
I could not understand the complexities of health insurance without an insurance broker	
Sample Size	**399**
Strongly Disagree-1	15%
Somewhat Disagree-2	18%
Neither Agree nor Disagree-3	18%
Somewhat Agree-4	25%
Strongly Agree-5	25%
Mean	**3.27**
I support a solution sponsored by Mississippi to improve access to health insurance	
Sample Size	**399**
Strongly Disagree-1	5%
Somewhat Disagree-2	7%
Neither Agree nor Disagree-3	19%
Somewhat Agree-4	37%
Strongly Agree-5	33%
Mean	**3.86**
It is currently easy to compare the different health plan options available to Mississippians	
Sample Size	**399**
Strongly Disagree-1	23%
Somewhat Disagree-2	31%
Neither Agree nor Disagree-3	20%
Somewhat Agree-4	19%
Strongly Agree-5	8%
Mean	**2.58**
Increasing access to health insurance is critical to economic growth in Mississippi	
Sample Size	**399**
Strongly Disagree-1	4%
Somewhat Disagree-2	8%

Neither Agree nor Disagree-3	16%
Somewhat Agree-4	40%
Strongly Agree-5	33%
Mean	**3.91**
The most important characteristic to increasing access to health care is to decrease premium costs	
Sample Size	**399**
Strongly Disagree-1	2%
Somewhat Disagree-2	6%
Neither Agree nor Disagree-3	11%
Somewhat Agree-4	33%
Strongly Agree-5	48%
Mean	**4.20**
Q14. Briefly describe your understanding of a health insurance exchange.	
Variable(s): Postcoded	
Sample Size	**399**
Understands	11%
Limited Understanding	22%
Doesn't Understand	67%
Q15. 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.	
Sample: Excludes Phone Survey Participants	
Sample Size	**351**
A 10% decrease in health insurance premiums	32.61
Attract and retain the best employees by offering health benefits	18.95
More easily compare health insurance plan options	14.66
Reduce business costs associated with sick, unhealthy, or injured employees	13.68
Simplify health insurance enrollment and administration	13.60
Other	6.50
Q16. Which ways would hearing about the Mississippi health insurance exchange most increase your interest?	
Top 3 Multiple Response Question	
Sample Size	**349**
Insurance agents or brokers	41%
Direct mail-piece to my office	35%
Business and community organizations (e.g. chambers of commerce, Elks Lodge, trade associations, etc.)	27%

Fellow business owners	27%
Health providers (e.g. physicians and nurses)	19%
Online advertising and e-mails	18%
Television advertisement	17%
Article or special report in the news	17%
State, county, and local leaders	14%
Family, friends, and colleagues	12%
Print advertisement	10%
Radio advertisement	5%
Health exchange enrollment bus in your town	4%
Other	3%
Church, religious group, or pastor	2%
Read about it at a community center (e.g. post office, library, etc)	2%
Billboard	1%
Q17. 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?	
Sample Size	**399**
The State of Mississippi should operate the state health insurance exchange	77%
The federal government should operate the state health insurance exchange	5%
Don't know / undecided	18%
Q18. 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.	
Sample Size	**399**
Three or fewer health plan options (most simple)	43%
Four to eight health plan options (moderately simple)	36%
Nine to twelve health plan options (moderately complex)	5%
All health plan options (most complex)	13%
Don't know	4%
Q19. In which of the following ways would your organization most prefer to receive education and information about the health insurance exchange?	
Sample Size	**399**
In-person presentation by an insurance broker or agent	40%
Health insurance exchange website with information tutorials and education videos	36%
Dedicated 24/7 toll-free telephone support with questions answered by a health insurance exchange expert	10%

Dedicated 24/7 e-mail/chat support with questions answered by a health insurance exchange expert	7%
Would not utilize any of the above options to learn more about the health insurance exchange	4%
Town hall meeting conducted by a health insurance exchange expert	3%
Other	1%
Q20. How would you most prefer for your organization to enroll annually in a health insurance plan?	
Sample Size	399
Insurance agent or broker who travels to your business and assists employees with enrollment	37%
Health insurance exchange website enrollment process that has online tutorials and education videos	28%
Health insurance exchange experts who travel to your business and assists employees with enrollment	16%
Paper enrollment application that is filled out individually and returned by mail	7%
E-mail/chat with a health insurance exchange expert who assists employees with enrollment	6%
Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment	4%
Other	3%
Q22. Now suppose you had the same options as the previous question, but the following fees apply.	
Sample Size	399
Health insurance exchange website enrollment process that has online tutorials and education videos (free)	58%
Insurance agent or broker who travels to your business and assists employees with enrollment ($500 annual fee)	15%
E-mail/chat with a health insurance exchange expert who assists employees with enrollment ($100 annual fee)	7%
Toll-free telephone call with a health insurance exchange expert who assists employees with enrollment ($150 annual fee)	7%
Paper enrollment application that is filled-out individually and returned by mail ($100 annual fee)	7%
Health insurance exchange experts who travel to your business and assists employees with enrollment ($400 annual fee)	6%
Q23. When comparing health insurance plan options, what are the top two characteristics most important to your organization?	
Top 2 Multiple Response Question	
Sample Size	399
Monthly premium cost	75%

What your plan covers (e.g. what services are covered)	43%
Deductible amount	26%
Physician, nurse, or hospital network	16%
Co-pay amount	15%
Prescription benefits	10%
Customer service quality and availability	6%
Other	5%
Availability of specialized benefits (e.g. maternity, psychiatric care, eye care, etc.)	3%
Q24. Many organizations want someone to whom their employees and HR manager can go to with questions.	
Sample Size	**399**
Health insurance exchange website with easy to understand FAQs (free)?	46%
Support from a health insurance exchange expert by 24/7 e-mail/chat ($2.50 per employee per m	16%
Support from a health insurance exchange expert by 24/7 telephone ($5 per employee per month)	11%
Support from a health insurance exchange expert by 24/7 e-mail/chat and telephone ($6 per employee per month)	10%
Support from an in-person insurance broker ($25 per employee per month)?	9%
Other	5%
Support from an in-person health insurance exchange expert ($20 per employee per month)?	2%
Q25. If you were not to utilize an insurance broker, how would you manage health insurance challenges?	
Sample Size	**399**
The health insurance exchange must provide dedicated 24/7 telephone support with an exchange expert	18%
I will contact the health insurance carriers (e.g. BlueCross BlueShield, United Health Care, etc) for assistance	18%
The health insurance exchange must provide dedicated 24/7 e-mail/chat support with an exchange expert	17%
I would be willing to pay slightly more for on-going support from an insurance broker	11%
Employees will deal with health insurance issues on their own	11%
I will manage our organization's health insurance challenges and questions on my own	10%
I will have a human resources employee manage all health insurance challenges and questions	9%
Other	4%
Friend, family, or colleague will provide assistance	2%
Q26. How interested are you in learning more about Mississippi's health insurance exchange?	

Top Box Scores	
Sample Size	399
Interested (4-5)	73%
Disinterested (1-2)	8%
Q26. How interested are you in learning more about Mississippi's health insurance exchange?	
Sample Size	399
Not interested at all - 1	6%
Disinterested - 2	3%
Neither interested nor disinterested - 3	19%
Interested - 4	45%
Very interested - 5	28%
Mean	3.87
Q26a. You suggested you were not interested in learning more about Mississippi's health insurance exchange. Reasons	
Variable(s): Postcoded	
Sample Size	399
Don't understand/complexity	4%
Don't support / high cost	11%
Currently satisfied with health insurance	2%
Don't know / did not provide response	83%
Q26b. You suggested you were interested in learning more about Mississippi's health insurance exchange. Reasons	
Variable(s): Postcoded	
Sample Size	399
Limited knowledge	29%
Don't know / did not provide response	28%
Cost savings	23%
Simplicity	6%
Other	6%
Increased quality	4%
Want to obtain health insurance	4%

Small Business Demographics	Total Column % (& others)
Q3. In which state is your company primarily located?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	399
Alabama	0%

Arkansas	0%
Florida	0%
Georgia	0%
Louisiana	0%
Mississippi	100%
North Carolina	0%
South Carolina	0%
Tennessee	0%
Other	0%
Q8. In which region of Mississippi do you live?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	**399**
Northeast (e.g. Olive Branch, Tupelo, Starkville)	30%
Northwest (e.g. Clarksdale, Tunica, Greenville)	18%
Southwest (e.g. Jackson, Vicksburg, Brandon)	31%
Southeast (e.g. Hattiesburg, Biloxi, Gulfport)	21%
Other	0%
Q27. In which of the following industries does your business or organization fall?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	**399**
Agriculture	1%
Mining	0%
Construction	9%
Manufacturing	6%
Transportation	3%
Wholesale trade	2%
Retail Trade	16%
Arts, Entertainment, and Recreation	1%
Accommodation and Food Services	4%
Finance, Insurance, and Real Estate	10%
Services	22%
Non-Profit Organization	8%
Other, please specify:	19%
Q28. How many years has your business been in operation?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	**399**
Less than a year	3%
1-2 years	8%
3-6 years	10%
7-12 years	11%
More than 12 years	69%

Appendix F – Individual Online Survey Results

Mississippi Health Insurance Exchange Survey (Individuals)	Total Column % (& others)
Q1. How important are the following in your decision to work for an employer?	
Top Box Scores (4-5)	
Sample Size	**662**
Salary / wages	91%
Health insurance benefits	82%
Company policies (e.g. paid vacation, sick leave, paid tuition, etc)	81%
Company reputation	78%
Geographic location	76%
Company culture	64%
The types of clients with whom the company works	59%
Q1. How important are the following in your decision to work for an employer?	
Health insurance benefits	
Sample Size	**662**
Not At All Important - 1	4%
2	4%
3	10%
4	26%
Very Important - 5	57%
Mean	**4.28**
Company culture	
Sample Size	**662**
Not At All Important - 1	6%
2	7%
3	23%
4	32%
Very Important - 5	32%
Mean	**3.78**
Salary / wages	
Sample Size	**662**
Not At All Important - 1	2%
2	1%
3	6%
4	22%
Very Important - 5	70%
Mean	**4.56**

The types of clients with whom the company works	
Sample Size	662
Not At All Important - 1	7%
2	8%
3	26%
4	30%
Very Important - 5	29%
Mean	3.66
Geographic location	
Sample Size	662
Not At All Important - 1	4%
2	4%
3	16%
4	27%
Very Important - 5	48%
Mean	4.12
Company policies (e.g. paid vacation, sick leave, paid tuition, etc.)	
Sample Size	662
Not At All Important - 1	3%
2	4%
3	12%
4	33%
Very Important - 5	48%
Mean	4.19
Company reputation	
Sample Size	662
Not At All Important - 1	4%
2	3%
3	16%
4	34%
Very Important - 5	44%
Mean	4.12
Q2. To what degree do you support the Patient Protection and Affordable Care Act?	
Excluded Variable(s): Don't Know	
Top Box Scores	
Sample Size	648
Support (4-5)	27%
Oppose (1-2)	42%
Q2. To what degree do you support the Patient Protection and Affordable Care Act?	
Excluded Variable(s): Don't Know	

Top Box Scores	
Sample Size	648
Strongly Oppose-1	26%
Oppose-2	16%
Undecided-3	31%
Support-4	14%
Strongly Support-5	13%
Mean	2.72
Q10. Do you currently have health insurance?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	642
Yes, I currently have health insurance	78%
No, I do not currently have health insurance	22%
Q11. How did you decide on your health insurance plan?	
Sample: Includes only those who currently have health insurance	
Sample Size	520
I took whatever my employer was offering	64%
I alone made the decision	12%
I made the decision with my spouse or partner	12%
I signed up for whatever my family was currently on	5%
I receive government health care (e.g. Medicaid, Medicare)	3%
Other	3%
An outside party (insurer, broker, etc) made the decision for me	1%
Q12. How much do you agree or disagree with the following statements?	
Top Box Scores (4-5)	
I trust the health insurance plan my employer offers	72%
I would have a better understanding of my health insurance plan if I chose it	64%
I wish I was in charge of choosing my own health insurance plan	60%
I would need assistance if I were to choose my own health insurance (e.g. broker, online tutorials, etc)	58%
If I needed help in enrolling in a health insurance plan, I would prefer an online tutorial to telephone support	47%
An insurance broker would enroll me in the best possible plan that met my needs	34%
Q12. How much do you agree or disagree with the following statements?	
Excluded Variable(s): Not Applicable, Don't Know	
I trust the health insurance plan my employer offers	
Sample Size	474
Strongly Disagree-1	4%
Somewhat Disagree-2	8%

Neither Agree nor Disagree-3	16%
Somewhat Agree-4	41%
Strongly Agree-5	31%
Mean	**3.88**
I wish I was in charge of choosing my own health insurance plan	
Sample Size	**462**
Strongly Disagree-1	6%
Somewhat Disagree-2	6%
Neither Agree nor Disagree-3	27%
Somewhat Agree-4	28%
Strongly Agree-5	32%
Mean	**3.73**
I would need assistance if I were to choose my own health insurance (e.g. broker, online tutorials, etc)	
Sample Size	**487**
Strongly Disagree-1	10%
Somewhat Disagree-2	15%
Neither Agree nor Disagree-3	17%
Somewhat Agree-4	28%
Strongly Agree-5	30%
Mean	**3.54**
An insurance broker would enroll me in the best possible plan that met my needs	
Sample Size	**476**
Strongly Disagree-1	14%
Somewhat Disagree-2	17%
Neither Agree nor Disagree-3	34%
Somewhat Agree-4	24%
Strongly Agree-5	11%
Mean	**3.01**
If I needed help in enrolling in a health insurance plan, I would prefer an online tutorial to telephone support	
Sample Size	**481**
Strongly Disagree-1	12%
Somewhat Disagree-2	18%
Neither Agree nor Disagree-3	23%
Somewhat Agree-4	25%
Strongly Agree-5	22%
Mean	**3.28**
I would have a better understanding of my health insurance plan if I chose it	
Sample Size	**482**
Strongly Disagree-1	4%

Somewhat Disagree-2	8%
Neither Agree nor Disagree-3	24%
Somewhat Agree-4	30%
Strongly Agree-5	33%
Mean	**3.81**

Q13. Suppose you had 100 points to distribute among the reasons that describe why you do not currently have health insurance. A reason that was a larger factor in why you don't have insurance would receive more points. A reason that was a smaller factor would receive fewer or no points.

Sample: Excludes participants that have health insurance	
Sample Size	**162**
Too expensive	50.85
My employer does not offer health insurance	23.70
I do not qualify for insurance	7.07
I'm in perfect health	7.02
Other	5.29
Lack of quality health plans	3.75
Complicated enrollment process	2.39

Q14. Briefly describe your understanding of a health insurance exchange.

Variable(s): Postcoded	
Sample Size	**662**
Understands	7%
Limited Understanding	16%
Doesn't Understand	77%

Q15. 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.

Sample Size	**662**
High quality health insurance	31.00
A 10% decrease in health insurance premiums	28.25
Increased access to health insurance	15.37
More easily compare health insurance plans	11.70
Simplify health insurance enrollment	11.19
Other	2.49

Q16. Through which of the following ways would hearing about the Mississippi health exchange most increase your interest?

Top 3 Multiple Response Question	
Sample Size	**662**
Employer	46%

Health providers (e.g. physicians and nurses)	35%
Family, friends, and colleagues	29%
Television advertisement	27%
Article or special report in the news	24%
Direct mail-piece to my office	18%
Print advertisement	16%
State, county, and local leaders	15%
Online advertising and e-mails	14%
Insurance agents or brokers	11%
Radio advertisement	10%
Church, religious group, or pastor	9%
Community organizations (e.g. community health center, YMCA/YWCA, local non-profits, etc)	6%
Health exchange enrollment bus in your town	5%
Other	4%
Billboard	3%
Read about it at a community center (e.g. post office, library, etc)	3%
Q17. 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?	
Sample Size	**662**
The State of Mississippi should operate the state health insurance exchange	53%
The federal government should operate the state health insurance exchange	19%
Don't know/ undecided	29%
Q18. 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 plans presented the more complex the enrollment process. Making the enrollment presentation simple may reduce the number of plans presented.	
Sample Size	**662**
Three or fewer health plan options (most simple)	27%
Four to eight health plan options (moderately simple)	42%
Nine to twelve health plan options (moderately complex)	8%
All health plan options (most complex)	17%
Don't know	6%
Q19. In which of the following ways would you most prefer to receive education and information about the health insurance exchange?	
Sample Size	**662**
Website with information tutorials and education videos	39%
In-person presentation by an insurance broker or agent	24%

Dedicated 24/7 toll-free telephone support with questions answered by an exchange expert	16%
Dedicated 24/7 e-mail/chat support with questions answered by an exchange expert	8%
Town hall meeting conducted by a health exchange expert	5%
Would not utilize any of the above options to learn more about the health insurance exchange	5%
Other	4%
Q20. How would you most prefer to enroll annually in a health insurance plan?	
Sample Size	662
Website enrollment process that has online tutorials and education videos	44%
Insurance agent or broker who travels to assist with enrollment	17%
Paper enrollment application that is filled out individually and returned by mail	15%
Health exchange experts who travel to assist with enrollment	10%
Toll-free telephone call with a health exchange expert who assists with enrollment	6%
E-mail/chat with a health exchange expert who assists with enrollment	6%
Other	2%
Q22. Now suppose you had the same options as the previous question, but the following fees apply.	
Sample Size	662
Website enrollment process that has online tutorials and education videos (free)	70%
Paper enrollment application that is filled out individually and returned by mail ($100 annual fee)	9%
E-mail/chat with a health exchange expert who assists with enrollment ($100 annual fee)	6%
None of the above	5%
Toll-free telephone call with a health exchange expert who assists with enrollment ($150 annual fee)	5%
Insurance agent or broker who travels and assists with enrollment ($500 annual fee)	3%
Health exchange expert who travels and assists with enrollment ($400 annual fee)	2%
Q23. When comparing health insurance plans, what are the top two characteristics you consider?	
Top 2 Multiple Response Question	
Sample Size	662
Monthly premium cost	59%
What your plan covers (e.g. what services are covered)	47%
Deductible amount	28%
Co-pay amount	27%
Physician, nurse, or hospital network	13%

Prescription benefits	12%
Availability of specialized benefits (e.g. maternity, psychiatric care, eye care, etc.)	9%
Customer service quality and availability	3%
Other	1%
Q24. Many individuals want someone to whom they can go to with health insurance questions.	
Sample Size	**662**
Health exchange website with easy to understand FAQs (free)	56%
Support from a health exchange expert by 24/7 telephone ($5 per month)	13%
Support from a health exchange expert by 24/7 e-mail/chat ($2.50 per month)	12%
Support from a health exchange expert by 24/7 e-mail/chat and telephone ($6 per month)	11%
Support from an in-person health exchange expert ($20 per month)	3%
Support from an in-person insurance broker ($25 per month)	3%
Other	2%
Q25. If you were not to utilize an insurance broker, how would you manage health insurance challenges?	
Sample Size	**662**
I will contact the health insurance carriers (e.g. BlueCross BlueShield, United Healthcare) for assistance	26%
The health exchange must provide dedicated 24/7 telephone support with an exchange expert	17%
My company has a human resources department I would contact	15%
The health exchange must provide dedicated 24/7 e-mail/chat support with an exchange expert	12%
I would speak directly to my employer with questions	12%
Friend, family, or colleague will provide assistance	7%
Other	5%
I will manage our organization's health insurance challenges and questions on my own	5%
I would be willing to pay slightly more for on-going support from an insurance broker	2%
Q26. How interested are you in learning more about Mississippi's health insurance exchange?	
Top Box Scores	
Sample Size	**662**
Interested (4-5)	64%
Disinterested (1-2)	13%
Q26. How interested are you in learning more about Mississippi's health insurance exchange?	
Sample Size	**662**
Not interested at all - 1	8%

Disinterested - 2	5%
Neither interested nor disinterested - 3	24%
Interested - 4	40%
Very interested - 5	23%
Mean	3.66
Q26a. You suggested you were not interested in learning more about Mississippi's health insurance exchange. Reasons	
Variable(s): Postcoded	
Sample Size	662
Don't understand/complexity	4%
Don't support / high cost	7%
Currently satisfied with health insurance	13%
Don't know / did not provide response	76%
Q26b. You suggested you were interested in learning more about Mississippi's health insurance exchange. Reasons	
Variable(s): Postcoded	
Sample Size	662
Limited knowledge	40%
Cost savings	25%
Want to obtain health insurance	11%
Simplicity	10%
Increased quality	5%
Don't know / did not provide response	5%
Other	5%

Individual Demographics	Total Column % (& others)
Q1. Which of the following best describes your current employment status?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	642
Employed full-time (non owner)	76%
Employed part-time (non owner)	18%
Not employed	4%
Retired	1%
Other	1%
Q3. In which state do you reside?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	642
Alabama	0%
Arkansas	0%

Florida	0%
Georgia	0%
Louisiana	0%
Mississippi	100%
North Carolina	0%
South Carolina	0%
Tennessee	0%
Other	0%
Q4. In which region of Mississippi do you live?	
Sample: Excludes Advocates, Health Providers, Insurance Agents	
Sample Size	**648**
Northeast (e.g. Olive Branch, Tupelo, Starkville)	23%
Northwest (e.g. Clarksdale, Tunica, Greenville)	15%
Southwest (e.g. Jackson, Vicksburg, Brandon)	30%
Southeast (e.g. Hattiesburg, Biloxi, Gulfport)	32%
Other	0%
Q6. What is your Gender?	
Sample Size	**662**
Male	37%
Female	63%
Q7. What is your age?	
Sample Size	**662**
Under 18	0%
18-24	10%
25-29	13%
30-34	14%
35-44	21%
45-54	24%
55-64	19%
65 and older	0%
Q8. Which of the following best describes your ethnicity?	
Sample Size	**662**
White	73%
Black or African American	22%
Asian	1%
American Indian or Alaskan Native	1%
Native Hawaiian or Other Pacific Islander	0%
Hispanic or Latino	1%
Other	1%
Prefer not to answer	2%
Q9. In 2010, what was your household income before taxes?	

Sample Size	**662**
$14,999 or less	8%
$15,000 to $24,999	14%
$25,000 to $34,999	15%
$35,000 to $49,999	17%
$50,000 to $74,999	19%
$75,000 to $99,999	12%
$100,000 to $149,999	7%
$150,000 or more	2%
Prefer not to answer	6%

Appendix G – Town Hall Survey Responses

Town Hall Meeting, Participant Responses	Total Column % (& others)
Q1. To what degree do you support the Affordable Care Act?	
Sample Size	**286**
Strongly Oppose - 1	33%
2	16%
3	16%
4	10%
Strongly Support - 5	25%
Mean	**2.77**
Q2. How would you rate your current level of knowledge about a health benefit exchange?	
Sample Size	**287**
No Knowledge At All - 1	16%
2	25%
3	29%
4	25%
Perfect Knowledge - 5	4%
Mean	**2.76**
Q3. By whom would you prefer Mississippi's health benefit exchange be operated?	
Sample Size	**285**
The State of Mississippi	68%
The Federal Government	12%
Undecided	19%
Q4. Increasing access to health care is critical to economic growth in Mississippi	
Sample Size	**286**
Strongly Disagree - 1	6%
2	11%
3	14%
4	21%
Strongly Agree - 5	48%
Mean	**3.95**
Q5. Which best describes health insurance your organization currently offers?	
Sample Size	**276**
Offer to full-time and part-time employees	18%
Offer only to full-time employees	68%
Have never offered	10%

Do not currently offer, but did in the past	5%
Q6. How important are health benefits in attracting and retaining quality employees?	
Sample Size	**276**
Not At All Important- 1	1%
2	2%
3	4%
4	21%
Very Important - 5	72%
Mean	**4.61**
Q7. After hearing about a Defined Contribution Plan, to what degree do you think it would be a valuable option for Mississippi's health exchange?	
Sample Size	**282**
Not At All Valuable- 1	2%
2	2%
3	4%
4	21%
Very Valuable - 5	71%
Mean	**3.61**
Q8. How many plan options would you like to see presented in the enrollment process?	
Sample Size	**273**
Three of Fewer Health Plan Options	26%
4-8 plan options	33%
9-12 plan options	8%
All Health Plan Options	34%
Q9. To whom would you turn for assistance when working with the exchange?	
Sample Size	**268**
Insurance Agent or Broker	40%
Health Exchange Expert	27%
Health Exchange Website	21%
E-mail / Chat with Health Exchange Expert	12%
Paper Application	0%
Q10. I can understand complexities of health insurance without help of broker	
Sample Size	**270**
Strongly Disagree - 1	37%
2	18%
3	21%
4	14%
Strongly Agree - 5	9%
Mean	**2.40**

Appendix H – Town Hall Flyer

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

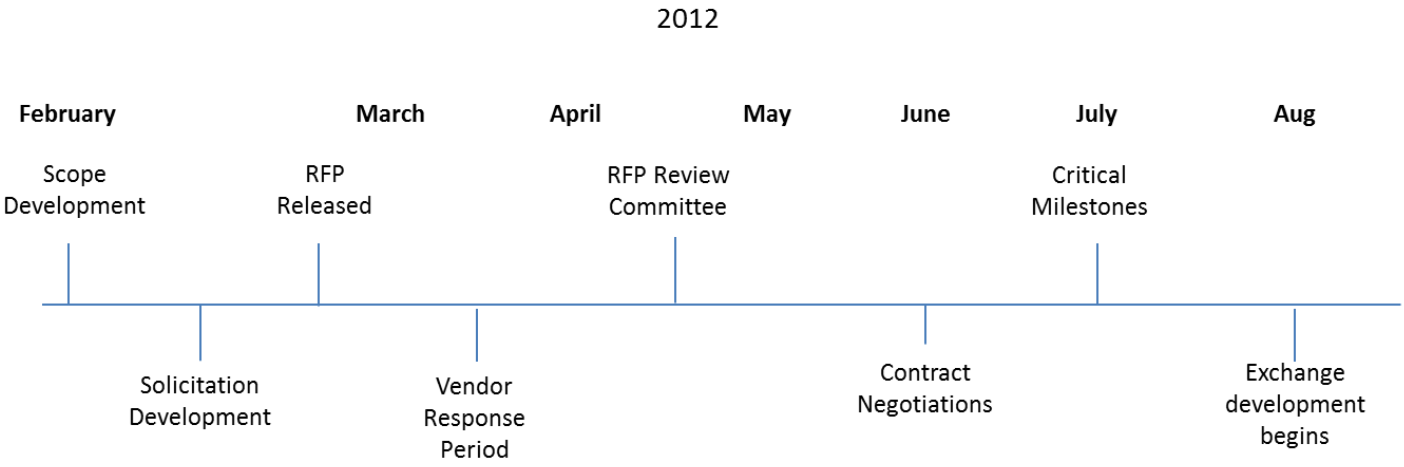
FOR MORE INFORMATION, PLEASE CONTACT:
(601) 359-2012

PAID FOR USING GRANT FUNDS

HEALTH INSURANCE EXCHANGE TECHNOLOGY

Technology Timeline

Mississippi Health Benefits Exchange
Technology Timeline



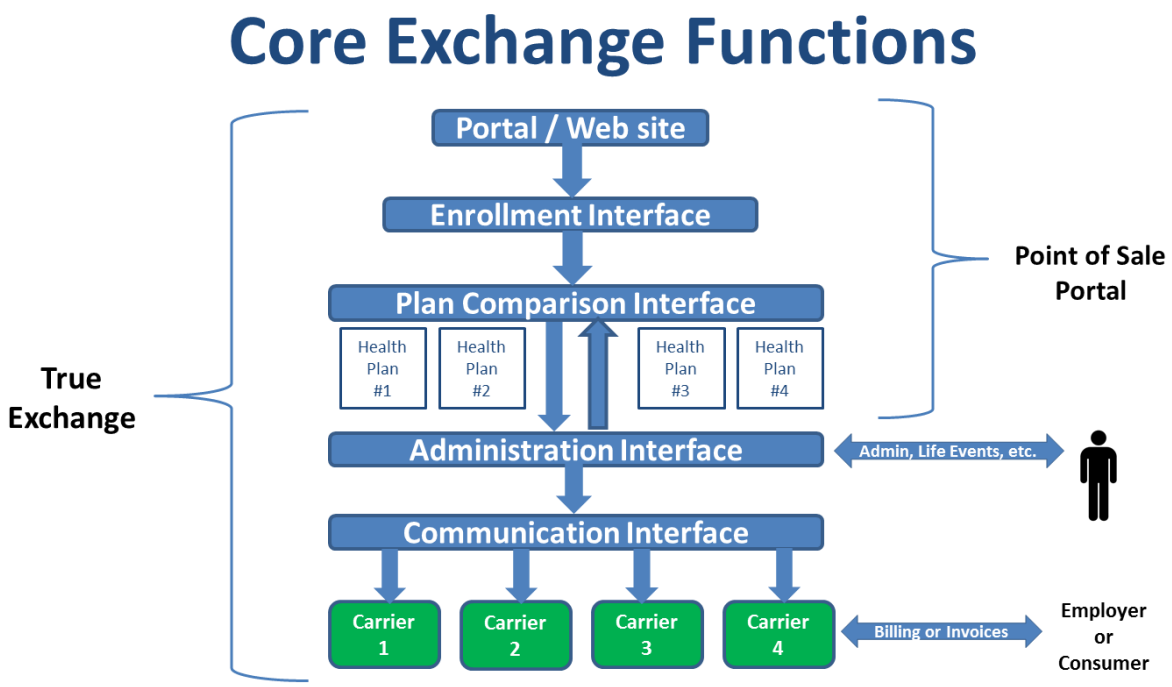
Highlights from Mississippi Exchange Gap Analysis Webinar (March 9, 2011)

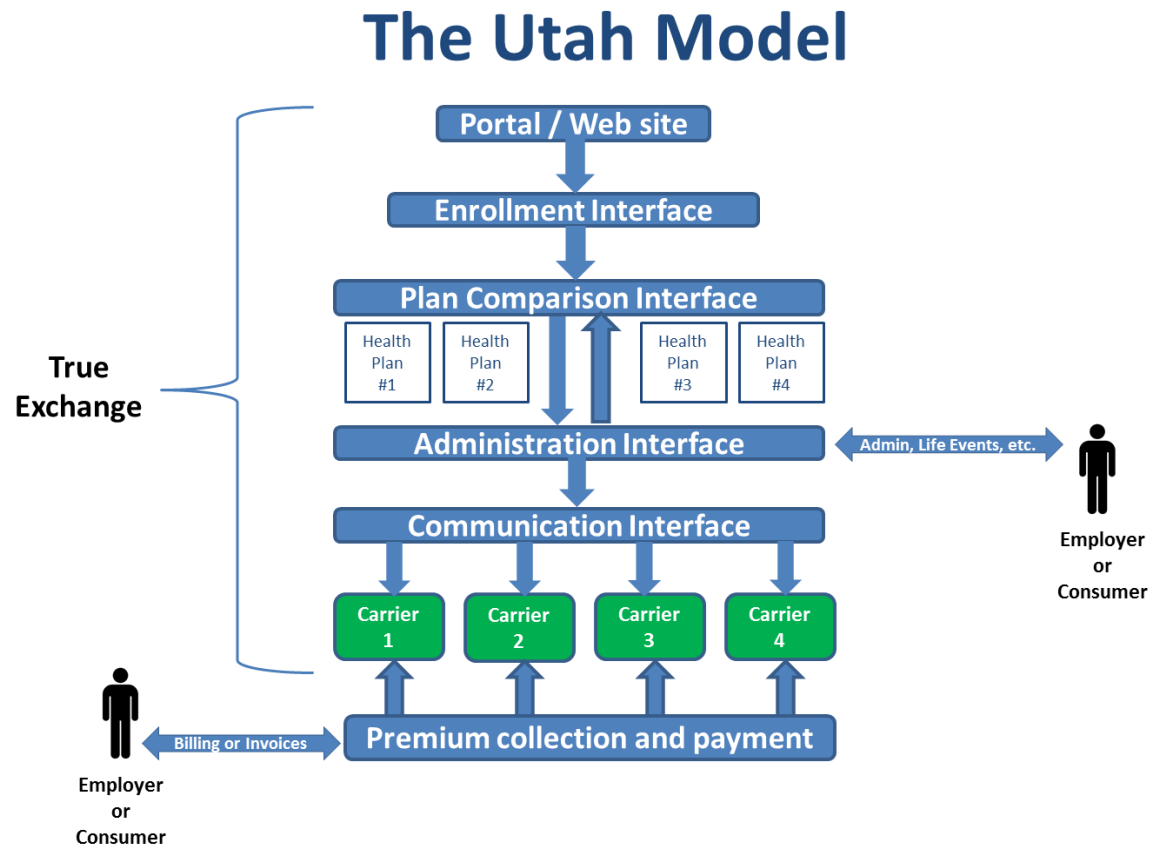
Exchange Capabilities and Services Fall Into Three Categories:

- Core Functions—essential to select and enroll in a plan
- Mandated Functions—required to satisfy PPACA
- Ancillary Functions—non-core capabilities

Core Functions:

- Exchange website—provides plan information to current and prospective enrollees comparison
- Plan comparison
  - Standardized format—benefit options presented in a common way
  - Comparison—tool enables plan evaluations by price, benefit, etc.

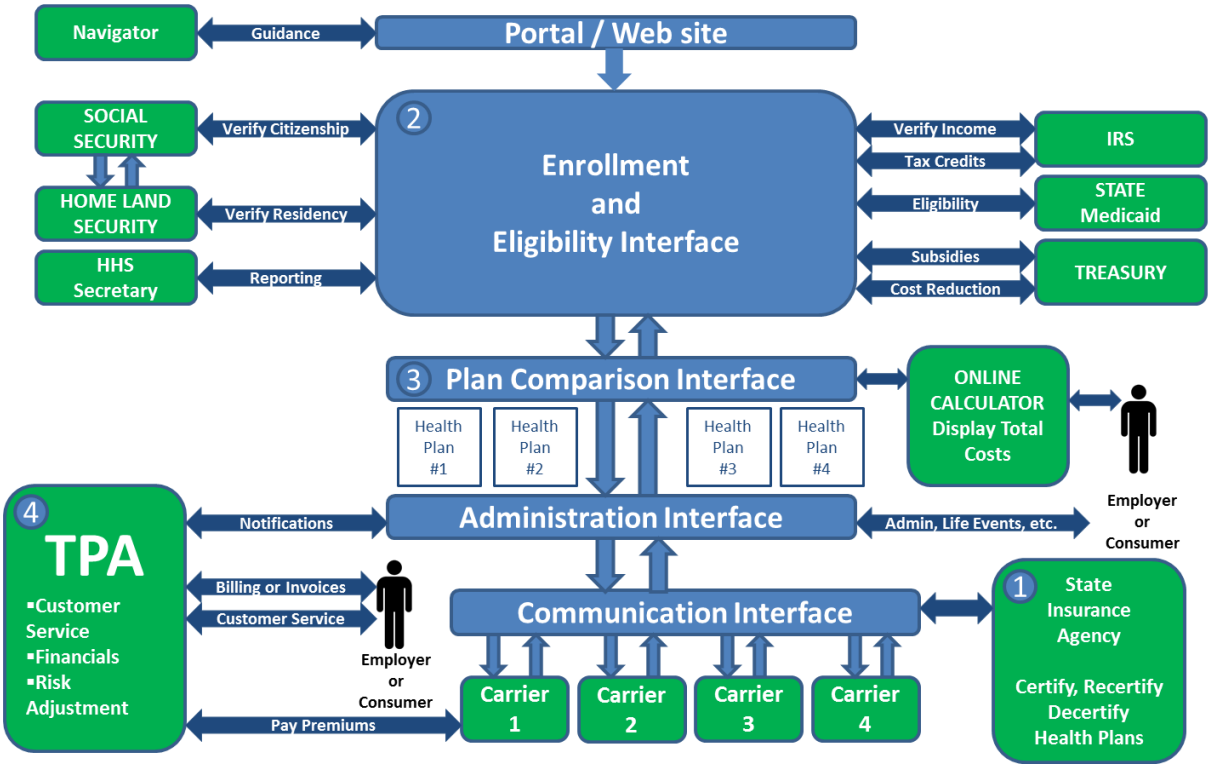




Mandated Exchange Functions:

Front End Functions	Back End Functions
▪ **Website** for commercial **health plan enrollment** and **Medicaid and CHIP enrollment** ▪ Information on **Medicaid and CHIP eligibility** ▪ Health **plan comparison** in a standardized and uniform format ▪ **Calculator** to determine actual cost of coverage after application of tax credits and cost sharing ▪ Enrollee **satisfaction survey results** ▪ Provide a **toll-free hotline**	▪ **Certification, Recertification and Decertification** of Health Plans ▪ **Assign a rating** to each qualified health plan ▪ **Medicaid and CHIP** eligibility ▪ **Certification of individuals** exempt from the individual responsibility requirement ▪ **Tax Credit** Eligibility ▪ **Premium Assistance** Eligibility ▪ **Navigator** program that provides grants to entities assisting consumers ▪ **Risk Adjustment** ▪ Consultation with stakeholders, including tribes, and Publication of data on the exchange's administrative costs

Mandated Exchange Functions



Ancillary Functions:

- Defined contribution
- Premium collection and payment

- Premium aggregation from multiple sources
- Health and wellness assessments and programs
- PBM

IT Gap Analysis

State of Mississippi Exchange IT Gap Analysis

The following sections describe Mississippi's readiness on critical elements as requested in Appendix C of the grant:

Technical Architecture, Applicable Standards, HIPAA, Accessibility, Security, Federal Information Processing Standards

Technical Architecture

The technical architecture is critical to supporting the necessary business functions and features of the health insurance exchange. Mississippi understands that the technical architecture must be:

- Flexible and utilize a services-based design capable of extending front-end services to stakeholders and back-end services to systems
- Based in open standards such as National Information Exchange Model (NIEM) and WSI, to improve system interoperability and reduce maintenance
- Based on industry best practice design, facilitating the transfer of conceptual design and business rules thereby accelerating adoption by other states
- Secure and adhere to HIPAA guidelines in order to provide a safe, reliable, and private exchange of information

Current Technical Architecture

This section provides a brief overview of the Mississippi *Envision* system architecture. *Envision* utilizes a three-tier application deployment architecture. **See Figure 1**. Starting on the left, the three tiers represented in the diagram are:

- Client work stations
- Sybase Enterprise Application Server middle tier
- Mainframe back end

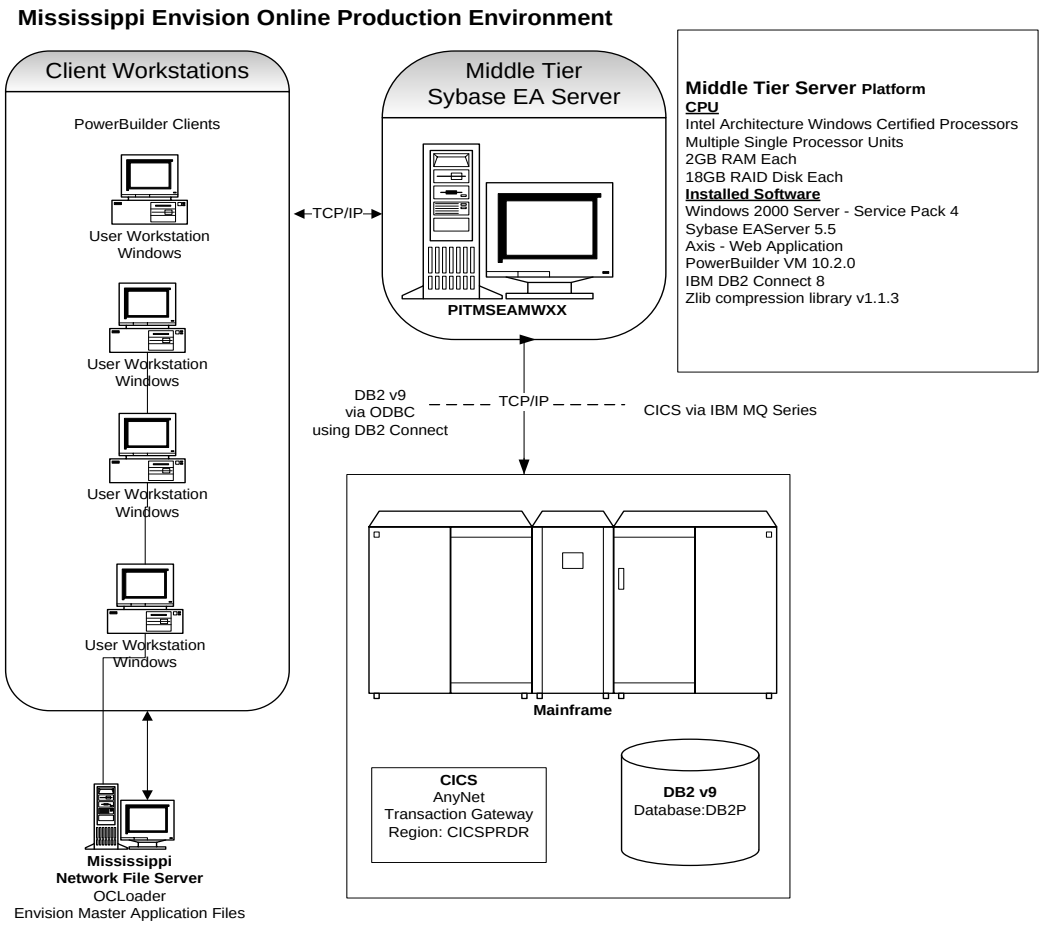


Figure 1

The hardware comprising the *Envision* system middle tier and back end is located in a secure ACS data center located in Pittsburgh, PA. This data center is connected to the ACS Mississippi FAS offices and to the DOM network by an ACS internal wide area network (WAN) comprised of leased frame relay lines.

The Client work stations run Windows with PowerBuilder run-time and the client presentation layer of the *Envision* application. The presentation layer contains front-end edit logic. The client windows presentation layer is built using ACS-developed class libraries that provide a consistent user-interface and navigation. The presentation layer includes windows for all MMIS data entry, maintenance and inquiry functions. Each individual subsystem uses the common class libraries to construct all of the necessary inquiry, maintenance and update business functions for operation of the MMIS. Each individual subsystem which presents an online client interface specifies in its chapter details of the windows provided within that subsystem for access to specific business functions.

The middle tier provides middleware connectivity to the database back-end and to eight CICS transactions which implement database intensive business logic and security control using Sybase Enterprise Application Server as a middleware application engine. This middleware layer provides access to CICS applications and DB2 on the back-end. It also provides clustering, load balancing, two-phase commit and fail over capability. The middle tier provides on-line business logic through the use of PowerBuilder non-visual objects built on the Enterprise Application Framework from Synergy Systems, and through Java components.

The middle tier is accessed by the online client screens for access to the MMIS back end data store and CICS transactions. The middle tier also provides access facilities used by additional client interfaces from MEDS, MEDSX, PDCS and EDI subsystems to enhance the functions provided by the online client interfaces. As in the case of the online client each individual subsystem which presents an additional client interface specifies in its chapter details of the windows or other client facilities provided within that subsystem for access to specific business functions.

The middle tier provides a unified, stable and well defined interface to system functions suitable for future development. By providing standard remote procedure call methods (SOAP, CORBA, IIOP) the *Envision* system will allow controlled access to system functions from other state systems. EA Server provides robust cluster management functions to ensure load sharing and transaction priority management, and future scalability to accommodate expanding user requirements.

The mainframe back-end runs IBM CICS and IBM DB2 relational database management system. The middle tier invokes eight CICS transactions. The CICS transactions support Claims Inquiry Search, Claim Correction, Member Lock-in, Category of Eligibility Update, Member Merge and Prior Authorization Maintenance, User Login and User Password Change functions. CICS connectivity is provided via IBM MQ Series. Connectivity to DB2 is provided to the middle tier through IBM DB2 Connect. In addition to supporting middle tier and workstation transaction and data requests, the back-end is used to run all batch processes and reports as well as the claims engine.

IBM CICS and DB2 provide services to manage transaction dispatching priority and resource sharing. Since all transaction requests are connected to DB2 and CICS through the uniform middleware interface the system is protected from rouge transactions which might disrupt the balance of system processing.

The middleware and mainframe servers are collocated at the ACS Data Center in Pittsburgh, PA to maximize throughput for data intensive operations. Collocation provides the maximum network throughput for traffic between the middleware servers and the mainframe, over which the largest result sets will be exchanged. When consistent with business logic needs, the middleware functions are designed to perform data reduction to minimize the amount of traffic over slower WAN communications lines.

The Envision MMIS system utilizes the ACS State Healthcare EDI Clearinghouse to provide HIPAA compliant transaction handling. Each MMIS core subsystem receives processes and returns those HIPAA mandated attributes which are utilized in the MMIS implementation of the DOM policy and edits. The EDI Clearinghouse maintains a complete record of all HIPAA transaction attributes received along with necessary identifiers to correctly associate incoming transaction attributes to MMIS generated transactions to construct outgoing transactions ("Retain and Attach").

Current/Legacy Software

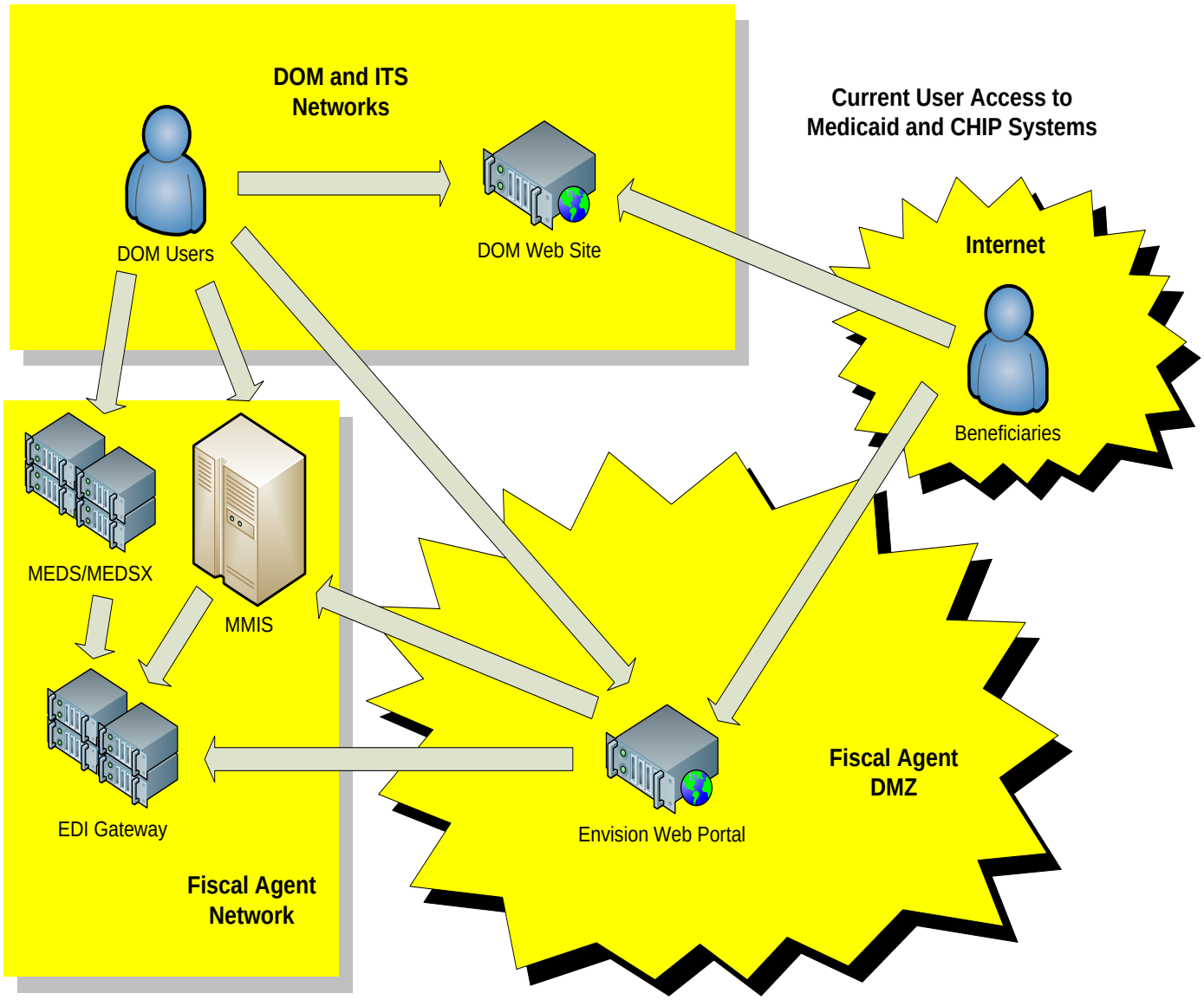
The table below describes Mississippi's current/legacy software:

Component	Description
Envision MMIS	Mississippi's HIPAA compliant and CMS certified Medicaid Management Information System.
Medicaid Web Site	Includes forms and instructions for obtaining Medicaid and CHIP eligibility.
Envision Web Portal	Web site that allows beneficiaries to review their claims, check their eligibility, and locate providers.
EDI Gateway	Processes HIPAA transactions (i.e. 837, 834, 835, 270/271, etc) either incoming or outgoing for providers or other payers.
MEDS/MEDSX	Determines eligibility for Medicaid and CHIP.

Current / Legacy Hardware

The table below describes Mississippi's current/legacy hardware:

Component	Description
Envision MMIS	IBM Mainframe with z/OS – PowerBuilder, DB2, and COBOL
Medicaid Web Site	IIS with ASP
Envision Web Portal	Sun Solaris Sparc Servers with WebSphere, IBM HTTP Server, and Oracle
EDI Gateway	IBM AIX Wintel Servers with Mercator
MEDS/MEDSX	Sun Solaris Sparc Servers with WebSphere, Oracle, LDAP, Actuate, and Tivoli


DOM and ITS Networks
DOM Users
DOM Web Site
Current User Access to Medicaid and CHIP Systems
Internet
Beneficiaries
MEDS/MEDSX
MMIS
EDI Gateway
Fiscal Agent Network
Envision Web Portal
Fiscal Agent DMZ

Target System Software

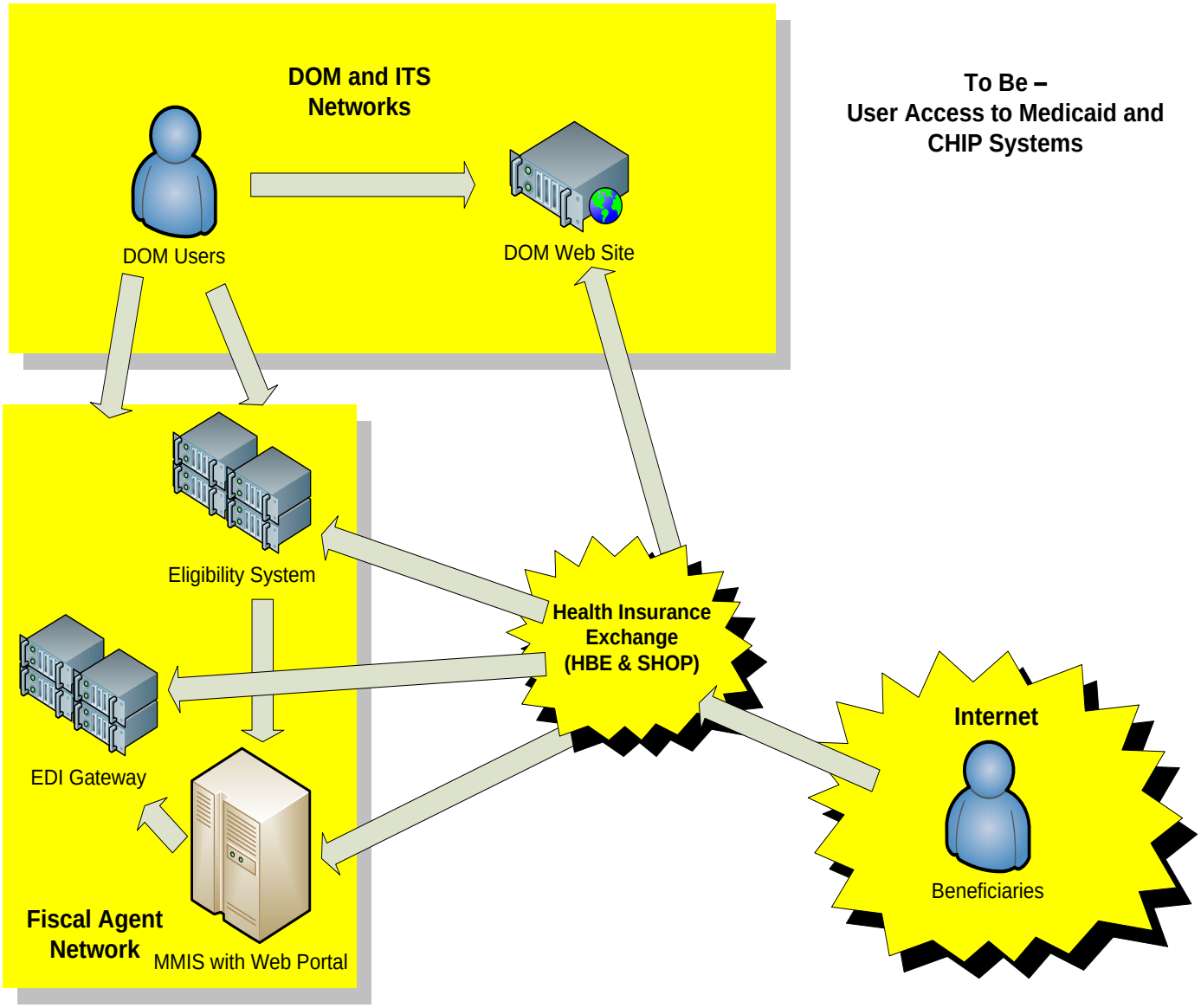
The table below describes Mississippi's target software for the health insurance exchange:

Component	Description
Envision MMIS	IBM Mainframe with z/OS – PowerBuilder, DB2, and COBOL
Medicaid Web Site	IIS with ASP
Envision Web Portal	Sun Solaris Sparc Servers with WebSphere, IBM HTTP Server, and Oracle
EDI Gateway	IBM AIX Wintel Servers with Mercator
MEDS/MEDSX	Sun Solaris Sparc Servers with WebSphere, Oracle, LDAP, Actuate, and Tivoli
Plan Comparison Health plan and consumer administration	Mississippi will utilize existing industry leading vendors to customize their COTS products or SAAS products to facilitate the plan comparison and consumer administration functionality.
Health Plan Ranking	Mississippi will utilize existing industry leading vendors to customize their COTS products or SAAS products to facilitate the health plan ranking functionality to meet the needs of the states exchange.
Online Calculator	Mississippi will utilize existing industry leading vendors to customize their COTS products or SAAS products to facilitate the online calculator functionality to meet the needs of the states exchange.
Financial Transactions	Mississippi will utilize existing industry leading vendors to customize their COTS products or SAAS products to facilitate the financial transactions to meet the needs of the states exchange.
Risk Adjustment	Mississippi will utilize existing industry leading vendors to customize their COTS products or SAAS products to facilitate the risk adjustment functionality to meet the needs of the states exchange.
Mobile Access	Mississippi will utilize existing mobile application developers to build and customize software to facilitate mobile access to the exchange.

Target System Hardware

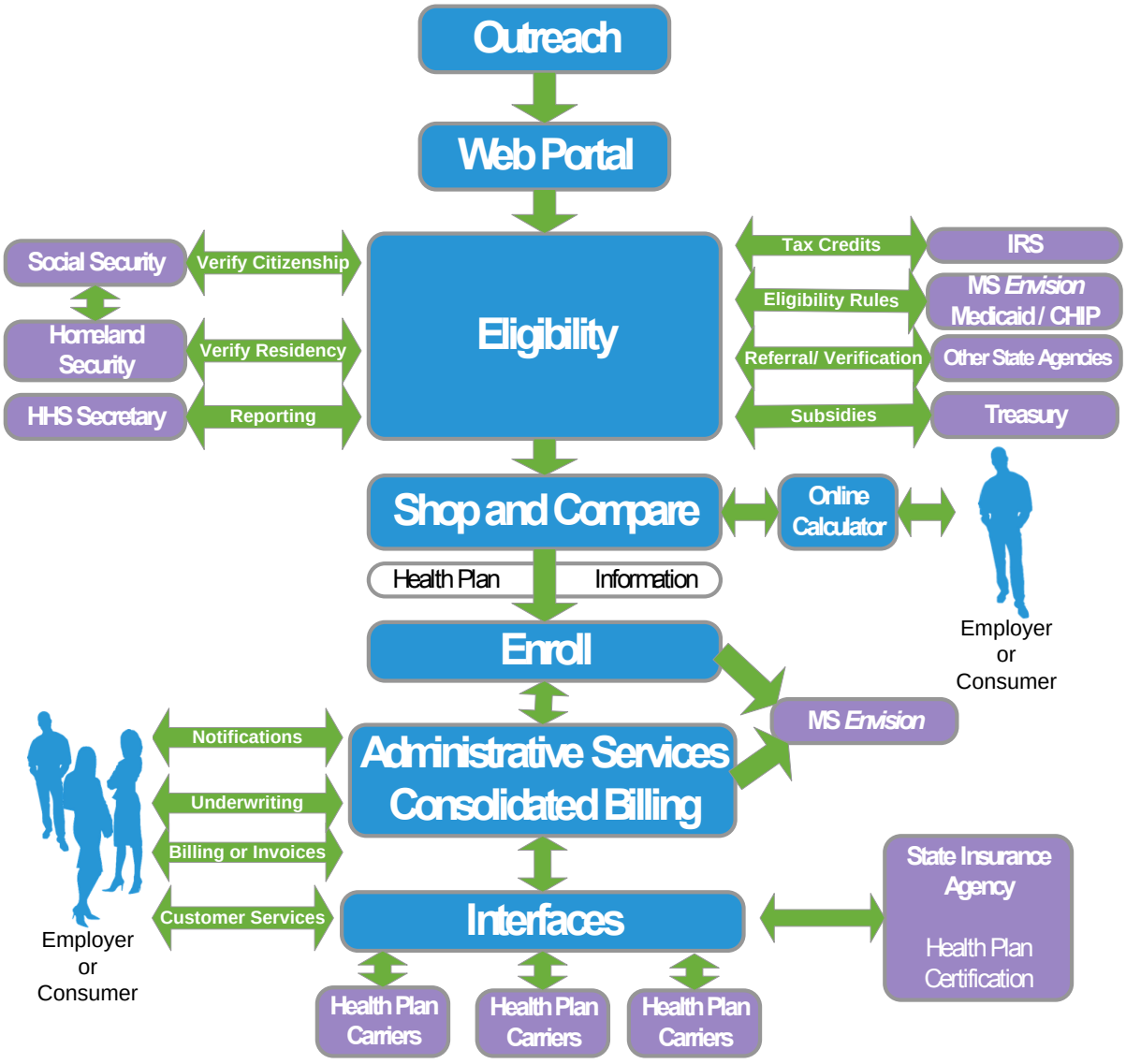
The table below describes Mississippi's target hardware for the health insurance exchange:

Component	Description
MMIS	An Open Systems platform written in a modern programming language.
Medicaid Web Site	A Wintel platform.
EDI Gateway	An Open Systems platform with a translator.
Eligibility System	An Open Systems platform written in a modern programming language.
Plan Comparison Health plan and consumer administration Health Plan Ranking Online Calculator Financial Transactions Risk Adjustment	Mississippi will utilize existing vendor technologies and hardware platforms that comply with the states minimum requirements and standards.


DOM and ITS Networks
DOM Users
DOM Web Site
To Be –
User Access to Medicaid and CHIP Systems
Eligibility System
Health Insurance Exchange (HBE & SHOP)
EDI Gateway
Internet
Beneficiaries
Fiscal Agent Network
MMIS with Web Portal

Exchange IT Mapping

Mississippi recognizes that getting from our current "as is" IT environment to our proposed "to be" Exchange environment will be a comprehensive process. Mississippi has mapped out the foundation "to be" environment below.



Technical Architecture Gap Summary

Mississippi will resolve the gaps in the current architecture through the acquisition of existing technologies and products and will continue to enhance its existing technologies and services.

These gaps can be organized and listed as follows:

Gap	Description
Consumer Web Portal	The face of the Mississippi exchange (web portal) will need to be developed to provide consumers with an entry / starting point that is intuitive easy to navigate.
Integration of Individual Eligibility Determination	Mississippi will rely on its current MMIS systems to facilitate individual Medicaid eligibility determination. However, Mississippi will need to develop the technology to facilitate the integration between the exchange and the current MMIS systems and include CHIP and employer eligibility factors into the Exchange as well.
Health Plan Comparison	Health plan comparison based on consumer selected preferences is a new process that will need to be built into the Mississippi exchange. Health plan comparison should allow the consumer to "model" different health plan coverage and costs based on their medical reality (average office visits, type of medication, chronic conditions, etc.) Mississippi plans to incorporate intuitive consumer assistance tools and technologies in the exchange.
Health Plan Ranking	Health plan ranking based on plan benefit design is a new process that will need to be developed into the Mississippi exchange. Additionally, based on yet to be determined HHS standards, quality rankings for each health plan will need to be tracked by the Mississippi Exchange.
Health Plan administration	Carriers currently submit health plans to the Mississippi department of insurance using the System for Electronic Rates and Form Filing (SERFF). Mississippi will need to develop the necessary interface to upload "qualified" and approved health plans to the exchange.
Customer information administration	Mississippi will need to develop the necessary technology and interface to allow consumers to administer and perform updates (life events, contact info, etc.). This includes employer/employee administration tools which facilitate accurate consolidated billing through the Exchange

Communication and Customer Support	Mississippi currently provides traditional methods of communication and customer support (phone, mail, fax, email). These systems and operational processes will need to be expanded to deliver modern methods of service and communication (Live chat support, messages, text, call me, and other channels). These communication channels may also include educational material through the Exchange web portal itself. Mississippi will implement a new customer service model that supports all users (i.e. employees, employers, brokers, community partners, health plans, etc.) Along with the new customer service model, Mississippi will need to establish an outreach infrastructure that encourages the uninsured, broker, navigator, and the small employer communities to use the Exchange to access health care coverage.
Cost Reduction Determination	Cost reduction determination is a new process and will require the development of technologies and processes that enable the Mississippi Exchange to determine the cost reduction amounts and communicate that information to the Treasury and other Federal and state agencies.
Citizenship and Residency Verification	Currently Mississippi uses SDX to verify citizenship and will continue to do so within the Exchange. Residency verification is a new process and that technology will need to be built into the Mississippi Exchange. There are new federal verification interfaces which Mississippi will need to account for in the Exchange design (IRS, Homeland Security, etc.).
HHS Reporting	Mississippi will need to develop the necessary technology to facilitate the new federal, state, public, operational, and analytical reporting functions and requirements of the exchange.
Financial Transactions	The technology to facilitate the payment of premiums and disbursement of subsidies and credits within the Mississippi exchange will need to be developed. Additionally, the aggregation of payments from multiple sources, consolidated billing for employers for multiple employees, and the procedures and processes for payment remediation (late payment, adjusted payments, collections) must be developed.
Mobile Access	Mobile access to the Mississippi exchange will be facilitated by developing mobile applications that are compatible with the most popular mobile devices. This may include Exchange participant alerts, bill notification and bill payment through the mobile device.

	As with paper-based communications, HIPAA requirements must be considered when setting up these applications.
Online Calculator	Mississippi will have to develop the technologies necessary to facilitate an online calculator that presents actual costs to the consumer in a clear and intuitive format.
Risk Adjustment	Risk adjustment is a new process and Mississippi will need to integrate existing risk adjustment technologies and processes into the exchange. This includes the administrative support for the commercial underwriting processes needed with small employer groups.

Application Standards

1561 Recommendations – The 1561 recommendations and NIEM standards are new to Mississippi. However, Mississippi is committed to implementing the 1561 recommendations for human services eligibility and enrollment processes to:

- Create a transparent, understandable and user-friendly online process that enables consumers to make informed decisions about applying for and managing benefits
- Provide a range of user capabilities, languages and access considerations
- Offer seamless integration between private and public insurance options
- Enable a consistent and transparent exchange of data elements between multiple data users (e.g. NIEM standards)
- Maintain strong privacy and security protections

Mississippi will incorporate the entire core Section 1561 recommendations.

In addition, Mississippi will work to incorporate NIEM standards as the state develops the business processes and scope of works for the exchange.

HIPAA - Maintaining application security is important to protect the sensitive information that is collected, processed, and stored in the health insurance exchange. The Mississippi Exchange will comply with all Federal standards of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

DOM and its Fiscal Agent are required to comply and address all aspects of the HIPAA Regulation. DOM requires all of its partners to sign a Business Associate Agreement (BAA) that directly interface with the MMIS system. DOM is building this BAA into all of its contracts to all vendors regardless of their function within our agency.

The exchange will create a clear, easy-to-understand privacy notice as part of both the paper application and electronic process that consumers using the exchange will need to acknowledge and sign off on.

While new systems are developed and existing systems are enhanced, Mississippi will continue to work to ensure that its systems are HIPAA compliant.

Accessibility
It is a federal mandate that public-facing web sites must minimize technical and usability barriers for individuals with disabilities. Mississippi plans to ensure the exchange complies with all federal and state accessibility regulations and will test the exchange to ensure the highest level of accessibility.

The Exchange will also be in compliance with Title II of the Americans with Disabilities Act. The Exchange will adhere to all standards for waiving unnecessary eligibility standards for individuals and will modify policies and procedures on an as-needed basis to ensure access to programs. In administering benefit services to students, the Exchange will comply with section 504 of the Rehabilitation Act, developed by the Office of Civil Rights and the U.S. Department of Education, which allows all students to participate in any program receiving federal financial assistance, regardless of disability.

Security
Mississippi understands that security is extremely important when dealing with confidential information related to health care programs. The State employs multiple layers of security in its systems for maintaining compliance and protecting data like personal health information (PHI) and personal identifying information (PII). Mississippi understands the federal Fair Information Practices (FIP) guidelines for collecting data, maintaining data integrity and quality, and providing transparency regarding data access and use.

DOM has reviewed the FIP guidelines and believes the standards are in direct relation to HIPAA compliance. DOM already issues notices to all beneficiaries regarding our Privacy Practices which address Notice/Awareness, Choice/Consent, Access/Participation, Integrity/Security, Enforcement/Redress, and Dependent Children which all are identified in the FTC Fair Information Practice documentation.

Mississippi will ensure that security measures in place will comply with all federal standards. During the development of the Exchange, security protocols will be implemented and extensively tested at each phase.

Federal Information Processing Standards (FIPS)
Mississippi is Department of Human Services is complying with the Federal Information Processing Standards. Mississippi will thoroughly evaluate the FIPS standards as it applies to the states exchange and make a decision as to how the exchange may comply with these standards. Mississippi will provide HHS with a formal response and decision regarding the FIPS evaluation.

Sample Technology RFI

Request for Information
RFI
Mississippi's Health Exchange
Issued by:
The State of Mississippi
Mississippi Insurance Department

I. Introduction

A requirement of the federal Patient Protection and Affordable Care Act (PPACA) (http://www.healthcare.gov/law/about/index.html) is that all states establish a health insurance exchange. While the law sets minimum standards, states are given flexibility in implementing exchanges that take into account the existing insurance markets in addition to the needs of individuals and businesses seeking insurance.

The Mississippi Insurance Department (MID) applied for and received a grant for the planning and establishment of the Mississippi Health Insurance Exchange. One of the goals of the grant is to assess the current technical infrastructure available and determine the required resources needed to develop a web portal.

II. Purpose of Request

The MID is interested in learning more about what existing technologies are available to facilitate the required functions of a health insurance exchange that serves the individual and group health insurance markets. The MID will be holding one hour demonstrations on (specify dates) to allow interested vendors to demonstrate their product / service offerings.

The following are the requirements to participate in the demonstrations.

1. The system/application must serve either the individual or group health insurance market.

2. The system/application must be in service or be far enough along in development to provide for a live system demonstration. **Screen shots or power point documents will not qualify as a live demonstration.**

3. The following functionality **must** be included in the demonstration:

    - Employer enrollment and management functions (if applicable)
    - Employee and/or individual consumer enrollment functions (as applicable)
    - Health plan comparison and selection, including any sorting or filtering functionality.
    - Consumer decision support tools that help the consumer choose a plan that best fits their needs or the needs or their family
    - Health plan product administration including loading and maintenance of plan design, rate, and premium information

4. The following functionality is not required but should be demonstrated if available:

    - Health insurance education tools as it relates to purchasing health insurance
    - User account administration and any customer support tools

- Premium collection, aggregation and payment functions
- Customer service facilitation, functions or options
- Additional functionality that you feel is important

5. **Optional:** Please provide estimated costs for the following functions.

   - Employer enrollment and management functions
   - Employee and/or individual consumer enrollment functions
   - Health plan comparison and selection, including any sorting or filtering functionality
   - Consumer decision support tools
   - Health plan product support including loading and maintenance of plan design, rate, and premium information
   - Customer service facilitation

6. A product/business owner or designee that is intimately familiar with the system/application and can respond to detailed functionality questions must conduct the demonstration.

Demonstrators must submit their company background, including populations served, and a listing of their existing clients (Appendix A).

Should include some language for an Appendix B – Designation of Confidential and Proprietary Information

The Department is unable to predict how many qualified demonstrators, based on the requirements above, will respond to this RFI. Therefore, in the event that it becomes necessary to schedule additional demonstrations because the period of Dates full, the Department will make the required arrangements to schedule the additional qualified vendors at a future date.

The MID will provide access to the internet, computer projector, and display but demonstrators must use their own computers for the demonstration.

The demonstrations will be held at:
Mississippi Insurance Department
XXXXX
Jacksonville, MS
Please contact Name at (xxx) xxx-xxx (xxxxxxxx@mid.state.gov) with any questions regarding this RFI and to schedule your demonstration.

RESPONDENTS MUST NOTE: This RFI is not a solicitation for proposals, bids or services, nor does it represent any other formal procurement device. The MID, at its sole discretion, may elect to conduct a formal solicitation based upon, among other factors, the information received in response to this RFI.

Appendix A

STATE OF MISSISSIPPI RFI #

FOR VENDOR:
Provide company name, address, contact person, telephone number, and appropriate information on the product(s) and/or service(s) with requirements similar to those included in this Request for Information. If a demonstrator is proposing any arrangement involving a third party, the named references should also be involved in a similar arrangement.

Company Name
Street Address
City, State and Zip
Contact Person
Phone Number
Product(s) and/or Service(s) Used

Company Name
Street Address
City, State and Zip
Contact Person
Phone Number
Product(s) and/or Service(s) Used

Company Name
Street Address
City, State and Zip
Contact Person
Phone Number
Product(s) and/or Service(s) Used

GRANT ASSISTANCE

As requested by MID, Leavitt Partners developed the following documents (plans and outlines for) in preparation for the department's application for federal exchange grant funds.

Evaluation Plan

Successful development and implementation of a Health Insurance Exchange requires careful coordination of tasks within the Establishment Core Areas, consistent tracking and monitoring of performance and progress, and timely reporting. To accomplish this goal, MID has developed an evaluation plan that tracks two measures: 1) key indicators and 2) the anticipated results from completing each task. Key indicators are measurable outcomes that can be tracked to ensure milestones, implementation objectives, and grant requirements are being met. Anticipated results are broad outcomes that serve as a check for the direction of the overall development and implementation process. Knowing the anticipated results of each task helps ensure the indicators are not only being met, but are producing the desired outcomes of the process.

The following tables illustrate the key indicators and anticipated results to be measured within each of the Exchange Establishment Core Areas. It also shows the estimated time frame for each task and current baseline information from which progress can be evaluated. The time frames and completion dates currently listed in the table are broad estimates that will be refined once the grant is awarded and details of the implementation plan can be finalized. As the implementation process moves forward, baseline information that is not already determined will be developed and included in the evaluation plan.

In addition to the baseline information, the responsible agency is listed. The responsible agency assigned to the task is accountable for ensuring key indicators are met, performance and progress is tracked, and anticipated results are achieved within the estimated time frame. Once the grant is awarded and details of the implementation plan can be finalized, specific persons within the agency will be assigned to each task as "project task owners," making it is clear who is responsible for tracking and monitoring the progress of the task. It will be the responsibility of this person to inform project managers and staff of progress and to identify progress deficiencies and needs for immediate action, such as redistributing resources, notifying other affected project task owners, and communicating with appropriate stakeholders. Project task owners will report progress to MID, which will consolidate the information from all reporting agencies into quarterly progress reports for HHS, Mississippi administrators and stakeholders, and other interested parties.

These tables will serve as the base of MID's evaluation plan. In preparation for the quarterly progress reports to HHS, MID will update information and data for each measure on a regular basis. This regular review will ensure all indicators are being met as well has highlight the need for any interventions when targets are not being completed or unexpected obstacles delay plans. When obstacles or delays do arise during the implementation process, MID will work with the project task owner and responsible agency to evaluate the cause of the obstacle and develop appropriate plans to either remove the obstacle or establish a new course of action. Once these plans are developed, time frames, baseline information, and key indicators of other

tasks in the evaluation plan will be reexamined to ensure anticipated results and broad goals are still being met.

As part of the evaluation plan—and based on the award of this grant—MID will also set strategic cost objectives for each task. Estimated budgets will be developed for each of the Exchange Establishment Core Areas and costs associated with the tasks within these areas will be tracked and evaluated over time. This information will be monitored by designated persons within the responsible agencies assigned to each task. These persons will report this information to MID, which will use the information to ensure the project is staying within the set budget as well as measure the cost of each task against the expected and realized benefits.

Tracking and reporting on a project with such diverse requirements and stakeholder involvement requires careful coordination and monitoring of performance data by MID. MID has successfully performed similar evaluation plans in the past. [Examples – including MID's methods and efficacy to monitor progress and evaluate the achievement of programs and goals]

Evaluation of the Mississippi Exchange will continue as it transitions from the implementation stage to the operational stage. The expected modular products and operations of the Exchange lend themself well to performance evaluation, creating natural outcome-based performance points. System interoperability and security standards will be clearly outlined during the implementation process and will serve as measures for program success. It is expected the basic measures will be set and additional measures will be added as functionality is fully defined, system integration goals are identified, and stakeholder input is provided. Stakeholder and participant satisfaction measurement strategies will be also designed and implemented to gauge the value of the system and ensure continuous quality assessment and improvement.

Table 1: Background Research

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Data analysis of the insurance market.	Exchange Planning Consultants	01/01/2011 – 09/30/2011	1. Initial demographic analysis of the health insurance market. 2. Preliminary analysis of eligibility for and enrollment in Medicaid, CHIP, the Exchange, and other State programs. 3. Research and analysis aimed at quantifying the potential market to be served by the expansion of Medicaid and the establishment of subsidized coverage. 4. Analysis of existing health plans and benefits in Mississippi utilizing existing resources.	Contract with Exchange Planning Consultants is finalized and consultants have started analysis. Initial demographic analysis of the health insurance market is complete.	Utilize data analysis to help determine Exchange structure and design.

Table 2: Stakeholder Consultation

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
General stakeholder consultation with all	MID Staff, Exchange Study Committee,	2011 – 2014, throughout.	1. Develop a plan to promote partnership	Initial stakeholder meetings held with	MID has clear understanding of stakeholder

relevant groups from all regions of the state.	Exchange Implementation Committee, Exchange Planning Consultants		and stakeholder involvement. 2. Relevant stakeholder groups identified. 3. Consultations held with all relevant stakeholder groups.[13] 4. Consultations held from all regions of the state.	representatives from MID, the Governor's Office, Medicaid, Hospital and Medical Associations, the Business Community, and the Insurance Industry. Larger stakeholder involvement plan is developed and relevant stakeholder groups are identified. Consultations held: 42 in-depth stakeholder interviews; 2 small group discussion with business owners; 2 small group discussions with brokers/agents.	needs. Utilize feedback to help determine the establishment and ongoing operation of the Exchange.
Establish	MID Staff,	05/15/201	1. The proper	To be	Determine

[13] Including consumer advocates patients, employees, unemployed and self-employed individuals, other consumers likely to be Exchange enrollees as well as consumers likely to be eligible for premium tax credits and cost-sharing reductions, representatives of small businesses, health insurance issuers, State HIT Coordinators, State Medicaid offices, State human services agency, and health care providers.

process for consulting with federally recognized Indian Tribal governments.	Exchange Study Committee, Exchange Implementation Committee, Exchange Planning Consultants	1 - 05/15/2012	entities and officials clearly identified. 2. Channels for communication identified and started.	determined.	appropriate meeting times and channels for input from Tribal governments.
Continue tribal government consultation	MID Staff, Exchange Study Committee, Exchange Implementation Committee, Exchange Planning Consultants	2012 - 2014; throughout	1. Quarterly meetings held with tribal government officials. 2. MID has clear understanding of tribal needs.	To be determined.	Utilize feedback to help determine the establishment and ongoing operation of the Exchange.

Table 3: Legislation and Regulatory Action

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Determine the necessary authority to establish an Exchange that meets ACA requirements.	Grant Project Director, MID Commissioner, Legal Consultants	01/01/2011 – 05/15/2012	1. Alternative authority mechanisms identified and evaluated (executive order, regulatory action, etc.) 2. Necessary public hearings held. 3. Additional legislation considered.	State legislation did not pass 2011 session. Alternative methods for establishing Exchange are being considered.	Establish the Mississippi Exchange through proper authority.

			4. Exchange established.		

Table 4: Governance

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Develop a governance model.	Grant Project Director, Legal Consultants, Exchange Planning Consultants	2011; throughout	1. Work with stakeholder groups to answer key questions about the governance structure of the Exchange. 2. Determine whether the state will pursue a regional Exchange, a state agency-based Exchange, a quasi-governmental Exchange, or a non-profit Exchange. 3. Determine how the governing body will be structured.	Initial stakeholder meetings held with representatives from MID, the Governor's Office, Medicaid, Hospital and Medical Associations, the Business Community, and the Insurance Industry Consultations held: 42 in-depth stakeholder interviews; 2 small group discussion with business owners; 2 small group discussions with brokers/agents. Proposed legislation	Utilize stakeholder feedback to determine a governance model and governing body for the Exchange.

				stated the Exchange will be operated by a board of directors as either a not-for-profit entity or a new agency of the State of Mississippi. The board will likely hire an executive director of the Exchange.	
Establish governance structure that conforms to the requirements of the Affordable Care Act and the regulations to be issued by HHS.	Grant Project Director, Legal Consultants	01/01/2011 - 05/15/2012; or 2012: Q2	1. Establish Exchange Board and governance structure. 2. Determine management team and staff sufficient to oversee the operations of the Exchange. 3. Determine any additional requirements to ensure public accountability, transparency, and preventions of conflict of interest.	To be determined.	Exchange Board will adopt a governance plan in accordance with articles, bylaws, and operating rules consistent with State and Federal requirements.

Table 5: Program Integration

Task	Responsible Agency	Time Frame: 05/15/2011 – 05/15/2012	Key Indicators to be Measured	Baseline Information	Anticipated Results
Complete a study to determine the most efficient way the Exchange will build on and work with other Federal and State health programs to promote collaboration for Exchange operation.	MID Staff, Exchange Implementation Committee	2011: Q2	Perform detailed business process documentation to reflect current State business processes and needed future State process changes to support Exchange operation.	MS's Comprehensive High Risk Pool is a nationally recognized model with knowledgeable staff. The Exchange will build upon, and possibly be integrated with the CHRP. There was language in the 2011 implementation bills that allowed the MS CHRP to operate the Exchange.	Use study to support development of Exchange implementation plan.
		2011: Q2	Regularly communicate with the State HIT Coordinators, MID, the State Medicaid agency, and the State Human Services agency to develop work plans for	To be determined.	Use the collaboration work plans to identify challenges in the program integration process, strategies for mitigating those issues,

			collaboration.		and timelines for completion.
Determine MID's role and responsibilities related to the insurance markets inside and outside the Exchange.	MID Staff, Exchange Implementation Committee	2011: Q2	Execute an agreement of the roles/responsibilities of the Exchange and MID as they relate to qualified health plans offered inside and outside the Exchange.	To be determined.	Develop a plan for regulating the Exchange and its products that promotes Exchange competiveness, while mitigating disruption to the outside insurance market.
		2011: Q2	Devise a strategy for limiting adverse selection between the Exchange and the outside market.	To be determined.	
Execute agreements with the State Medicaid agency, any other applicable State health subsidy program, and other specific health and human services programs that will be involved in the Exchange.	MID Staff, Exchange Implementation Committee	2011: Q2	Execute an agreement with the State Medicaid agency and any other applicable State health/human services program, that includes: 1. Determination of the roles/responsibilities related to eligibility determination, verification, and enrollment. 2. Identification of challenges in the program integration	To be determined.	Develop the appropriate Exchange and Medicaid IT systems needed to effectively address eligibility determinations and other integrated functions.

			process, strategies for mitigating those issues, and timelines for completion. 3. Strategies for compliance with "no wrong door" policy. 4. Standard operating procedures for interactions between Exchange and OASHSPs. 5. Cost allocation between Exchange grants, FFP, and other fund streams.		

Table 6: Exchange IT System

Task	Responsible Agency	Time Frame: 02/15/2011 – 05/15/2012	Key Indicators to be Measured	Baseline Information	Anticipated Results
Complete an analysis of existing systems and products.	MID Staff, Exchange Implementation Committee	2011: Q1	Conduct gap analysis of existing systems and the end goal for systems development.	To be determined.	Use analysis to support development of Exchange IT system implementation plan.
		2011: Q1	Complete review of product	To be determined.	

			feasibility, viability, and alignment with Exchange program goals and objectives.		
Develop preliminary program integration plans, designs, and documentation.	MID Staff, Exchange Implementation Committee	2011: Q2	Complete preliminary business requirements and develop IT architectural and integration framework.	To be determined.	Develop a process to capture updates and changes to business and system requirements, development, testing, and implementation of Exchange IT Systems.
		2011: Q2	Complete Systems Development Life Cycle (SDLC) implementation plan.	To be determined.	
		2011: Q3	Complete security risk assessment and release plan.	To be determined.	
		2011: Q3	Complete preliminary detailed design and system requirements documentation.	To be determined.	
Finalize program integration plans, designs, and documentation.	MID Staff, Exchange Implementation Committee	2011: Q4	1. Finalize IT and integration architecture. 2. Complete Final business requirements and Interim detailed design and system requirements	To be determined.	Exchange IT system implementation plan complete.

			documentations.		
		2012: Q1	Complete Final requirements documentation.	To be determined.	
Develop baseline system and complete testing of all system components.	MID Staff, Exchange Implementation Committee	2012: Q1/Q2	1. Complete preliminary and interim development of baseline system. 2. Ensure compliance with business and design requirements.	To be determined.	IT system is fully tested and prepared for deployment.
		2012: Q3	Complete final development of baseline system including software, hardware, interfaces, code reviews, and unit-level testing.	To be determined.	
		2012: Q4	Complete testing of all system components including data, interfaces, performance, security, and infrastructure.	To be determined.	
		2013: Q3	Complete final user testing including testing of all interfaces.	To be determined.	

		2013: Q3 or pre-open enrollment	1. Complete pre-operational readiness review to validate readiness of all system components. 2. Complete end-to- end testing and security control validations.		
Prepare integrated Exchange system for deployment.	MID Staff, Exchange Implementation Committee	As early as mid-2013	1. Prepare and deploy all system components to production environment. 2. Obtain security accreditation.	To be determined.	Exchange IT system is properly secured, accredited, and officially opened for use.
Provide ongoing support to all systems components.	MID Staff, Exchange Implementation Committee	2014	Support business operations and maintenance of all systems components.	To be determined.	Ongoing support is provided.

Table 7: Financial Management

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Establish a financial management structure and commit to hiring experienced	MID Staff, Exchange Implementation Committee	05/15/2011 – 05/15/2012; **2011**	Define the financial management structure and the scope of activities required to	To be determined.	Financial management structure reviewed and established. Accountants retained.

accountants to support financial management activities			comply with requirements.		Necessary legislation regarding user-fees passed (if determined applicable).
			Develop a plan for hiring experienced accountants to support financial management activities of the Exchange, including responding to audit requests and inquiries of the Secretary and the GAO as needed.	To be determined.	
			Adhere to HHS financial monitoring activities carried out for the Planning Grant and under the Establishment Cooperative Agreement.	To be determined.	
			Begin defining financial management structure and the scope of activities required to comply with requirements.		
			1. Develop a plan to ensure sufficient	To be determined.	

			resources for ongoing operations. 2. Determine if legislation is necessary to assess user fees.		
			Assess adequacy of accounting and financial reporting systems.	To be determined.	
			Conduct a third party objective review of all systems of internal control.	To be determined.	

Table 8: Oversight and Program Integrity

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Ensure program integrity related to Federal and State funds utilized to start-up and operate the Exchange. Ensure steps are taken to prevent waste, fraud, and abuse.	MID Staff, Exchange Board of Directors	05/15/2011 – 05/15/2012; **2011**	Continue the planning process for the prevention of waste, fraud, and abuse related to the Exchange Planning and Exchange Establishment grants and to ensure program integrity.	To be determined.	Necessary staff hired. External audit procedures for the Exchange established. External auditors retained.
			Hire staff for oversight and	To be determined.	

			program integrity functions.		
			Establish procedures for external audit by a qualified auditing entity for an independent financial audit of the Exchange.	To be determined.	

Table 9: Health Insurance Market Reforms

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Show progress implementing the health insurance market reforms that are set forth in Subtitles A and C of the Affordable Care Act.	Exchange Board of Directors	05/15/2011 – 05/15/2012; **2011**	Implement steps for insurance market reforms: 1. Hold stakeholder consultations on health reform issues; 2. Pass necessary legislation for the creation of an Exchange; and/or 3. Implement other necessary regulations for market reform.	Initial stakeholder meetings held with representatives from MID, the Governor's Office, Medicaid, Hospital and Medical Associations, the Business Community, and the Insurance Industry Consultations held: 42 in-depth stakeholder interviews; 2 small group discussion with	Health insurance market reforms are implemented through appropriate and accessible channels.

				business owners; 2 small group discussions with brokers/agents. State legislation did not pass 2011 session. Alternative methods for establishing Exchange are being considered.	
		05/15/2011 – 05/15/2012; **2012**	Develop a plan for implementing the reforms and enforcing consumer protections.	To be determined.	

Table 10: Assistance to State Residents

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Determine what services to provide to State residents and how to provide certain services, including responding to requests for informational assistance, providing a toll free telephone hotline, and helping	MS Consumer Assistance Program, Grant Project Staff	2011	Coordinate with the existing MS Consumer Assistance program for ombudsman activities.	To be determined.	Use data and information from ombudsman activities and existing consumer assistance programs as base for resident assistance and accountability plan.
		2011	Analyze data from consumer assistance programs and report on plans for use of information to strengthen	To be determined.	

individuals learn whether they are eligible for Medicaid, CHIP and applicable State health subsidy programs.			qualified health plan accountability and Exchange functions.		Establish resident assistance plan, including procedures for coverage appeals.
		2012	Establish protocols for appeals of coverage determinations including review standards, timelines, and provision of help to consumers during the appeals process (if State chooses to operate functions in the Exchange).	To be determined.	
		2012	Draft scope of work for building capacity to handle coverage appeals functions.	To be determined.	
		2012	Continue to analyze data from consumer assistance programs and report on plans for use of information.	To be determined.	

Table 11: Business Operations of the Exchange

Task	Responsible Agency	Time Frame	Key Indicators to be Measured	Baseline Information	Anticipated Results
Establish processes for	Exchange Board of	2013: Q1	1. Begin developing standards based on	To be determined	Qualified health plan

certification, recertification, and decertification of qualified health plans.	Directors, Consultants		the identified planning activities that will be required for certification of a qualified health plan. 2. Launch plan management and bid evaluation system to allow upload of qualified health plan bids and other required information.	.	certification, recertification, and decertification processes are developed and established.
Establish Exchange call center.	MS Consumer Assistance Program	2013: Q3	1. Collaborate with MS's Consumer Assistance Program to utilize existing call center functionalities and staff. 2. Launch functionality and publicize number. 3. Prominently post call center information on the Exchange website.	To be determined.	Call center is developed and established.
Establish Exchange website.	Exchange Board of Directors, Consultants	2011: Q1	Begin developing requirements related to online comparison QHPs.	To be determined.	Exchange website is developed and established with fully operational comparison tools.
		2011: Q1	Begin developing requirements related to online application and selection of QHPs.	To be determined.	
		2011: Q1	Begin developing the premium tax credit and cost-sharing reduction	To be determined.	

			calculator.		
		2011: Q1	Solicit requests for assistance.	To be determined.	
		2011: Q1	Begin developing linkages to other State health/human services programs.	To be determined.	
		2012: Q1	Begin systems development.	To be determined.	
		2012: Q3	Submit content for informational website to HHS.	To be determined.	
		2012: Q4	Complete systems development and user testing of information website.	To be determined.	
		2013: Q1	Launch information website.	To be determined.	
		2013: Q1	Collect and verify plan data for comparison tool.	To be determined.	
		2013: Q3	Test comparison tool with consumers and stakeholders.	To be determined.	
		Before open enrollment	Launch comparison tool with pricing information but without online enrollment function.	To be determined.	
		As early as mid-2013	Launch functioning comparison tool with pricing information and	To be determined.	

			online enrollment functionality (first day of open enrollment).		
Establish Exchange quality rating system.	Exchange Board of Directors, Consultants		1. Utilize the Federal quality rating system developed by HHS in development of draft contract for QHPs. 2. Include quality rating functionality in system business requirements for the Exchange website. 3. Complete system development of quality rating functionality. 4. Complete testing and validation of quality rating functionality.	To be determined.	Exchange quality rating system is developed and established.
Establish Exchange Navigator program.	Exchange Board of Directors	2013: Q2	1. Determine Navigator's role/responsibilities, including: determining eligibility, providing assistance with the filing of appeals and complaints, and providing information about consumer protections. 2. Conduct preliminary planning activities related to the	It is envisioned the navigator would provide the consumer with foundational information about the Exchange and then direct the consumer to a broker	Navigator program is developed and established. Navigator grantees are chosen and contracts/grants are awarded.

			Navigator program including developing high level milestones and timeframes. 3. Determine Navigator grantees and award contracts or grants.	to facilitate the purchase of a health plan.	
Address and evaluate each of the remaining minimum functions of an Exchange.	Exchange Board of Directors, Consultants		1. Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid. 2. Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs. 3. Enrollment process. 4. Applications and notices. 5. Individual responsibility determinations. 6. Administration of premium tax credits and cost-sharing reductions. 7. Adjudication of appeals of eligibility determinations. 8. Notification and appeals of employer liability. 9. Information	At this time, MID and the Governor's Office envision separate ABHE and SHOP Exchanges.	All minimum functions of an Exchange are evaluated and developed, as determined necessary and appropriate by MID.

			reporting to IRS and enrollees. 10. Outreach and education. 11. Free Choice Vouchers. 12. Risk adjustment and transitional reinsurance. 13. SHOP Exchange-specific functions.		

05/31/2011

LEAVITT PARTNERS

Mississippi Health Insurance Exchange Stage II Research

Overall Research Plan

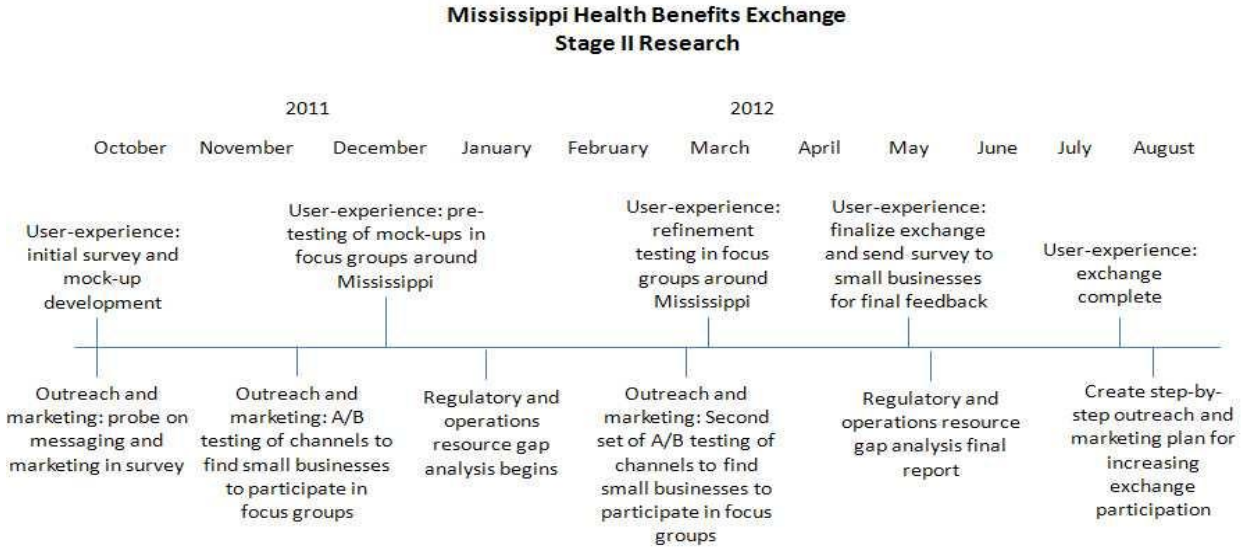
The research plan for the Mississippi Health Benefits Exchange involves two primary stages. Stage I of the research includes following (March 2011 – July 2011):

- Developing a foundational understanding of the challenges and unique needs associated with creating a health benefits exchange in Mississippi
- Garnering stakeholder input and feedback from legislators, consumer groups, carriers, brokers, small businesses, policy groups, and others who will be impacted by an exchange
- Analyzing public exchanges in other states with the goal of creating a successful exchange
- Conducting initial user-experience and outreach research to create an exchange that will result in high participation rates

Stage II of the research includes the following (October 2011 – August 2012):

- In-depth user-experience research:
    - In-depth interviews and focus groups with small businesses and individuals to gather initial feedback on the user-experience
    - Survey(s) of small businesses to gather initial feedback on the user-experience
    - User testing with small businesses throughout Mississippi
    - Exchange wireframe testing and feedback from hundreds of potential participants
    - User experience optimization once exchange experience is relatively finalized
- Outreach and marketing testing:
    - A/B media channel testing to attract small business participants to focus groups
    - Concept testing, message testing, optimal sales and marketing channel research, target audience segmentation
    - Development of a step-by-step plan for increasing exchange participation
- Resources and capabilities gap analysis:
    - Gap analysis of regulatory and operations resource needs to create a successful exchange

The different phases of the Stage II research are found in the timeline below:



User Experience: Development and Testing

Stage I of the Mississippi Health Benefits Exchange research revealed the importance of a simple user-experience. While Stage I revealed other general characteristics necessary for a successful exchange, researchers did not dig into the specifics of the exchange user-experience. Stage II will focus on actually building the health exchange. Research will include probing on questions about choice vs. simplicity, necessary support services, and whether the exchange will be available only online or through multiple channels (e.g. phone, mail, and in-person). To answer these questions, MID should employ the following plan.

a. USER-EXPERIENCE: PRE-TESTING PHASE

Small business leaders stressed the importance of building an exchange "by Mississippians, for Mississippians." During the user-experience pre testing phase, MID will rely heavily on input from Mississippi small businesses and individuals to explore and develop a suitable user-experience. First, MID will create and launch a survey to garner consumer insights on how

small businesses and individuals would like to interact with the exchange once built (e.g. enrollment, managing plans, and customer service).

MID will proceed with the following methodology during the user-experience pre-test stage:

Individual and Small Group User-Experience Survey:

- Construct a questionnaire tailored from aggregated research, in-depth interviews, and user characteristics from Stage I of the research
- Design a tailored sample to reflect the broad demographic and socioeconomic diversity in Mississippi
- Probe on the type of user-experience participants want, how to best render the exchange (e.g. trade-off between choice and simplicity), and deduce a unique user-experience theme specific to Mississippi
- Understand what aspects pose complications for consumers and how to address potential issues
- Probe on delivery methods and mediums (e.g. online, telephone, paper, in-person)
- Digest quantitative data to provide direction in creating an Exchange mock-up

The MID team should aggregate quantitative data obtained via survey to further probe on the user-experience Mississippi residents want. Post survey launch, MID should work to develop a series of mock-ups depicting the exchange.

MID should pre-test the constructed exchange mock-ups with various stakeholders to garner user feedback. The mock-ups will be presented via laptop to ensure a more real experience for participants. Additionally, a call script will be created to test the possibility of administering aspects of the exchange by telephone.

Focus Group Pre-testing in Mississippi:

- Design a custom user experience that is supported by both quantitative and qualitative data
- Consult with third party developers to construct the user-experience
- Conduct focus group demonstrations throughout the State of Mississippi to garner real-time reactions, perceptions, and feedback from potential users
- Participants will vary from small group owners, brokers, and individuals
- The target areas will include Tupelo, Olive Branch, Greenville, Jackson, and Gulf Port

b. USER-EXPERIENCE: DEVELOPMENT PHASE

The second phase of the user-experience will focus on refining the exchange mock-up to reflect the feedback gathered during the pre-test phase. During the second phase, MID should dig deeper into the nuances of Mississippians to facilitate a custom user-experience package. The user-experience will be tested on different demographic and socioeconomic participants to ensure the package is tailored for all Mississippians.

MID should amalgamate all responses from the pre-testing phase into a general conception of what the user-experience should be. MID should then fine-tune the exchange mock-up to reflect the captured data from the pre-test. A second series of focus groups will be conducted to test the validity of the mock-up to ensure positive consumer responses from Mississippians.

Product Research and Development

- Analyze pre-test exchange mock-up designs and their associated user responses
- Develop two interactive mediums (website and mail) for later focus group participants
- If necessary work with an associated third party developer to facilitate an interactive user experience medium

Exchange User Focus group

- Refine user-experiences (e.g. enrollment methods, information processes, etc.)
- Present experiences in two mediums (website and mail)
- Present a series of user-experiences to the participants and gauge their sentiment toward the process
- The target areas will include Tupelo, Olive Branch, Greenville, Jackson, and Gulf Port.
- Record all feedback, suggestions, concerns, etc. and implement them into the final user-experience for MID

c. USER-EXPERIENCE: POST-DEVELOPMENT PHASE

The Post-Development phase of the user-experience is to finalize the exchange and gather final feedback from hundreds of potential exchange participants throughout the state.

MID should work with developers to wireframe a beta-version of the exchange online (and possibly by telephone). A survey will then be sent to hundreds of small businesses throughout

Mississippi to test the exchange and then answer a series of questions about their user-experience.

User-Experience Survey

- Work with developers to create a finalized version of the exchange
- Construct a questionnaire tailored for consumers participating in the mock-up exchange
- Require participants to test the wire-framed version of the exchange
- Probe participants on the user-experience
- Digest quantitative data to provide final direction in tailoring the optimal exchange for Mississippians

The end result of the user-experience testing portion of this work will be an exchange that is tailored to the needs of Mississippians and one which will garner high participation rates. Additionally, it is expected that user testing will serve as a tool for making various businesses throughout the state aware of the exchange, further increasing participation rates.

User Experience: Worksteps

Quantitative Research: Individual and Small Group User-Experience Survey:

- Construct a questionnaire tailored from aggregated research, in-depth interviews, and user characteristics from Stage I of the research
- Online survey programming
- Sample creation
- Online survey using post-cards and email to recruit
- Survey monitoring / weekly or daily frequency updates
- Statistical data analysis
- Excel frequency and cross-tabs
- Raw data file
- Digest quantitative data to provide direction in creating an Exchange mock-up
- Working with developers to create exchange mock-ups to be tested in focus groups

Initial Pre-testing in Mississippi

- Questionnaire design
- Sample design
- Recruiting and honorariums

- Identifying and securing focus group locations Logistics
- Focus groups conducted in:
    - Tupelo
    - Olive Branch
    - Greenville
    - Jackson
    - Gulfport
- Expert facilitation by QRCA and PRC qualified moderator
- Video and audio recording to track feedback from participants
- Integration of report findings into further exchange development
- Amalgamate quantitative and qualitative data to implement new data in the mock-up experience
- Work with third party website developers and programmers to create a functioning web portal that is operational offline

Secondary Testing in Mississippi

- Questionnaire design
- Providing laptops and electronic devices for testing exchange
- Sample design
- Recruiting and honorariums
- Identifying and securing focus group locations Logistics
- Focus groups conducted in:
    - Tupelo
    - Olive Branch
    - Greenville
    - Jackson
    - Gulfport
- Expert facilitation by QRCA and PRC qualified moderator
- Video and audio recording to track feedback from participants.
- Integration of report findings into further exchange development and wire-framing

Quantitative Research: Individual and Small Group User-Experience Survey:

- Working with developers to create a full wireframe version of the exchange for testing
- Construct a questionnaire tailored from aggregated research, in-depth interviews, and user characteristics from pre-test phase of the research

- Sample creation
- Instrument design
- Online survey programming
- Survey tracking / weekly or daily frequency updates
- Telephone, mail, and online survey
- Statistical data analysis
- Excel frequency and cross-tabs
- Raw data file

Data Synthesis and Presentation Creation

- Deductively review all data and assumptions
- Evaluate assumptions and derive key findings and recommendations
- Integrate qualitative research, in-depth interviews, and audit research findings into a written report or PowerPoint
- Quality assurance of report
- Initial presentation to small group of stakeholders
- Interim report revisions
- Final presentation
- Final report revisions

Timeline

It is expected that the user-experience portion of the research will be conducted between October 2011 and May 2012.

Outreach and Marketing

Stage I research revealed the importance of education and outreach in order to create a successful Mississippi Health Benefits Exchange. MID should begin initial research on possible outreach and marketing methods while conducting analysis on the user-experience. Fortunately, Mississippi will save time and money by piggy-backing on the user-experience research to conduct the outreach and marketing portion of this research. MID should explore various outreach mediums and messaging during the user-experience survey and focus group phases of the user-experience (e.g. advertising via print, media, in-person, and online, etc). This will allow MID to measure the effectiveness of various outreach mediums throughout the State of Mississippi.

When conducting outreach and marketing research, there is often a disparity between what respondents say in a survey and what they actually do. Therefore, MID should work to make use of every opportunity to track how Mississippians actually seek information about health insurance and an exchange. Fortunately, user-experience testing provides opportunities for such testing.

Accordingly, MID should proceed with the following methodology:

Outreach and marketing channel and messaging testing:

- The initial survey sent to respondents to garner insights about the user-experience will include a portion focused on outreach and marketing to provide a baseline from which researchers will develop hypotheses
- Advertise for user-experience testing in local newspapers, by telephone, email, and other media and track which source has the highest response rate
- A/B testing of messaging to determine the value proposition that will result in the highest participation rates

Potential exchange participant focus groups:

- Probe individuals and small group employers regarding the most effective channels for outreach and marketing
- Better understand what would lead a participant to enroll in the exchange
- Understand key messaging and marketing collateral (e.g. case studies) that should be provided in order to lead individuals to enroll in and utilize the health exchange
- Discover the depth of understanding about health insurance and the exchange. Develop an education plan that will simplify insurance and the exchange resulting in higher participation rates

Small group and individual surveys:

- Test a set of refined messaging campaigns
- Finalize outreach and marketing plan (including education components)
- Quantifiably confirm insights and findings from initial survey, A/B testing, and focus groups
- Consolidate findings into a step-by-step outreach and marketing plan to significantly increase participation in the exchange

The final deliverable in the outreach and marketing phase of the research is to create a step-by-step outreach and marketing plan that will result in high participation rates. This approach will maximize the validity of MID's recommendations while minimizing project costs.

Outreach and Marketing Worksteps

Survey and Focus Group Marketing Channel and Message Testing

- Develop questions for initial user-experience survey that will provide baseline insights for developing hypotheses about outreach and marketing
- Determine various media in which to test exchange outreach campaign for user-experience focus groups
- Develop A/B messaging for exchange
- Execute logistics for A/B testing and recruiting in local media
- Develop interview guide questions for focus groups that include questions about outreach, marketing, and education of the exchange
- Piggy-back with user-experience focus group testing
- Track response rates through various media and messaging campaigns
- Refine approach and test in secondary focus groups for user-experience
- Synthesize findings into draft step-by-step approach

Final Survey

- Consolidating all findings from initial quantitative survey, A/B testing, focus group recruiting testing, and focus groups
- Developing 2 to 3 hypotheses regarding media channels, messaging, and education to test among survey respondents
- Consolidate findings from survey into final report

Step-by-Step Outreach and Marketing Guide

- Deductively review all data and assumptions
- Evaluate assumptions and derive key findings and recommendations
- Quality assurance of report
- Initial presentation to small group of stakeholders
- Interim report revisions
- Final presentation
- Final report revisions

Timeline

It is expected that the outreach and marketing phase of this research will be conducted between October 2011 and July 2012.

Resources and Capabilities Analysis

MID should conduct an audit of Mississippi's current resources and capabilities and provide the state with specific resources recommendations needed to properly implement an exchange. Resource gap analysis includes both the regulatory and the operations functions of the exchange. Conducting the resource and capabilities analyses will require an extensive understanding of MID (regulatory aspects of exchange) and Mississippi Comprehensive Health Insurance Risk Pool Association (operations aspect of exchange).

MID should obtain a range of analyses and recommendations to complete the audit of Mississippi's resources and capabilities. The following baseline analysis is recommended:

- Creating a model of the resources and capabilities needed for proper exchange implementation
- Conducting an employee and resource audit of the resources the state has committed to an exchange (resource and responsibilities map)
- Identifying gaps between state's current resources and ideal exchange implementation scenario
- Providing specific descriptions of human capital and resource needs

While the above audit recommendations will provide the state with robust strategic direction, MID can conduct deeper analysis and provide a more specific action plan for ensuring the necessary resources and capabilities to ensure the exchange's success. However, scaling-up the analysis will also scale-up project costs.

For example, a more rigorous recommendation may include:

- Creating a model of the resources and capabilities needed for proper exchange implementation
- Conducting detailed interviews with each employee, manager, and individual associated with the creation and maintenance of the exchange
- Analyzing work-load demands based on projections of exchange participation
- Creating database outlining exchange employee capabilities and productivity-levels

- Juxtaposing current state resources and employee capabilities with the model of resources needed for ideal project execution
- Identifying gaps between state's current resources and ideal exchange implementation scenario
- Writing a specific action plans, job descriptions, and acquisition forms for recruiting human capital and purchasing infrastructure
- Overseeing deployment of resources and following-up on a semi-annual basis for two years to conduct ongoing audits on the exchange resources and capabilities

It is advised that Mississippi health officials meet with MID to determine the ideal approach.

Research will allow MID to provide Mississippi exchange stakeholders with data and recommendations including:

1. Specific state models Mississippi should follow or avoid to maximize implementation
2. Step-by-step recommendations for best implement an exchange
3. Map of current resources, needed resources, and recommendations for filling gaps

Resources and Capabilities Analysis Worksteps

Initial Qualitative Research

- Review all news, commentary, blogs, whitepapers, research, government data and documents related to the exchange implementation
- Leverage internal expertise at MID in researching and implementing state exchanges
- Gather data from trade conferences and industry events
- Identify key academics, state leaders, industry analysts and exchange opinion leaders to participate in qualitative research
- Amalgamate research findings to provide direction for qualitative research portion

Qualitative Research: In-Depth exchange Interviews

- Develop interview guides for:
  - Leaders of other public exchanges to determine resource needs
  - Internal interviews with employees of Mississippi's high risk pool and the Mississippi Insurance Department
- Create contact list from internal contacts and secondary research
- Recruit and schedule interviews with participants
- Conduct 30-35 in-depth interviews with participants. Each interview will last 45 to 90 minutes
- Save and file digital recordings

- Synthesize interviews in individual internal reports
- Send honorariums to federal, state and industry participants

Resource and Capability Audit (Baseline)

- Based on domain expertise and research, create model of the necessary human capital and resources needs in order to properly implement exchange in Mississippi
- Work with state through in-depth interviews with employees, management, and others to map current human and resource assets in Mississippi
- Gap analysis of where Mississippi currently stands and where they need resources to achieve maximum exchange success
- Recommend skills, human capital, and other resources that will allow for best implementation
- Creating resource map of exchange needs juxtaposed with current Mississippi resources

Data Synthesis and Presentation Creation

- Deductively review all data and assumptions
- Evaluate assumptions and derive key findings and recommendations
- Integrate qualitative research, in-depth interviews, and audit research findings into a written report or PowerPoint
- Quality assurance of report
- Initial presentation to small group of stakeholders
- Interim report revisions
- Final presentation
- Final report revisions

Timeline

It is expected that the resource and capabilities section of this research will be conducted between January 2012 and June 2010.

06/02/2011

Mississippi Health Insurance Exchange Stakeholder Engagement Facilitation

Stakeholder Feedback

Gathering stakeholder input throughout the exchange review and creation process will be critical for the successful implementation of the exchange. In accordance with Mississippi's vision for stakeholder engagement, MID should oversee the formation of an Exchange Advisory Board (EAB), Community Input Groups (CIGs), and Technical Advisory Groups (TAGs) to most effectively gather stakeholder feedback. Stakeholder groups will represent a variety of perspectives including consumer groups, community representatives, health care providers, insurance carriers, brokers, and government leaders. This approach is designed to elicit a broad swath of ideas and expertise in a highly collaborative manner. The specific details of various stakeholder groups and their worksteps are outlined below.

1. Exchange Advisory Board
   There should be established an Exchange Advisory Board (EAB) for the purpose of facilitating stakeholder feedback and reporting findings and recommendations to the Board of Directors. The EAB should include diverse perspectives including the business community, the insurance industry, providers, brokers, and consumer advocacy representatives and be comprised of ten or fewer individuals. The role of the EAB is to ensure progress among the Community Input Groups (CIG) and accurately consolidate and communicate stakeholder feedback to the Board of Directors. One to two members of the EAB should be assigned to oversee the progress of each CIG and it is recommended they report their progress to the Board of Directors a minimum of three times annually. Meetings in which members of the EAB report to the Board of Directors should follow normal guidelines for state Open and Public Meetings, including posting notice and an agenda with sufficient advance notice so as to allow maximum stakeholder participation. The EAB's final recommendations will be presented to the Exchange Board in August of 2012.

2. Community Input Groups
   Each Community Input Group (CIG) be multi-stakeholder in nature with membership established by the EAB. The CIGs should be given a list of specific tasks, issues and time line for bringing recommendations back to the EAB. The CIGs may, with the approval of the EAB, create Technical Advisory Groups (TAGs) to address very specific or technical

issues assigned to the CIGs by the EAB. The CIGs will supervise any TAGs created and report input group recommendations to the EAB. The EAB should expect each CIG to provide findings, tangible ideas, and feedback regarding specific policies and processes as part of insurance implementation efforts. Community Input Groups should generally expect to meet once or twice monthly, depending on the complexity of the issue, the urgency of the issue, and reporting schedule as prescribed by the EAB. CIGs should record all meetings and be prepared to report to the EAB with both written and oral presentations. In order to maximize opportunities for stakeholder participation, dates, times and locations of meetings for the Community Input Groups should be made available on the MID website. While interim reports may be requested by the EAB, CIGs should expect to present final recommendations to the Exchange Advisory Board in July 2012.

3. Technical Advisory Groups
   As described above, Technical Advisory Groups (TAGs) may be formed at the request of a Community Input Group and with the approval of the Exchange Advisory Board. The purpose of a TAG is to closely study very specific, technical issue areas and then to make recommendations to the Community Input Group. TAGs should generally expect to meet once or twice monthly, depending on the complexity of the issue assigned, the urgency of the issue, and reporting schedule of the Community Input Group to which the TAG is a subsidiary. TAGs should record all meetings and be prepared to report to CIGs with both written and oral presentations. The work and recommendations of TAGs should be supervised and vetted by their respective CIGs and reported to the EAB by the CIGs, along with other CIG recommendations. While interim reports may be requested by CIGs, TAGs should expect to present final recommendations to CIGs in June 2012.

Stakeholder Feedback—Areas of Interest

Ultimately, the Exchange Board and Exchange Advisory Board will decide specific areas of research where Community Input Groups and Technical Advisory Groups will be most effective. The following areas present the important focus areas for garnering stakeholder feedback.

Community Input Groups (CIGs) – Areas of Focus:

- Outreach and Education
- Choice and Transparency
- Federal Compliance
- Implementation and Oversight

Technical Advisory Groups (TAGs) – Areas of Focus (sub-bullets):

- Outreach and Education
  - Points of access
  - Driving adoption

- Choice and Transparency
  - Plan options
  - Decision support
- Federal Compliance
  - Federal compliance: AHBE
  - Federal compliance: SHOP
- Implementation and Oversight
  - Public Program Integration (including churn management)
  - Resource management
  - Regulation

MID should be intricately involved in ensuring the stakeholder portion of this work is highly successful. MID will conduct primary research throughout the exchange planning, design, and implementation. Additionally, MID will make themselves available to provide direction and knowledge about the exchange. An MID staffer should attend each Exchange Advisory Board and Community Input Group meeting. MID will also provide recording and back-up recording equipment for all Exchange Advisory Board, Community Input Group, and Technical Advisory Group meetings.

MID's primary work will be to ensure that all stakeholder groups provide actionable findings for the Exchange Board. MID will develop meeting notes into full reports and recommendations. They will then send reports back to stakeholders to ensure that findings have been accurately captured. Finally, they will ensure that all stakeholders feel that their voice has been heard and fairly considered.

The table (TABLE 1) at the end of this section is for illustrative purposes only and is intended to provide the MID with a visual representation of the issues, tasks for the Exchange Advisory Board, Community Input Groups, Technical Advisory Groups, and reporting schedule associated with a large-scale stakeholder input project. As stated previously, the EAB will name the input and advisory groups, identify the issues and sub-issues, and invite participants. Reporting schedules will depend on the complexity of the issues involved as well as the legislative calendar (for those issues requiring legislative action.) MID and the EAB should work closely in managing this stakeholder process.

06/02/2011

Mississippi Health Insurance Exchange Technology Procurement

Request for Proposal Design and Development

MID will offer education and technical assistance to the Exchange Executive Director (the Director) and the Exchange Board of Directors (the Board) to craft a Request for Proposals (RFP) designed to reflect the outcomes associated with the preliminary background research as well as the findings of the Exchange Advisory Board. MID should work closely with the Exchange staff and Board of Directors to assist them with overseeing the following parts of the Exchange implementation process:

A. WORKSTEPS

Developing Exchange Implementation Scope of Work (SOW)

- MID will assist the Director and the Board in crafting a Scope of Work (SOW) that includes all major design elements desired by the State of Mississippi for exchange implementation. Inherent in this approach should be a commitment to seek out and leverage existing resources and technologies in both the public and private sectors in order to facilitate specific or all components of the exchange.

Exchange Implementation Full RFP Development

- An Exchange Implementation RFP will need to be produced in an effort to secure the vendors and technologies necessary to fill any technological deficiencies. The RFP should require respondents to provide a comprehensive response to the Statement of Work. However, the RFP should also allow respondents to provide alternative and creative strategies for the development of an exchange focusing on possible implementations that include ancillary components and cost reduction strategies. It is absolutely critical that the Exchange craft an RFP that asks crucial questions of potential respondents. MID should work closely with the Director and the Board to produce a comprehensive document that is highly reflective of the state's needs with respect to technology and the desired Exchange model.

Exchange RFP Review Committee

- The Exchange should establish a Vendor Review Committee consistent with established contracting guidelines. Ideally, the committee will consist of personnel that, collectively, have experience in both health policy and technology infrastructure implementation. This committee will be responsible for the following:
    - Finalization and issuing the Exchange Implementation RFP
    - Evaluating the vendor responses to the RFP conducting oral presentations
    - Providing a final recommendations to the Board of Directors

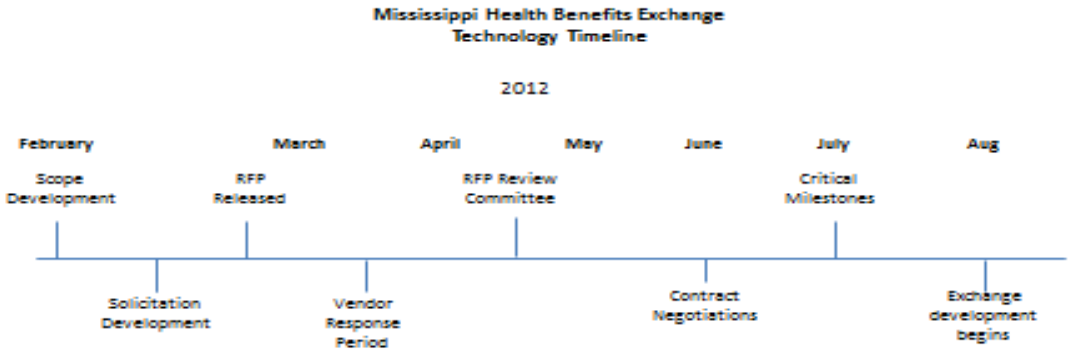
- As requested by the Exchange, MID should be available in an advisory capacity to the RFP Review Committee. While the ultimate decision will be that of Board, MID should provide expertise and practical insight as needed and requested.

Developing Critical Milestones for Implementation

- This phase of exchange implementation involves developing and articulating critical milestones as well as an associated timeline for exchange implementation. Milestones and timelines will largely be a function of available funding, the State I market and policy research, and the findings and recommendations of the stakeholder input groups.

Timeline

It is anticipated that the work performed in conjunction with this proposal will follow the timeline below:


Mississippi Health Benefits Exchange
Technology Timeline
2012
February
March
April
May
June
July
Aug
Scope Development
RFP Released
RFP Review Committee
Critical Milestones
Solicitation Development
Vendor Response Period
Contract Negotiations
Exchange development begins

LEAVITT PARTNERS HEALTH INSURANCE EXCHANGE CLIENT INFORMATION UPDATES

As part of an ongoing information and education effort, Leavitt Partners supplied MID with weekly newsletters beginning February 2011 and continuing through the duration of the engagement. Information sources for the newsletters included newspapers, trade publications, government websites, and peer-reviewed journals. These updates were not intended to be in-depth reports; rather they were meant as a "dashboard" of sorts, highlighting news and information associated with insurance exchange design, development, and establishment at both the state and national levels. The following updates are in reverse order, with the most recent appearing first.

- **Exchange Establishment:** Governor Chafee issues an Executive Order establishing the Rhode Island Health Benefits Exchange; Nevada and Tennessee begin holding stakeholder sessions.
- **Exchange Funding:** Idaho Gov. Otter announces his approval for state to apply for federal funding; Arkansas' Insurance Commissioner asks state legislators for their support in applying for a federal grant; and Minnesota Gov. Dayton defends his authority to use their $4 million grant.
- **Partnership Model:** HHS released information on the State Partnership Model, which provides states with three options for their role in the exchange: 1) *Option 1* – States take the lead on working with and overseeing health plans in the exchange. 2) *Option 2* – States conduct outreach and education, provide in-person consumer support, and manage the call center and the consumer website. 3) *Option 3* **–** Both Option 1 and Option 2. However, because states would only be operating a portion of the exchange, State Partnership exchanges would legally be considered a federal exchange.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 09/16/2011 – 09/23/2011

Federal News

Insurance Exchanges: Lessons From The Life And Death Of Pac Advantage 09/22/2011

In 2001, PacAdvantage, the largest non-profit health insurance exchange in the country, was peaking, with enrolled membership reaching nearly 150,000. At the same time our suppliers — insurance carriers — were starting to squirm. The exchange offered guaranteed-issue health insurance plans to qualified small businesses in California. But with the carriers balking at participating over concerns about adverse selection, we increasingly had fewer options to offer our small business customers.

http://healthaffairs.org/blog/2011/09/22/insurance-exchanges-lessons-from-the-life-and-death-of-pac-advantage/

Exchange Timeline 09/20/2011

A timeline published on the HHS website indicates that in the fall of 2011 through the summer of 2012, states will identify the kinds of technical assistance they need, as soon as possible. Exchanges will begin to be approved in summer 2012, with June 29 the last date to apply for exchange establishment grants. The deadline for conditional or full approval of an exchange is Jan. 1, 2013. States may move from conditional to full approval after that date, though, HHS says. Enrollment of consumers is to begin in 2013 and full use of the exchanges is set to launch in 2014.

CQ Healthbeat News

Providers seek vendor help with ACOs 09/21/2011

As health organizations begin to feel their way toward accountable care models, a new report from KLAS explores how providers and vendors are putting the pieces together, finding varying levels of confidence in IT solutions' integration ability. For the new report, titled "Accountable Care: Providers Forge the ACO Trail," KLAS interviewed 197 providers at 187 organizations to get a picture of how they're approaching accountable care – and how health IT tools are helping (or hindering) their efforts.

http://www.healthcareitnews.com/news/providers-seek-vendor-help-acos?topic=02,04,08,12,29,19

States still unclear on health insurance exchanges 09/20/2011

States are facing three options in building the exchanges: run one themselves, do it in a partnership with the federal government or let the Health and Human Services Department take over entirely. States officials hoping to gain some clarity on what a federal exchange could look like, left a D.C meeting with a lot of questions still unanswered. Representatives from 46 states met with CCIIO and HHS officials in Washington yesterday and Monday. "I haven't learned anything new about what the federal exchange would look like," one state insurance official told Reuters. However, it did became clear, three attendees said, that states partnering with the federal government would effectively give up authority over determining who is eligible to enroll in an exchange.
http://www.reuters.com/article/2011/09/21/us-usa-health-insurance-idUSTRE78K08220110921

Four Insurers to Pool Claims In Research Database 09/20/2011

Calling health care spending the "single biggest financial issue facing the nation," a group of four national health insurers announced plans Tuesday to pool more than 5 billion health care claims into a single database that researchers can mine to identify trends in cost, utilization and intensity of care. The Health Care Cost Institute is a not-for-profit research group governed by a six-member board of academic, actuarial and medical professionals who will oversee the database created using data from four insurers: Aetna, Humana, Kaiser Permanente and UnitedHealthcare. The database will include government data from Medicare and Medicare Advantage plans, and it may eventually include information from other private insurers
http://www.kaiserhealthnews.org/Daily-Reports/2011/September/21/claims-datasbase.aspx .

States Raise Concerns With 'Partnership' Models For Exchanges 09/20/2011

A meeting of state and federal health officials turned tense this week as state regulators raised objections to the Obama administration's proposals for insurance exchanges. A person who attended the two-day meeting said states complained about proposals for a "partnership" model in which states and the federal government would jointly operate some exchanges. "The feds were more defensive than I have ever seen them," the attendee said.
http://thehill.com/blogs/healthwatch/health-reform-implementation/182829-states-raise-concerns-with-partnership-models-for-exchanges

WellPoint sets up private insurance exchange to compete with states 09/20/2011

WellPoint, the nation's largest health insurer is setting up a private health insurance exchange to compete with those created and managed by governments under federal health care reform legislation. The exchange is a joint effort between WellPoint, Blue Cross Blue Shield of Michigan, and Health Care Service Corporation. The exchange will serve all national markets and create a defined contribution solution for employers.
http://civsourceonline.com/2011/09/20/wellpoint-sets-up-private-insurance-exchange-to-compete-with-states/?utm_source=rss&utm_medium=rss&utm_campaign=wellpoint-sets-up-private-insurance-exchange-to-compete-with-states

Ario's Last Day 09/19/2011

Friday marks Joel Ario's last day as CCIIO's exchange director. Ario oversaw exchange planning grants, Early Innovator Grants, several rounds of establishment grants, and the first two sets of exchange regs. He was also considered a solid working partner for the states. CCIIO Director Steve Larsen and Deputy Director Tim Hill are picking up Ario's portfolio, and CCIIO is on the lookout for a state liaison to serve as a main point of contact for states' exchange questions.
Politico

Partnering with States to Implement Affordable Insurance Exchanges 09/19/2011

Today, we are proposing the Affordable Insurance Exchange "Partnership Options" Opportunities initiative that will give States new choices to consider as they plan their Exchanges for 2014. While some States may choose to fully operate an Exchange, others might wish choose to perform some functions and let the federal government perform others for them. This is exactly what the Partnership Options proposal offers. States can choose their role in the Partnership Exchange from three basic options. These options are:
Option 1 – Plan management. States take the lead on working with health plans who want to participate in the exchange to offer coverage.
Option 2 – Selected consumer assistance. States will help you understand your options—they will do conduct outreach and education, provide in-person consumer support for Exchanges, and manage the call center and the consumer website where you can get the most up to date information.
Option 3 – Both Option 1 and Option 2.
http://blog.cms.gov/2011/09/19/partnering-with-states-to-implement-affordable-insurance-exchanges/

http://www.healthcare.gov/news/factsheets/2011/09/exchanges09192011a.html

States Head to DC with Questions about Health Insurance Exchanges 09/19/2011

Leaders from the Health and Human Services Department will discuss exchanges with representatives from 46 states, Washington, D.C., and the territories. HHS has been tight-lipped about the two-day, closed-door meeting. But there's plenty to talk about. Many states want more information about the federal fallback exchange that HHS can set up in states that don't establish their own, and HHS is eager to sell reluctant states on a partnership model. And even states that are eager to implement health care reform want to see regulations on essential health benefits. States will have a much better idea of how to build their exchanges once HHS releases those rules.
http://www.kaiserhealthnews.org/Daily-Reports/2011/September/19/waivers-health-excahnges-and-health-care-compacts.aspx

Administration tries to sell states on health insurance exchanges 09/19/2011

Worried that the federal government could end up running new insurance marketplaces for dozens of states, the Obama administration is making a new pitch Monday for cooperation to 46 states and the District of Columbia. Health officials from the states are meeting in Washington with the administration, which is proposing several models for ways to divide exchange duties between Washington and the states.
http://www.bostonherald.com/news/us_politics/view/20110919administration_tries_to_sell_states_on_health_insurance_exchanges/

Implementing Health Insurance Exchanges: State Profiles 09/18/2011

This series of briefs examines the states' progress in setting up the state-based health insurance exchanges through which millions of Americans are expected to purchase coverage under the Affordable Care Act (ACA) beginning in 2014. The exchanges, a key component of the law, are expected to enable consumers to compare a selection of qualified health insurance options in order to find the plan that best meets their needs and budget. These briefs review the states' progress, including where each individual state is in the legislative process; whether the state has received funding from the federal government to establish the exchanges; and the next steps each state is taking to implement its exchange.
http://www.kff.org/healthreform/8223.cfm

State News

Arkansas:

Lawmakers asked to OK applying for health exchange grant 09/16/2011

Arkansas Insurance Commissioner Jay Bradford today asked state legislators to signal their support for the state to apply for a federal grant to fund continued planning for a state health insurance exchange. In a meeting with lawmakers, Bradford and Cynthia Crone, planning director for the exchange, said the grant likely would be about $5 million. The deadline to apply is Sept. 30. Bradford said Gov. Mike Beebe had directed the state Insurance Department not to apply for the grant unless legislators indicate they approve. "If we don't get a letter from the governor with your encouragement to go through the process (of applying), we're bailing," Bradford said
http://arkansasnews.com/2011/09/16/lawmakers-asked-to-ok-applying-for-health-exchange-grant/

Arizona:

Ariz. groups urge state to create health exchange 09/19/2011

In the wake of industry efforts to create an Arizona exchange in a fashion to their liking, social service advocates are offering their own wish-list of features that they say would help consumers. Meanwhile, some conservatives are urging the state to refrain from creating an exchange, a step they argue could be seen as endorsing the overhaul. Legislators could be presented the issue in their 2012 session, but two bills to create an exchange died in the 2011 regular session amid strong opposition by many majority Republicans to the overhaul.
http://www.gvnews.com/news/state/ariz-groups-urge-state-to-create-health-exchange/article_1b737940-bcb9-512f-894d-0e95f52bb60f.html

Idaho:

Otter gives go-ahead to apply for fed grant to start Idaho health insurance exchange 09/20/2011

Idaho Gov. Butch Otter announced today that he's decided to allow the Idaho Department of Health & Welfare and the Idaho Department of Insurance to apply for federal grant funding to start an Idaho health insurance exchange. "It's a difficult choice, but one I find far preferable to submitting to a federally established insurance exchange, with all the loss of control over our own destiny that entails," Otter said. He said the exchange will be designed to make health coverage more accessible and affordable for Idahoans.

http://www.spokesman.com/blogs/boise/2011/sep/20/otter-gives-go-ahead-apply-fed-grant-start-idaho-health-insurance-exchange/

Illinois:

State Releases Key Health Benefits Exchange Planning Reports 09/19/2011

The Illinois Department of Insurance today released reports commissioned by the State of Illinois to aid in the process of establishing a state-based health insurance exchange (Exchange) in Illinois. According to the reports, an Illinois Exchange is projected to decrease the number of uninsured in Illinois by almost half – from 12 percent of the population to 7 percent. 1.4 million currently uninsured Illinoisans will receive coverage through the Exchange by 2020. The reports highlight the significant role of the Exchange as the sole access point for hard-working individuals, families and small businesses to claim federal tax credits to purchase private health coverage. The reports also highlight the complex process that will establish the new insurance marketplace in Illinois, and the necessity of passing enabling legislation to create the exchange by the end of 2011.

http://www.wifr.com/news/headlines/State_Releases_Key_Health_Benefits__Exchange_Planning_Reports__130128178.html?ref=178

Report: Health-benefits exchange could cost up to $8 million annually 09/17/2011

A health insurance exchange would cost Illinois $57 million to $89 million a year to operate and could be funded through a tax on all insurance companies offering coverage in the exchange, according to a report released Friday. It's unknown whether the proposed assessment would be passed on to consumers. The assessment would be equivalent to between 2.2 percent and 3.4 percent of premiums paid for each person covered through the exchange, or $8.90 to $13.50 per member per month, according to the report from Wakely Consulting Group and Health Management Consultants.

http://www.sj-r.com/top-stories/x1408087962/Report-Health-benefits-exchange-could-cost-up-to-89-million-annually

Kansas:

Brownback under fire for rejecting health care grant 09/20/2011

Gov. Sam Brownback has come under fire from Democrats and some Republicans ever since his administration rejected a $31.5 million federal "early innovator" grant for health care reform that it had earlier voiced support for. A woman from Wichita submitted a petition last week with more than 3,000 signatures protesting rejection of the grant. Like other petitions, it will be analyzed to see if those signing are Kansans. Then a report about the petition and its signers will be forwarded to the governor and his constituent services staff will prepare a response.

http://www.kansas.com/2011/09/20/2024523/governor-under-fire-for-rejecting.html

Maine:

Recommendations Regarding the Maine Health Benefit Exchange 09/201/2011

Report to the Governor and the Joint Standing Committee on Insurance and Financial Services. From the Advisory Committee on Maine's Health Insurance Exchange

http://www.dirigohealth.maine.gov/Documents/Advisory%20Committee%20Report%20on%20Health%20Insurance%20Exchange%20(Final%209-20-11).pdf

Minnesota:

Criticism, contention mounts over health insurance exchanges 09/21/2011

Republican lawmakers have taken Gov. Mark Dayton to task for using a $4 million federal grant to help lay a cornerstone of President Barack Obama's politically-divisive health care law. But Dayton administration officials, backed by documents, say that the governor has authority not only to use the $4 million, but $28 million in total during the current two-year budget cycle. State law gives the administration authority to spend federal grants if it follows required budgeting procedures.
http://minnesota.publicradio.org/display/web/2011/09/20/criticism-contention-health-insurance-exchange/

Missouri:

Tea party rally aims to remind governor of Missouri vote 09/18/2011

Many supporters of a state measure voted into law in 2010 noted they needed new signs for the Saturday morning rally they held on the north side of the Missouri Capitol. "I never thought I would need it again after the vote in August," one man said as he handed out signs and a light rain began to fall. He was referring to what was known as Proposition C, a measure designed to exempt the state from the federal insurance mandate. The measure passed overwhelmingly last year, but supporters say recent actions by Gov. Jay Nixon and the general assembly go against the spirit of the measure by working to establish a state-run health insurance exchange.
http://www.newstribune.com/news/2011/sep/18/tea-party-rally-aims-remind-governor-missouri-vote/

Montana:

Insurance commissioner pushes for some Montana control over mandated health insurance exchange 09/22/2011

The federal government is giving states like Montana another chance to run at least parts of the insurance exchanges. Montana Insurance Commissioner Monica Lindeen said developing federal rules opens the way for more state involvement in the health insurance exchanges, even in places like Montana where the legislature rejected an option to have the state run the exchanges with federal grants. Lindeen said she will be meeting with stakeholders, such as medical providers and patient advocates, in the coming weeks to discuss ways the state could be involved. After that, Lindeen said she will make a decision on the exchanges. The Democrat remains confident that Montanans would rather deal with the state on the exchanges rather than the federal government, making it worthwhile to explore the issue despite the controversial nature of the federal health care law.
http://www.therepublic.com/view/story/bd7a6c0eabd4471b88d408c4f0062d30/MT--Lindeen-Health-Care/

Nevada:

Exchange Week 09/19/2011

There has been little exchange progress in Nevada since Republican Gov. Brian Sandoval signed an exchange bill three months ago, but the state is kicking off a series of listening sessions with small focus groups this week. The Division of Health Care Financing and Policy will host separate listening sessions on Wednesday with minority communities and low-income consumers in Las Vegas, and the department meets with consumer advocates on Thursday.
Politico

New York:

Sen. Hannon on Health Exchange Status 09/20/2011

Senate Republicans say there is no rush for the state to set up a health insurance exchange. The exchange is a requirement of the Affordable Health Care Act. And Senator Kemp Hannon, who chairs the Senate Health Committee, says he is getting mixed messages on what exactly the requirements are.
http://www.capitaltonight.com/2011/09/sen-hannon-on-health-exchange-status/

Rhode Island:

Executive Order: Chafee Establishes Health Exchange 09/19/2011

In a move viewed as one of the state's first steps toward providing health insurance for all of its residents, Governor Chafee today will issue an Executive Order establishing the Rhode Island Health Benefits Exchange. In addition to establishing the Exchange, the Governor appointed a board that will oversee the project, naming U.S. Attorney Meredith "Meg" Curran as chair. Donald Nokes, President & Co-Founder of NetCenergy, will serve as vice-chair. The Exchange Board will recommend design and policy decisions for the Exchange as it is developed. The Exchange is scheduled to start enrolling Rhode Islanders in health insurance by late 2013. Both Gov. Chafee and the Legislature want to set up an exchange in a quasi-public entity, but Chafee only has the power to set up an exchange in an executive office. Senate President Teresa Paiva Weed will bring up legislation early in 2012 to get a quasi-public exchange going.

http://www.golocalprov.com/news/health-exchange/

Tennessee:

State Weighing Whether to Run Insurance Exchange 09/19/2011

Many Tennessee lawmakers say they're still waiting to see whether the federal healthcare overhaul will hold up in court. But with the clock ticking to figure out whether the state will set up its own insurance exchange as part of that law, officials are already working to hash out a recommendation. Gunderson says while the state contemplates an exchange, officials are gathering input from insurers, healthcare providers and patient advocates across Tennessee. Officials expect to offer a recommendation by early next year.

http://wpln.org/?p=30349

Wyoming:

Health exchange legislation timeline 09/19/2011

The state committee studying health insurance exchanges must complete is recommendations before the Wyoming Legislature goes back into session in January. According to discussion at last week's meeting, it sounds like the committee will meet twice next month. Members will start going over cost projections and examples of exchange legislation written by other states. Then in December, the group will meet over three days to draft the legislation for Wyoming. Whatever comes out of the meeting will be sent to the Legislature.

http://trib.com/news/opinion/blogs/wolfjammies/article_47a810e9-10f4-5fc9-850f-f220e2761b69.html

- **Establishing exchanges:** Governor Snyder says Michigan will implement an exchange. The MI Health Marketplace will be a nonprofit governed by an executive board appointed by the governor. He wants the Legislature to have an exchange bill ready before Thanksgiving.
- **Pushing back on exchanges:** Several Republican lawmakers in New York are blocking the state from holding a special session to take up the exchange bill from last session; Republican Senators in Missouri also delayed a state board from formally accepting federal grant money the state had been awarded to establish a Show-Me Health Insurance Exchange.
- **Desire for exchanges:** Stakeholders in New Jersey and consumer advocates in Ohio push for active, state-based exchanges; however, Wyoming Gov. Matt Mead says the state needs a viable state alternative to federal health care reform.
- **Governance:** The Virginia Health Reform Initiative Advisory Council voted to create a state health insurance exchange as a quasi-public body, similar to the Virginia Housing Development Authority, rather than a new arm of the State Corporation Commission.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 09/09/2011 – 09/16/2011

Federal News

NADP/DDPA Exchange White Paper 09/16/2011

The Affordable Care Act (ACA) allows for separate dental policies to provide coverage for 'pediatric oral services' as part of the Essential Health Benefits Package (EHBP) to be offered in the small group and individual market. In addition, the state Exchanges must also allow for standalone dental policies to be offered on the Exchanges. As state policymakers work towards implementing Exchanges, the National Association of Dental Plans (NADP) and Delta Dental Plans Association (DDPA) have provided options, recommendations, and background for best practices on how to include dental policies into health Exchanges.
http://www.nadp.org/Advocacy/HealthCareReform/ExchangeWhitePaper.aspx

NADP Survey Reports on Employer-Sponsored Dental Coverage: Will Small Employers Keep Dental Coverage Outside the New Health Exchanges? 09/15/2011

An increased number of employers are offering separate dental plans than ever before, according to the National Association of Dental (NADP) Plans 2011 Group Purchaser Behavior Study released today. The study also reveals more than 80 percent of all companies surveyed are likely to invest in -- or continue -- offering health benefits rather than pay a $2,000 penalty to the federal government when the Affordable Care Act is implemented in 2014.
http://www.marketwatch.com/story/nadp-survey-reports-on-employer-sponsored-dental-coverage-2011-09-15

States Take Wide Variety of Approaches to Obamacare Exchange Mandate 09/14/2011

Perhaps the biggest state challenge recently has been whether to set up a health insurance exchange as required by President Obama's health care law. States are all over the map—both literally and figuratively.
http://news.heartland.org/newspaper-article/2011/09/14/states-take-wide-variety-approaches-obamacare-exchange-mandate

As states lag in implementing health-care law, bigger federal role looks likely 09/10/2011

Across the country, states are lagging in preparations to erect the health insurance market-places at the heart of the 2010 health care overhaul, bogged down by a combination of partisan hostility and practical hurdles. Faced with the delay, administration officials have been ramping up talks with state leaders in recent weeks over ways the federal government could pitch in without having to completely take over — speaking both informally and at a series of regional meetings underway.
http://www.washingtonpost.com/national/health-science/as-states-lag-in-implementing-health-care-law-bigger-federal-role-looks-likely/2011/08/29/gIQA8k6ZIK_story.html

Yes, the Federal Exchanges can offer Premium Tax Credits 09/12/2011

Section 1311 of the ACA requests the states to establish American Health Benefit Exchanges and sets out the duties of the exchanges. Section 1321 of the ACA, however, provides that if a state elects not to establish and exchange or fails to do so, HHS must "establish and operate" an exchange in such a state and "take such actions as are necessary to implement" the other requirements of title I of the ACA, which includes offering premium tax credits.
http://thehealthcareblog.com/blog/2011/09/12/yes-the-federal-exchanges-can-offer-premium-tax-credits/

A Low-Cost Short Cut to Primary Health Care 09/12/2011

Direct primary care (DPC), a low-cost alternative to conventional health care, is sometimes described as the middle-class version of "concierge" or "boutique" medical practices started in the 1990s to cater to the wealthy. DPC providers will also soon be allowed to compete within state-based insurance exchanges thanks to a provision included in the 2010 health-care reform legislation, The term "direct practice" was first used in legislation in Washington in 2007 that clarified these practices were not insurance companies under state law—but they do provide basic, preventive medical care.
http://www.cnbc.com/id/44175865

State of the States: Health Insurance Exchange Developments 09/09/11

This Week in the States: A new wrinkle emerged to complicate the decision states face on whether to establish their own exchange or defer to the federal government to do so. Investor's Business Daily published a piece this week in which they highlighted a drafting error in the Affordable Care Act that could be read to prohibit individuals purchasing coverage in a federally-established exchange from receiving the premium tax credits that are its biggest draw.
http://www.mckennalong.com/assets/attachments/MLA%20Exchange%20Legislation%20State%20of%20the%20States%2009.09.11.pdf

State News

Alabama:

Health insurance exchange commission to hold inaugural meeting Friday 09/15/2011

The inaugural meeting of Gov. Robert Bentley's Health Insurance Exchange Study Commission will be Friday in Montgomery. The meeting is set for 10 a.m. in the Capitol auditorium. Bentley in June created the commission to help Alabama comply with the federal Patient Protection and Affordable Care Act of 2010 that requires health insurance exchanges.
http://www.gadsdentimes.com/article/20110915/NEWS/110919847?Title=Health-insurance-exchange-commission-to-hold-inaugural-meeting-Friday

Colorado:

Eye-popping salaries proposed for health care exchange 09/16/2011

Eye-popping salaries proposed for employees of the health benefits exchange being formed in Colorado grabbed the attention of Republicans and Democrats alike on Thursday. A subcommittee of the board charged with establishing the exchange is considering a draft budget for its federal grant application that would create 24 positions and pay those employees a total of more than $3 million annually to manage the health care cooperative.
http://www.chieftain.com/news/local/eye-popping-salaries-proposed-for-health-care-exchange/article_b0062332-e01d-11e0-b452-001cc4c002e0.html

Florida:

Fla. passes up over $100 million in federal grants 09/13/2011

Gov. Rick Scott and the Republican-led Legislature have rejected or declined to pursue more than $106 million in federal grant money and returned another $4.5 million for programs linked to federal health care initiatives, including cancer prevention, leading critics to say he is putting his conservative agenda ahead of residents' needs.

http://www.fosters.com/apps/pbcs.dll/article?AID=/20110913/GJLIFESTYLES/110909485/-1/SANNEWS

Maine:

Maine Panel Wants Some More Time 09/15/2011

Gov. Paul LePage's exchange steering committee finalized its recommendations last night and had been scheduled to send them to LePage today, but the nine members want some more time to think things over. Members will consider the recommendations over the weekend and hold an email vote on Monday. They advisory panel's final recommendations call for the exchange to be established within an existing state department under the direction of a governor appointee.

Politico

Michigan:

Work set to start on health insurance exchange after Snyder delivers his state prescription 09/14/2011

The exchange, called MI Health Marketplace, will be established as a nonprofit. Legislation is being completed that may start in the Senate. It will create a structure and framework to authorize the exchange and move it forward as a nonprofit, said Steven Hilfinger, director of the Michigan Department of Licensing and Regulatory Affairs. "It creates a structure for the decision-making and implementation," he said. The nonprofit would be governed by a board that would be appointed by the governor and have the ability to appoint an executive director. There also would be an advisory board that would include representatives of small business, consumers, insurance plan providers, agents and others "who help facilitate the market," Hilfinger said. Gov. Rick Snyder wants the Legislature to have a bill done before Thanksgiving.

http://www.crainsdetroit.com/article/20110914/FREE/110919963#

Michigan governor wants to set up health insurance exchange, offer citizens healthy choices 09/14/2011

Governor Snyder said he wants the GOP-controlled Legislature to begin implementing requirements in the federal law this fall. That includes passing legislation setting up Michigan's version of a health insurance exchange called the MI Health Marketplace. Snyder wants to give a nonprofit company the authority to set up the exchange, and warned the federal government will step in with its own plan if Michigan doesn't have plans for an exchange in place by January 2013. More than half a million consumers are expected to purchase a policy through the exchange once its running in 2014. Snyder urged lawmakers to pass the necessary legislation by Thanksgiving so the state can use federal funding to set up the exchange and meet the requirements in the federal law.

http://www.therepublic.com/view/story/cb649d87f8c140f6afedd7cd44bc29e2/MI--Healthier-Michigan-Snyder/

Health Exchange Planning 09/08/2011

On September 8, the Health Exchange Planning workgroup in Michigan released its recommendations. They recommend Michigan establish a single, state-specific Exchange mindful of regional needs. They argue the Exchange should be an independent public authority with the option to seek non-profit status at a later date. Small employers should be defined as having between 1 and 100 employees.

http://house.michigan.gov/SessionDocs/2011-2012/Testimony/Committee11-9-8-2011-1.pdf

Missouri:

Mo. delays work on health insurance exchange 09/15/2011

After several Republican senators raised concerns, Missouri insurance officials backed off plans Thursday to start spending millions of federal dollars on the computer technology needed to implement part of the new federal health care law backed by President Barack Obama. A state board had been scheduled Thursday to formally accept the federal grant money, establish a Show-Me Health Insurance Exchange unit, designate a project manager and allocate $13.7 million for consultants to work on the technical aspects of the insurance exchange. But the governing board for the Missouri Health Insurance Pool called off the votes after several Republican senators complained that Democratic Gov. Jay Nixon's administration appeared set to implement the health-insurance exchange without legislative approval.

http://www.forbes.com/feeds/ap/2011/09/15/general-mo-health-insurance-exchange_8682602.html

New Jersey:

Taking the First Steps toward a New Jersey Health Exchange 09/14/2011

Discussion among panelists and findings from a report released by Rutgers University last month reveal that there is general agreement that New Jersey should create its own exchange -- streamlined and simple to use (Volume II of the report can be found here). Panelist Ray Castro, senior policy analyst with research organization New Jersey Policy Perspective, said that while New Jersey is already ahead of other states in terms of health policies, "by having our own exchange we're going to be able to tailor the exchange to meet the needs in our state. Panelists did disagree with some of the findings of the report, which were presented at the forum. Chiefly these centered on whether a state exchange should act as act as an active purchaser, bargaining for reasonable rates with insurance companies, or simply serve as a clearinghouse with issuer-set policies and prices to pick from.

http://www.njspotlight.com/stories/11/0915/0115/

New York:

No Special Session for New York 09/12/2011

A spokesman for New York State Senate Majority Leader Dean Skelos tells PULSE there won't be any special session to take up the exchange bill they never voted on last session. This also means they won't be applying for an establishment grant just yet.

Politico

G.O.P. Senators in Albany Block Federal Aid to Fulfill Part of Health Law 09/11/2011

Several Republican lawmakers in New York, saying they do not want to have anything to do with what they call "Obamacare," have thus far succeeded in blocking the state from seeking large amounts of federal assistance to put into place a mandatory health insurance exchange — a state-run marketplace where individuals and small businesses can buy insurance. State Senator Gregory R. Ball of Putnam County described his resistance as his duty as a Republican.

http://www.nytimes.com/2011/09/12/nyregion/republican-senators-in-albany-resist-us-aid-for-health-care-law.html?_r=1

Ohio:

Consumer Advocates Push for Active Health Insurance Exchange 09/09/2011

Health care advocates said failure to implement a key provision of the new federal health care law in Ohio would be a waste of taxpayer resources. During a news conference Thursday, Ohio Consumers for Health Coverage urged the Kasich Administration and GOP lawmakers to develop a health insurance exchange, or online marketplace designed to help consumers shop for plans and link them with public subsidies for coverage.

http://uhcanohio.org/content/consumer-advocates-push-active-health-insurance-exchange

Oklahoma:

Officials debate health-care costs 09/15/2011

State Medicaid officials estimated that federal health-care mandates would cost the state up to $41.6 million in 2014 and $95 million per year by 2020, but said that impact would be considerably offset by the economic impact of the new jobs that would result from new patients. An analyst for the Oklahoma Council of Public Affairs said, however, that the state's cost would be $11.4 billion in the first 10 years as private employers dump their workers' health insurance.
http://www.tulsaworld.com/news/article.aspx?subjectid=11&articleid=20110915_16_A1_OLHMIY265616

Virginia:

Health-care reform council recommends quasi-public exchange board 09/10/2011

The Virginia Health Reform Initiative Advisory Council voted Friday to create a state health insurance exchange as a quasi-public body, similar to the Virginia Housing Development Authority, rather than a new arm of the State Corporation Commission, as big insurers had preferred. The board overseeing the exchange would be comprised of between 11 and 15 members appointed by the governor and the General Assembly and chaired by Dr. Hazel. The advisory council's recommendations will go to Gov. Bob McDonnell by Oct. 1 for consideration in legislation to be introduced in the General Assembly in January.
http://www2.timesdispatch.com/news/virginia-politics/2011/sep/10/tdmain01-health-care-reform-council-recommends-qua-ar-1298298/

Wyoming:

Wyoming Gov. Mead wants state alternative to federal health reform 09/13/2011

Wyoming needs a viable state alternative to federal health care reform, an adviser to Gov. Matt Mead said Tuesday. Mead feels strongly the state can't oppose the federal law without pursuing its own strategy for improving health care in Wyoming, health care policy adviser Elizabeth Hoy said at a Casper conference focused on health reform. The governor's health care strategy has three major parts: 1) Increasing information technology in the health care arena. 2) Supporting changes to Wyoming's health care delivery system by fostering an environment that allows the private sector to make improvements. 3) Using the state's purchasing power to leverage better value.
http://billingsgazette.com/news/state-and-regional/wyoming/article_5a48e7ec-1231-5b82-b46b-b76c2efec030.html

- **New states to the exchange process:** The Alaska governor's office announced the state would pursue its own health exchange, while Arizona begins to look at its exchange options.
- **States revisiting the exchange process:** New Mexico Gov. Susana Martinez vetoed exchange legislation in April, but has recently tapped Dan Derksen to lead the state's Office of Healthcare Reform, which includes establishing an exchange.
- **Utah-style exchange:** Maine's exchange advisory council expects to vote on draft exchange legislation by next week. All signs point to the committee recommending a Utah-style exchange.
- **Advisory committees:** Minnesota Department of Commerce Commissioner Mike Rothman announced he will assemble an advisory task force for the design and development of a Minnesota-made exchange.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 09/02/2011 – 09/09/2011

Leavitt Partners Blog Posts

Patient Care under PPACA: Will Smaller Hospitals be Left Behind? 08/26/2011

Dr. John Nelson outlines how pay cuts will likely widen gap between smaller and larger hospitals: An interesting article suggests that the disparity between affluent hospital/s and those that are struggling may widen under health reform. The article points out in a credible fashion why this may be so. Smaller hospitals that are less well-capitalized may be at risk because they may be unable to provide the infrastructure necessary to cope with changes mandated by the PPACA.
http://www.leavittpartnersblog.com/paitent-care-under-ppaca-will-smaller-hospitals-be-left-behind-10003099

Federal News

RWJF Brief Examines Health Insurance Exchange Draft Regulations 09/07/2011

A new issue brief from the Robert Wood Johnson Foundation's State Health Reform Assistance Network provides assesses the three draft regulations that "provide a new level of operational detail that informs state planning efforts, guides the design and implementation of business processes, IT and administrative systems, and, ultimately, will impact consumer experience with state exchanges and Medicaid." The issue brief provides "an overview of the main provisions of the proposed rules and their implications for state implementation."
http://www.rwjf.org/coverage/product.jsp?id=72795&cid=XEM_205594

Oops! No ObamaCare Tax Credit Via Federal Exchanges? 09/07/2011

Because of a quirk in ObamaCare, people who buy health insurance through a federally run exchange may not be eligible for premium subsidies. It turns out that the legislation isn't so clear, the latest example of what analysts predicted would be a stream of surprises from the mammoth health law. Section 1311 of ObamaCare instructs state governments to set up an exchange. If a state refuses, Section 1321 lets the federal government establish an exchange in the state. Yet ObamaCare states that the tax credit is available to people who are enrolled in an "an exchange established by the state under (Section) 1311." It makes no mention of people enrolled in federal exchanges being eligible for the tax credit.

http://www.investors.com/NewsAndAnalysis/Article/584085/201109071840/ObamaCare-Subsidy-Error-Found.htm

Private exchanges offer yet another alternative to group health plans 09/05/2011

With potentially more than 50 state-based versions of a public health insurance exchange set to emerge by 2014, another version of a post-health reform insurance market is emerging: the private exchange. A private exchange is an existing concept taking on a new name. The idea also has been pitched as a "defined benefit" plan and has been part of a package with a health reimbursement account. Simply put, a private exchange is an alternative to a group health benefit plan. Rather than paying a portion or all of a premium, an employer pays each of its workers a flat amount and sends each to choose his or her plan.
http://www.ama-assn.org/amednews/2011/09/05/bisb0905.htm

State of the States: Health Insurance Exchange Developments 08.26.11

Please click here to view an updated edition of the McKenna Long & Aldridge LLP State of the States report on Health Insurance Exchange Development. Although 10 states have passed laws establishing exchanges since 2010, only three (CA, CO, MD) had appointed boards to carry out their duties prior to this week. That group swelled to five when Connecticut Governor Dan Malloy and state legislative leadership appointed eight individuals to join six cabinet officials who are ex officio members of that state's exchange. Lt Governor Nancy Wyman will chair the group. Governor John Kitzhaber also announced his appointments to the Oregon Health Exchange Board of Directors. States still to name directors include Hawaii, Nevada, Washington, Vermont, and West Virginia.
http://www.mckennalong.com/news-advisories-2586.html

State News

Alaska:

Alaska Trip Spotlights Rural Challenges For HHS 09/07/2011

Alaska has a message for HHS Secretary Kathleen Sebelius: Don't assume that health care delivery reform can work the same way in every state. That's the lesson Sen. Mark Begich (D-Alaska) says he tried to impart to Sebelius as he toured some of the state's health and early child care centers with her last week. Sebelius went to learn first-hand about the state's health services, the Indian Health Service, and how the health law is being implemented. The visit may have had immediate benefits, too. Shortly after Sebelius's visit, the Republican governor's office announced the state would pursue its own health exchange after several attempts to block implementation of the law.
Politico

Arkansas:

Arkansas Exchange Watch 09/06/2011

Insurance Commissioner Jay Bradford really wants the state to set up its own exchange, and it seems the state will soon be taking a step in that direction. The steering committee meets on Tuesday as the state prepares to apply for a Level One exchange grant by the end of the month.
Politico

Arizona:

Arizona Exchange Watch 09/06/2011

Strong GOP opposition kept the state's exchange bill from making any real progress in the 2011 session, but the state is starting to look at its exchange options. Tuesday is the last day to respond to Arizona's RFI on infrastructure needed to streamline an exchange with its Medicaid program.
Politico

Colorado:

One-stop help for needy divides lawmakers 08/28/2001
Colorado lawmakers are divided over a proposal for a one-stop Internet portal that would determine coverage eligibility within the state's developing health insurance exchange. Democrats say the approach would ensure that all residents can be informed of their eligibility for such programs. However, Republicans argue the approach would cost the state millions of dollars by promoting Medicaid and other safety-net programs for which citizens can qualify.
http://www.chieftain.com/news/local/one-stop-help-for-needy-divides-lawmakers/article_553589d0-d135-11e0-aa1f-001cc4c03286.html

Florida:

Florida Risks Federal Takeover of Health Insurance Exchange 09/06/2011
As far as Gov. Scott is concerned, Florida has officially rejected the $1 million federal grant intended for the creation of the state health insurance exchange, the governor's office confirms. Florida has until Sept. 30th to spend the grant. Otherwise, it will be re-allocated by the Department of Health and Human Services – most likely distributed to other states who have a need for the money. While it was reported in February that Florida was declining to spend the federal funding, critics speculated that a refusal was different from an outright rejection, believing that state officials were hedging their bets in case the federal health care law were to be deemed constitutional by the Supreme Court.
http://healthystate.org/archives/16393

Illinois:

Health care expansion to cost Illinois, study finds 09/03/2011
Expanding Illinois' Medicaid program under the federal health-care reform law will cost the state $1.3 billion a year in 2020 and beyond, according to an analysis by the nonpartisan Rand Corp. The annual cost is at least six times higher than what state officials have estimated since the federal Affordable Care Act became law in March 2010. Until now, officials at Gov. Pat Quinn's Illinois Department of Healthcare and Family Services have said the expansion of eligibility standards for the public insurance program, scheduled to take effect in 2014, would be financed almost entirely by the federal government.
http://www.carmitimes.com/health/x549436870/Health-care-expansion-to-cost-Illinois-study-finds

Maine:

Maine Exchange Watch 09/06/2011
About three weeks after forming, the state's exchange advisory council is moving. The council meets on Thursday to review draft legislation, which it expects to vote on by the following week. All signs point to recommending a Utah-style exchange.
Politico

Minnesota:

Gallup: Minnesota has nation's third lowest uninsured rate 09/09/2011
Minnesota has the third lowest number of residents lacking health insurance coverage, according to a survey by Gallup. The state ranks below Massachusetts and Vermont, two New England states that have instituted universal health care insurance programs. According to the survey, 9.4 percent of Minnesotans lack health insurance. Massachusetts topped the list of states with the lowest number of uninsured at 5.3 percent. In 2006, the state instituted a mandate requiring residents to carry health insurance. Vermont has the second lowest uninsured rate at 9.2 percent. Vermont recently enacted the nation's first single-payer health care system.
http://minnesotaindependent.com/87356/gallup-minnesota-has-nations-third-lowest-uninsured-rate

Commerce commissioner creates Health Insurance Exchange Advisory Task Force 09/07/2011
Minnesota Department of Commerce Commissioner Mike Rothman announced he will assemble a task force to advise on the design and development of a Minnesota-made health insurance exchange. The Minnesota Health Insurance Exchange Advisory

Task Force will consist of 15 members appointed by Commissioner Rothman and will represent a balance of interests, including consumers, employers, labor, health care providers, health insurers, Medicaid, agents and those with experience navigating health plan enrollment, and experts in public and private health care markets and public health improvement. In addition, four legislators representing the majority and minority in both the House and Senate.
http://hometownsource.com/2011/09/06/commerce-commissioner-creates-health-insurance-exchange-advisory-task-force/

Montana:

Guest opinion: Montanans need voice in insurance shoppers exchange 09/08/2011
As Montana's commissioner of securities and insurance, I work every day to protect all Montanans from scams, fraud and misinformation about insurance. These days, with all the confusion surrounding health-insurance reform, that's no small task. Lately, the health-insurance exchanges have been a particularly sticky point of confusion. Let me take this opportunity to clear the air.
http://billingsgazette.com/news/opinion/guest/article_cf5304af-1ef6-5807-a07c-ecd521188ebb.html

Top Montana Republican: Don't Go There 09/07/2011
Montana Insurance Commissioner Monica Lindeen has been insistent, if not successful, in her efforts for the state to set up an insurance exchange. The Legislature killed Lindeen's exchange bill in April, and she is openly exploring alternative opportunities to work with the feds on an exchange — but don't expect the Legislature to sit idly by. House Majority Leader Tom McGillvray took to the op-ed pages of the Billings Gazette to accuse Lindeen of "willfully ignoring" the Legislature's intent. "The Legislature gave her no money or authority to set up these exchanges and she needs to honor that."
Politico

Nevada:

Consumers Can Review Health Insurance Rates at New State Website 09/02/2011
Nevada consumers and small businesses can now review and comment on rate hikes in their health insurance policies online. The Division of Insurance has launched Nevada Health Rate Review in compliance with a provision of the Affordable Care Act (ACA) that went into effect on Sept. 1.
http://www.nevadanewsbureau.com/2011/09/02/consumers-can-review-health-insurance-rates-at-new-state-website/

New Mexico:

New Mexico Taps Exchange Leader 09/07/2011
New Mexico's Legislature actually passed an exchange bill, but Gov. Susana Martinez vetoed the legislation in April, citing a lack of exchange rules from HHS. Now that a flurry of exchange rules have been issued, it appears New Mexico may be on its way to building an exchange. Martinez has tapped Dan Derksen to lead the state's Office of Healthcare Reform, and one of his duties will be establishing an exchange, according to The Associated Press. Derksen, a family practice physician, was president of the New Mexico Medical Society just two years ago.
http://www.newswest9.com/story/15395165/physician-named-to-nm-health-care-reform-office

New York:

Medicaid redesign group meets in Rochester 09/09/2011
A subcommittee of Gov. Andrew Cuomo's Medicaid Redesign Team met in Rochester on Thursday to discuss streamlining state and local responsibilities for administering Medicaid benefits under the federal Affordable Care Act.
http://www.democratandchronicle.com/article/20110909/NEWS01/110909004

Legislation: Despite Arkansas Gov. Beebe stating he would not push the legislature to take up the exchange bill in the January 2012 fiscal session, the exchange study committee says it is "… pretty well on track to be ready to begin operating an exchange, assuming that we can get authorization from the state."

- **Governance:** Health-care advocates, unions, doctors' groups, and businesses in Illinois argue that the state should have a limited role in running the health insurance exchanges.
- **Federal Funds:** Gov. Haley said she will not apply for federal funds to help South Carolina set up its own exchange. Haley believes the federal plan is not the right fit for South Carolina.
- **Exchange Alternative:** After returning its innovator grant funds, Kansas signed a $135 million contract with Accenture for a new state computer system designed to centralize applications for Medicaid and operate as an alternative to the PPACA-required health exchange.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 08/26/2011 – 09/02/2011

Leavitt Partners Blog Posts

Patient Care under PPACA: Will Smaller Hospitals be Left Behind? 08/26/2011

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http://www.leavittpartnersblog.com/paitent-care-under-ppaca-will-smaller-hospitals-be-left-behind-10003099

Federal News

Despite Opposition, States Move Forward on ACA, Look to Strengthen Health Security for All 09/02/2011

In 2011 state legislative sessions, lawmakers across the nation in search of common-sense solutions found themselves wrestling with dual challenges on almost every issue: historic budget shortfalls and a charged and starkly changed political climate resulting from an historic wave election in 2010 that saw conservatives take control of 20 new chambers. Both of these factors were front and center on health care measures, as responsible lawmakers joined in the face of these challenges to advance the efficient implementation of the Affordable Care Act, protecting the health security of the most vulnerable and advocating loudly for effective reforms in their statehouses, the courts, and the court of public opinion alike.
http://www.progressivestates.org/news/dispatch/psn-2011-health-care-roundup-despite-opposition-states-move-forward-on-aca-look-streng

NAIC Wary Of Exchange Approval Process 09/01/2011

The nation's insurance commissioners are raising concerns about how much flexibility states will have to tweak their exchanges once the new insurance markets are up and running. Under the first set of exchange rules, released in July, states that want to alter their exchange plans would have to get permission from HHS — going through a 90-day federal process similar to the approval states must get from CMS to change their Medicaid or CHIP programs. It's a process that would surely aggravate Republican administrations planning to set up an exchange. On a Wednesday conference call, members of the National Association of Insurance Commissioners' exchange subgroup said they believed the Medicaid state waiver program may be too "burdensome" to use as a model for the exchange approval process.
Politico

Uninsured Largely Unaware Of Benefits Coming From Health Overhaul 08/30/2011

When it comes to last year's Affordable Care Act, there's not much people agree on. Except, says Kaiser Family Foundation President and CEO Drew Altman, this one thing: "It really does help the uninsured; 32 million uninsured people will get coverage." But according to the foundation's latest monthly tracking poll, it appears that only about half of uninsured people have any idea that help is on the way. And less than a third (31 percent) say they think the law will help them obtain health insurance.
http://www.npr.org/blogs/health/2011/08/30/140041726/uninsured-largely-unaware-of-benefits-coming-from-overhaul

Poll: Employees Don't Want Changes in Their Health Insurance 08/29/2011

Employees love to gripe about rising health care costs, but a new poll finds most are not willing to sacrifice to pay less for their insurance. Only 27 percent of people with insurance provided through their employer said they would accept a more restricted list of doctors and hospitals in their networks, according to the latest monthly poll from the Kaiser Family Foundation. (KHN is an editorially-independent program of the foundation.) Less than a third of those polled were willing to pay more for brand name drugs or pay higher deductibles in return for lower premiums.
http://capsules.kaiserhealthnews.org/index.php/2011/08/poll-employees-dont-want-changes-in-their-health-insurance/

Health reform implementation in one map 08/29/2011

Even though the Affordable Care Act establishes that every state must have a health exchange — an insurance marketplace, which will launch in 2014 — most states need to pass legislation to create the authority to set up the marketplace. The above map, sent to us by the Center for Budget and Policy Priorities, shows where states are in that process. And perhaps more interestingly, it shows that you can't predict where states are in that process by looking at the party that controls them.
http://www.washingtonpost.com/blogs/ezra-klein/post/health-reform-implementation-in-one-map/2011/08/29/gIQA3pvJnJ_blog.html

State News

Alaska:

State of Alaska moving ahead with health exchange plan; will seek help designing exchange 09/01/2011

The state of Alaska plans to solicit consultants to help design a health insurance exchange. Gov. Sean Parnell angered some lawmakers by refusing federal funds for an exchange, a marketplace for coverage options. Parnell believes the federal health care overhaul calling for exchanges is unconstitutional and Alaska is among states challenging the law in court. But since it is the law, Parnell said the state would proceed with developing an exchange with its own money. Health and Social Services Commissioner William Streur plans to issue a request for proposals in the coming weeks, seeking consultants to help design an exchange. If successful, another request would go out soliciting a vendor to implement it.
http://www.therepublic.com/view/story/e3b00c4967474d9e93e6cf0428a3ed2e/AK--Alaska-Health-Secretary/

Arkansas:

Insurance Exchange Team Progressing 08/29/2011

A 21-member committee is making progress toward creating a health-insurance exchange for the state despite the number of hurdles it will have to overcome before it can be put in place. "I think we're pretty well on track to be ready to begin operating an exchange, assuming that we can get authorization from the state," said state Rep. Barry Hyde, D-North Little Rock, who is on the Arkansas Health Benefits Exchange Planning Steering Committee. "That's going to be the sticking point. … That's where the world is going to stop."
http://www.arkansasbusiness.com/article.aspx?aid=128217.54928.140345

California:

California broke -- but barrels ahead with health exchange 08/29/2011
California will lead the nation in implementing the healthcare overhaul, but one conservative argues the state is in no condition to take on the expensive initiative. In 2014, the Golden State will enact the Health Benefit Exchange, an Internet healthcare marketplace that will allow Californians to comparison-shop for insurance. The federal government recently gave the state a $39-million planning grant for taking on the initiative.
http://www.onenewsnow.com/Business/Default.aspx?id=1419312

Colorado:

From food stamps to health benefits, proposal to streamline Colo. entitlements has opposition 08/28/2011
Colorado's exchange is in development. An oversight committee composed of 10 state lawmakers — five Democrats and five Republicans — also is guiding the state through the changing health care law and construction of an exchange. A subcommittee tackling eligibility and enrollment for the exchange's online portal has developed four recommendations for what the website should include. One of the options would qualify Medicaid applicants for other entitlements such as food assistance and Temporary Aid to Needy Families.
http://www.therepublic.com/view/story/5b3f885955d4470b954c7c847cb34f6d/CO--Streamlining-Entitlements/

Illinois:

Few want state to run Illinois' health-care exchanges 08/31/2011
Almost no one wants the state running Illinois' new health-care exchanges. Health-care advocates, unions, doctors' groups and business people testified in unison this week before the Legislature's rule-making body, the Commission on Government Forecasting and Accountability that the state should have a limited role in running the health-care exchanges, but they were divided on their reasons.
http://www.foxillinois.com/news/illinois/Few-want-state-to-run-Illinois-health-care-exchanges-128833453.html

Business, consumer advocates have different ideas on health insurance exchange 08/30/2011
The powerful board that will run the state's health-insurance exchange in 2014 and beyond should include representatives from the insurance industry with business expertise, officials from the Illinois Chamber of Commerce told lawmakers Tuesday. But advocates for consumers said giving the industry a vote on the proposed board would be an advantage for businesses that already are slated to profit from expansion of health-insurance coverage under the Affordable Care Act.
http://www.sj-r.com/business/x1413001561/Business-consumer-advocates-have-different-ideas-on-health-insurance-exchange

Kansas:

Kansas Signs $135M Contract to Build Alternative to Health Insurance Exchange 08/31/2011
*Kansas signed a $135 million contract with Accenture this week for a new state computer system designed to centralize applications for Medicaid, according to a **Kansas Reporter** report. The new system, known as the Kansas Eligibility Enforcement System, is designed to serve as the state's alternative to a health insurance exchange, required by the federal healthcare law starting in 2014.*

http://www.beckersasc.com/asc-coding-billing-and-collections/kansas-signs-135m-contract-to-build-alternative-to-health-insurance-exchange.html

Kansas says no to insurance exchange, refuses to comply on HCR 08/31/2011

On Tuesday, the Governors administration clarified their position and said that they would not create an exchange until the US Supreme Court made a ruling on the constitutionality of the law. The announcement came on the heels of the state's acceptance of a $3.2 million grant funded by money from the health care reform law to provide support for public health immunizations and programs to help people stop smoking.
http://civsourceonline.com/2011/08/31/kansas-says-no-to-insurance-exchange-refuses-to-comply-on-hcr/#disqus_thread

North Dakota:

Crowd gives mixed take on insurance exchanges 08/31/2011

There was a variety of opinions amongst the crowd with some optimistic about the opportunities an exchange could provide with other doubtful or pessimistic of its requirement. One small business owner said she wants the new exchange to be accessible to small businesses, detailing the tax credit and subsidies available while helping break down plans. "The comparison option is important because small employers never felt like we could offer insurance to our employees," she said. "To see the cost and tax credits available all in one place is vital for an exchange to be effective." Others had doubts at how effective to exchange could be at providing competition for a small state.
http://bismarcktribune.com/news/local/govt-and-politics/crowd-gives-mixed-take-on-insurance-exchanges/article_bd81290e-d43c-11e0-bc85-001cc4c002e0.html

South Carolina:

No thanks: Haley to reject fed health exchange funds 09/01/2011

Gov. Nikki Haley said she will let federal deadlines slip by and not accept millions in federal funds to help South Carolina set up its own health insurance exchange. Haley and Tony Keck, whom Haley appointed to head the state's Department of Health and Human Services, say the federal plan is not the right fit for South Carolina.
http://www.thestate.com/2011/09/01/1954190/haley-wont-take-health-care-exchange.html#RSS=local

- **New State Partnership:** U.S. Department of Health and Human Services officials told Montana legislators Tuesday that the agency is working on a new partnership model to let state agencies help run the exchange — perhaps without the need for legislative authorization.
- **Legislation:** Arkansas Gov. Beebe said he would not push the legislature to take up the unfinished exchange bill in the January 2012 fiscal session; while the exchange advisory committee set up by Maine Gov. LePage is planning to have draft legislation ready for public eyes by Sept. 2.
- **Federal Funding:** After hearing from Gov. Otter and the heads of state departments, Idaho lawmakers from both parties say they support applying for a federal grant; Nevada plans to apply for another grant in December of up to $30 mil to create a state agency and develop the exchange infrastructure; a Kansas exchange establishment committee will continue its work despite Gov. Brownback rejecting a $31.5 mil grant.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 08/19/2011 – 08/26/2011

Leavitt Partners Blog Posts

Patient Care under PPACA: Will Smaller Hospitals be Left Behind? 08/26/2011

Dr. John Nelson outlines how pay cuts will likely widen gap between smaller and larger hospitals: An interesting article suggests that the disparity between affluent hospitals and those that are struggling may widen under health reform. The article points out in a credible fashion why this may be so. Smaller hospitals that are less well-capitalized may be at risk because they may be unable to provide the infrastructure necessary to cope with changes mandated by the PPACA.
http://www.leavittpartnersblog.com/paitent-care-under-ppaca-will-smaller-hospitals-be-left-behind-10003099

Federal News

Rebellion by states could be hazardous to health care overhaul 08/26/2011

This year alone, 13 states have enacted laws trying to exempt their residents from major provisions of the health care law, while more than half have filed or joined lawsuits challenging the law's constitutionality. Some states are hedging their bets by taking preliminary steps to implement the law while refusing federal funds and mandates as the high-stakes political battle over the health care plan continues to play out. All told, 17 states have enacted laws rejecting parts of the Affordable Care Act, according to a report by the National Council of State Legislatures.
http://www.washingtontimes.com/news/2011/aug/25/rebellion-by-states-could-be-hazardous-to-health-c/?utm_source=RSS_Feed&utm_medium=RSS

So the Glass is 89 Percent Full? 08/25/2011

According to the latest Towers Watson survey of midsize to large companies, 9 percent of the companies say they're "somewhat likely" to stop offering health benefits to their workers in 2014 and give them a financial subsidy instead — and another 2 percent say they're "very likely" to do that. That means the other 89 percent of employers aren't expecting to drop coverage — a much rosier picture than the McKinsey survey painted — but those aren't the ones we'll be hearing about in 2014. The survey

does find that 70 percent of the companies don't think exchanges will be a viable alternative to employer-sponsored coverage in 2014. A couple of other important nuggets: 70 percent of the companies expect to lose their "grandfathered" health plan status by 2012, and 33 percent of the companies are "very confident" and another 23 percent are "somewhat confident" that they'll get hit by the Cadillac tax in 2018.
http://www.towerswatson.com/press/5328

Insurers Making Many Structural Changes 08/24/2011
Health insurers are pursuing new initiatives to deal with the reform law, according to a new report from the Boston Consulting Group. The group categorized three major shifts: experimentation with provider reimbursement and collaboration models; planning to try to deal with exchanges; and (especially at smaller plans) diversifying into new customer and product segments. The group surveyed 120 insurance executives.
http://www.bcg.com/documents/file81733.pdf

Administration may give states second chance to avoid fully federally run insurance exchange 08/24/2011
U.S. Department of Health and Human Services officials told Montana legislators Tuesday that the agency is working on a new partnership model to let state agencies help run the exchange — perhaps without the need for legislative authorization.
http://www.washingtonpost.com/national/administration-may-give-states-second-chance-to-avoid-fully-federally-run-insurance-exchange/2011/08/23/gIQAI44HZJ_story.html

Exchanges May Face Backlash Over Subsidy Overpayment 'Clawback' (with Table: Maximum 'Clawback' for Subsidy Recipients) 08/23/2011
Beginning in 2014, low-income individuals will be eligible for federal tax credits with which to purchase coverage through an insurance exchange. But an increase in annual income or change in family status during the course of the year will require some enrollees to refund at least a portion of the entire subsidy. "This is a disaster," says Timothy Stoltzfus Jost, a health law professor at the Washington and Lee University School of Law in Virginia, and a consumer representative for the National Association of Insurance Commissioners. "A lot of people will believe they received a grant to pay for coverage when in fact they got a loan that they might have to pay back."
http://aishealth.com/archive/nhex0811-06

CMS taps Terremark cloud services for insurance exchanges 08/19/2011
The Centers for Medicare and Medicaid Services will use the cloud computing services of Terremark Federal Group Inc., of Herndon, Va., to support its Healthcare.gov plan finder and the system demands of the health insurance exchange program being created in the 50 states. The vendor will enable CMS to increase its capabilities for infrastructure as a service instead of owning and managing the assets. Cloud computing services include project management and collaboration tools.
http://www.govhealthit.com/news/cms-taps-terremark-cloud-services-insurance-exchanges

State News

Arkansas:

Arkansas Gov.: Exchange Legislation Probably Won't Happen 08/24/2011
Arkansas Gov. Mike Beebe said yesterday he would not push the legislature to take up the unfinished exchange bill in the January 2012 fiscal session, which typically just focuses on the budget. The state's Surgeon General Joe Thompson told the Arkansas News that the state would need to take up the bill during that time or risk losing federal money. "The Legislature made their decision on that, and we're going to live with that," the governor said. "It takes a (two-thirds) majority vote to put an item on, and that support is just not there."
Politico

California:

State health exchange taps Obama aide for director job 08/25/2011

The state's new health benefit marketplace, an instrumental arm of the 2010 federal health care overhaul, will announce today that it has tapped an Obama administration official as its first executive director. ***Peter V. Lee****, deputy director for the Center for Medicare and Medicaid Innovation at the Centers for Medicare and Medicaid Services, will assume the* ***California Health Benefit Exchange*** *job on Oct. 17, 2011. He will receive a salary of $250,000, more than the $173,987 that Gov.* ***Jerry Brown*** *receives.*
http://blogs.sacbee.com/capitolalertlatest/2011/08/state-health-exchange-taps-oba.html

Colorado:

Hickenlooper insists: Health care insurance exchange is apolitical 08/19/2011

Gov. John Hickenlooper on Wednesday night cautioned against turning the proposed health care insurance exchange into a political issue, and instead focused on consumer benefits to having such a virtual insurance marketplace. "Not everywhere, but in many parts of our community, there is this persuasion that this is a political issue, that this is going to divide us on whether we're Republicans or Democrats," Hickenlooper told an audience inside the auditorium of the North Middle School Health Sciences & Technology Campus. "But I think that this framework is exactly the opposite. It allows us a legitimate opportunity to define not just health care exchanges, but the issue around health care, and truly in an apolitical way."
http://coloradostatesman.com/content/992996-hickenlooper-insists-health-care-insurance-exchange-apolitical

Connecticut:

Advocates Not Happy with CT Board 08/26/2011

The recently-named exchange board in Connecticut is not going over well with consumer advocates who say the board has too many representatives from insurers serving. The Connecticut Mirror reports advocates are "troubled that the only consumer representative was the health care advocate and that there were three former insurance executives on a board." ""That is a huge and unfortunate oversight that is destined to affect consumers' experience once the exchange is operational," said Jennifer Jaff, executive director of Advocacy for Patients with Chronic Illness.
Politico

Connecticut begins implementing Obama health care law 08/25/2011

Connecticut Lt. Governor Nancy Wyman announced Wednesday the 14 members of the Connecticut Health Insurance Exchange, which by 2014 will offer individuals a variety of coverage. Connecticut governor Dan Malloy and legislative leaders selected most members of the board, which will oversee the quasi-public authority that governs the exchange, a marketplace for individuals and small businesses to buy health care coverage as part of federal health reform.
http://www.thestatecolumn.com/health/connecticut-launches-health-insurance-exchange/

Idaho:

Idaho 'at crossroads' on health insurance exchange 08/22/2011

Idaho is "at a crossroads," the governor told members of the Legislature's joint health care task force, which is meeting at the state Capitol today. Otter doesn't need the lawmakers' OK to apply for a grant, but after hearing from him and the heads of the state departments of Insurance and Health and Welfare, lawmakers from both parties said they support applying for the grant — even some who are leery of think we should any participation in national health care reforms. "We can go forward and establish our own exchange, and I," said Rep. Janice McGeachin, R-Idaho Falls, the House Health and Welfare Committee chairwoman. "It's my sense that we probably should consider applying for the grant."
http://www.spokesman.com/stories/2011/aug/22/idaho-crossroads-insurance-exchange/

Illinois:

$5 million is just the beginning of Illinois' health care exchange costs 08/24/2011

Illinois is touting a $5 million federal grant to set up health-care exchanges as part of the national health care law, but residents may not have access to an exchange for a couple years. Illinois wants to have an exchange ready for federal review by 2013, said Kate Gross, assistant director for health planning at the Illinois Department of Insurance. If Illinois fails to set up its

exchange by January 2014, it will be required to use an exchange chosen by federal officials. The $5 million, Gross said, will be spent "on groups of consultants or firms to … begin to help (us) truly figure out all of the pieces that we're building."
http://illinois.statehousenewsonline.com/6759/5-million-is-just-the-beginning-of-illinois-health-care-exchange-costs/

Kansas:

Statehouse Live: Health exchange committee will continue work despite Brownback's rejection of grant 08/24/2011
A committee working on establishing a health insurance exchange in Kansas decided on Wednesday to continue its efforts even though Gov. Sam Brownback rejected a $31.5 million federal grant to set up the exchange, and many in the Legislature want nothing to do with it.
http://www2.ljworld.com/news/2011/aug/24/statehouse-live-health-exchange-committee-will-con/

Governor Seeking Federal Grant for Key Component of 'Obamacare' Exchange 08/19/2011
Gov. Sam Brownback's administration is moving forward with efforts to use federal grant money to fund development of information technology that would be used to support a health benefits exchange under the Affordable Care Act, commonly known as "Obamacare." If the grant's strings require any connection to an Obamacare exchange it's certain to run afoul of a recent Kansas Republican Party resolution supporting tea party sentiments against the federal healthcare legislation.
http://kansas.watchdog.org/7448/governor-seeking-federal-grant-for-key-component-of-%E2%80%98obamacare%E2%80%99-exchange/

Maine:

Maine Panel Close to Draft Bill 08/25/2011
The exchange advisory committee set up by Gov. Paul LePage is planning to have draft legislation of an exchange bill ready for public eyes by Sept. 2. The group will meet Sept. 8 to review the legislation and is aiming to vote on final recommendations on Sept. 14.
Politico

Minnesota:

Private health exchange concept gathering steam in Minnesota 08/19/2011
Offering employees more choice through a private health exchange, which is based on a defined contribution approach to health insurance, appears to be gathering steam in Minnesota. Doherty Employer Services, a Minneapolis human resources outsourcing firm announced Friday that starting on Sept. 1, the company will offer the My Plan by Medica private health exchange program to its business customers. Through My Plan by Medica, companies can choose how much they want to spend on employees' healthcare while it will also allow individual employees to select the coverage they want from among 20 different health plans. It is a novel approach to providing employee health benefits. Medica is one of the largest health insurance companies in Minnesota.
http://www.medcitynews.com/2011/08/private-health-exchange-concept-gathering-steam-in-minnesota/

Mississippi:

Launch near for health care exchange 08/22/2011
A one-stop shop for health insurance customers in Mississippi could be up and running early next year, as other states refuse to carry out programs tied to the federal health care overhaul. "The idea of an exchange has been around for a long time," state Insurance Commissioner Mike Chaney said. "This is about health care for our citizens."
http://www.clarionledger.com/article/20110822/NEWS01/108220311/Launch-near-health-care-exchange?odyssey=mod%7Cnewswell%7Ctext%7CHome%7Cs

Montana:

Montana Aims to Help Create Health Insurance Exchange with Feds 08/24/2011

Montana can partner with the federal government to build a state Internet health insurance marketplace known as an "exchange" that's required by 2014, but details on how to do it are still being worked out, a top federal health official said Tuesday. Marguerite Salazar, regional director for the U.S. Health and Human Services Department, also told a legislative panel that Montana can take over operation of the exchange once the federal government gets it up and running.
http://billingsgazette.com/news/state-and-regional/montana/article_166291e0-cdba-11e0-9d58-001cc4c002e0.html

Nevada:

State gets grant to design health care acquisition system 08/19/2011

The state has received a $4 million federal grant to design a system that will help uninsured Nevadans shop for health insurance. Charles Duarte, administrator of the Division of Health Care Finance and Policy, said Friday his agency will seek another grant in December of up to $30 million to carry out provisions of the Affordable Care Act passed by Congress last year. The money will be used to create a state agency, find office space and staff and develop the infrastructure needed to implement the health care law by 2014.
http://www.lvrj.com/news/grant-given-to-state-to-assist-in-health-care-reform-128098953.html

Oregon:

HHS Officials Arrive in Portland Next Week to Discuss Health Insurance Exchange 08/23/2011

Portland will be the site for a multi-state listening session with national policymakers, HHS officials, advocates, health plan executives and business leaders. At this multi-state event hosted by the U.S. Department of Health and Human Services, the participants will look at the framework behind the insurance exchanges which will create competitive marketplaces so that individuals and small employers can compare private health insurance options on the basis of price, quality and other factors. Discussion will also revolve around the rules for health insurance exchanges – re-insurance, risk corridors and risk adjustment "to assure stability in these newly established markets," according to a letter sent by Susan Johnson, regional director of HHS Region X who's organizing the meeting with Herb Schulz, who holds a similar role with Region IX.
http://www.thelundreport.org/resource/hhs_officials_arrive_in_portland_next_week_to_discuss_health_insurance_exchange

South Carolina:

Auditors studying grants' progress 08/21/2011

State auditors are scrutinizing how the South Carolina Department of Insurance spent more than $2.4 million in federal grants. The S.C. Legislative Audit Council expects to release its findings by the middle of next month, council Director Tom Bardin said last week. In a March 14 request, five Democratic state legislators said they wanted an audit of the Insurance Department's "use and expenditures" of three federal grants associated with federal health care reform to "determine compliance with the law and terms" of the funds.
http://www.postandcourier.com/news/2011/aug/21/auditors-studying-grants-progress/

HHS released proposed rules Wednesday that will require private health insurance plans to use simple, standardized information forms next year. The forms will describe benefits and costs in easy-to-understand terms so that consumers can comparison shop for the best coverage. A proposed template can be found here.

- While PPACA gives HHS the authority to create a federal exchange for states that don't set up their own, it doesn't clearly provide the funding to do so. With only $1 billion appropriated for all federal administrative costs, it's unclear how HHS is going to fund a federal exchange.
- A group of health care experts, consumer advocates, lawmakers and state officials exploring exchange options in Georgia voted Tuesday to pursue legislative options for creating a Georgia health insurance exchange.
- GOP legislators in Minnesota are criticizing Gov. Mark Dayton's administration for what they call its "go-it-alone" approach to building an exchange and its acceptance of $4.2 million in federal funds.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 08/12/2011 – 08/19/2011

Leavitt Partners Blog Posts

If you don't Like the Way you look… Blame the Mirror 08/11/2011

The Standard & Poor's rating agency announced Friday that it has downgraded the U.S. credit rating to AA+ from its top rank of AAA. Leavitt Partners Andrew Croshaw shares his thoughts." Since credit ratings simply reflect the likelihood of default for an issuer of debt, the recent downgrade simply means that it is now slightly more likely that the U.S. could default on its debt obligations in the future. Instead of being frustrated with mirror for reflecting the image we see, let's get busy confronting the portrait.

http://www.leavittpartnersblog.com/if-you-don%E2%80%99t-like-the-way-you-look%E2%80%A6-blame-the-mirror-10003079

Federal News

IOM to Miss Essential Benefits Deadline 08/18/2011

Reuters reported last night that the Institute of Medicine could be late on its report laying out the methodology of defining essential health benefits to HHS. The IOM has long stated they'd have the report done by the end of September, but Reuters says the release could be pushed into October. While the essential health benefits rule is a key missing puzzle piece of the health reform law, and stakeholders and states really do need EHB questions answered, the IOM's deadline was merely a self-imposed one. Reuters reports the 18-member committee recently signed off on an initial report and a panel of experts will review it before a final recommendation is sent to HHS.

Politico

New health insurance rules would let consumers compare plans in 'plain English' 08/17/2011

Starting as soon as March, consumers could have a better handle on such questions, under new rules aimed at decoding the fine print of health insurance plans. Regulations proposed by the Obama administration on Wednesday would require all private health insurance plans to provide current and prospective customers a brief, standardized summary of policy costs and benefits. To make it easier for consumers to make apples-to-apples comparisons between plans, the summary will also include a

breakdown estimating the expenses covered under three common scenarios: having a baby, treating breast cancer and managing diabetes. A proposed template can be found here.
http://www.washingtonpost.com/national/health-science/new-health-insurance-rules-would-let-consumers-compare-plans-in-plain-english/2011/08/17/gIQAmZzFMJ_story.html

New Affordable Care Act Policy Helps Consumers Better Understand and Compare Benefits and Coverage 08/17/2011

Today, the Departments of Health and Human Services (HHS), Labor, and the Treasury proposed new rules under the Affordable Care Act that will enable consumers to easily understand their health coverage and determine the best health insurance options for themselves and their families. Likewise, these proposed rules will assist employers in finding the best coverage for their business and their employees. Under the proposed rules announced today, health insurers and group health plans will provide consumers with clear, consistent and comparable information about their health plan benefits and coverage. The new forms, scheduled to be available in 2012, will be a critical resource for more than 180 million health insurance consumers with private health insurance coverage.
http://www.hhs.gov/news/press/2011pres/08/20110817a.html

New Standardized Insurance Forms Could Make Buying Easier 08/17/2011

Obama administration officials proposed rules Wednesday for simple, standardized information forms health insurers and employers will be required to use beginning next year. The forms are intended to describe benefits and costs in the same easy-to-understand terms so that consumers can comparison shop for the best coverage. The materials will include a four-page benefits summary, a list of commonly used terms, and two pages of coverage fact labels – modeled after the nutrition labels on prepared foods – that show how much a plan pays for the average national cost of some common medical conditions. The federal health law says the materials must be printed in at least 12-point type, larger than the type in a typical newspaper article.
http://www.kaiserhealthnews.org/Stories/2011/August/17/standardized-health-insurance-coverage-labels.aspx

There May be no Money for a Federal Exchange 08/17/2011

HHS has been doing its darndest to encourage states to set up their own insurance exchanges because setting up a federal exchange isn't going to an easy process politically or policy-wise. But there's another really big problem: There is no money to pay for federal exchanges. A quirk in the Affordable Care Act is that while it gives HHS the authority to create a federal exchange for states that don't set up their own, it doesn't actually provide any funding to do so. By contrast, the law appropriates essentially unlimited sums for helping states create their own exchanges. And with only $1 billion appropriated for all federal administrative costs, it's a little hazy how exactly HHS is going to fund a federal exchange if and when they need to.
Politico

The Cheap Way Out 08/15/2011

Health advocates are raising concerns that families may struggle to find health coverage because of a provision in the new IRS rule that says insurance only needs to be affordable for individuals — not for families. Under the law, a health plan is considered unaffordable if an employee would have to spend more than 9.5 percent of his or her income for the taxable year. But the IRS rule issued Friday morning sides with the Joint Committee on Taxation's interpretation that the affordability requirements apply only to the employee — not whether coverage is affordable for the employee's family.
Politico

Health reform's 'churning' challenge 08/15/2011

"Churning," or when individuals churn off and on different insurance programs, can trigger changes in provider networks, benefit packages and cost sharing. The Affordable Care Act takes a number of steps to deal with this. On Friday, the department of Health and Human Services released over 200 pages of regulations that focus on how Medicaid and exchanges will insure seamless coverage. Tricia Brooks of the Georgetown Health Policy Institute describes the new rules as a "big leap forward." The rules propose that states review Medicaid eligibility annually, creating less chance for disruption. They clarify that, for those that do bump up onto exchange, Medicaid will remain in effect until new coverage starts.
http://www.washingtonpost.com/blogs/ezra-klein/post/health-reforms-churning-challenge/2011/08/02/gIQAg4ppGJ_blog.html

NAIC: Multi-state health exchange plans could stymie competition 08/15/2011

The National Association of Insurance Commissioners (NAIC) is telling federal officials that its proposal for regulating new federally mandated multi-state health insurance plans could upset state insurance markets and erode consumer protections. Because the new "Multi-State Plans" would be held to different standards than other health insurance plans, larger health insurers could have a competitive advantage over smaller ones, the organization of the nation's state insurance regulators warned in a letter to the U.S. Office of Personnel Management (OPM).
http://ifawebnews.com/2011/08/15/naic-multi-state-health-exchange-plans-could-stymie-competition/

Implementing Health Reform: Medicaid and Exchange Eligibility Determinations 08/13/2011

On August 12, 2011, the Department of Health and Human Services issued two notices of proposed rulemaking (NPRMs) in its ongoing efforts to implement the Affordable Care Act (ACA). The first addresses eligibility for Medicaid and the Children's Health Insurance Program (CHIP) after the 2014 implementation of the ACA Medicaid expansions. The second governs eligibility determinations by the exchanges for the ACA premium tax credits and cost-reduction subsidies. Both address coordination between the exchanges and the Medicaid and CHIP programs. The exchange rule also contains standards for evaluating eligibility for employers to participate in the SHOP exchange program.
http://healthaffairs.org/blog/2011/08/13/implementing-health-reform-medicaid-and-exchange-eligibility-determinations/

Government lays out health insurance exchange details 08/12/2011

Friday's proposed rules highlight the expectation of a smooth connection between state-run exchanges and the federal systems to make sure they connect and share information. For example, the exchanges should be able to plug into federal tax databases to check income status and determine eligibility for federal subsidies or tax credits -- from a single, one-time application. The government will also offer individuals and families tax incentives that make it cheaper to buy insurance coverage on the exchanges. The amount of the tax credit will be tailored to income and the insurance premium. Households that don't have enough cash to pay the insurance premium up front can get advance payments from the Treasury Department directly to the insurance company.
http://www.reuters.com/article/2011/08/12/us-usa-health-exchanges-idUSTRE77B4P920110812

State News

Arizona:

Arizona Probes Exchange Systems 08/17/2011

Though Arizona's exchange bill didn't gain any traction this year and likely won't next year, the state put out a request for information Monday to learn how it could align its Medicaid and CHIP enrollment and eligibility systems with an exchange. "The purpose of the RFI is to identify viable available or proposed solutions as well as estimated pricing requirements, and ideas that best fit the state of Arizona," the RFI reads. The RFI is indicative that even red states, with some exceptions, typically aren't turning a blind eye to the exchanges. The RFI, which closes Sept. 6.
Politico

Georgia:

Group exploring options for Georgia health insurance exchange 08/17/2011

A group of health care experts, consumer advocates, lawmakers and state officials voted Tuesday to pursue legislative options for creating a Georgia health insurance exchange. Gov. Nathan Deal, while opposing the federal health care overhaul, appointed the committee in June to study whether the state should design its own insurance marketplace -- a key part of the overhaul. The federal government will set up exchanges for states that opt out of running their own.
http://www.ajc.com/news/group-exploring-options-for-1114927.html

Kansas:

Insurance Exchange Work Groups To Continue Meeting 08/19/2011

Work groups that for the last several months have been planning and pulling together information for a Kansas health insurance exchange will continue meeting despite Gov. Sam

Brownback's recent rejection of a $31.5 million federal grant intended to help launch the online clearinghouse in time for a 2013 health reform deadline. Chairs of the various study groups (which collectively number more than 100 people drawn mostly from the insurance and health care industries) met today in a small, third-floor conference room at the Kansas Insurance Department to talk about what they should do next given the governor's grant spurning.
http://www.khi.org/news/2011/aug/18/insurance-exchange-work-groups-continue-meeting/

GOP Delegates Pass Strong Anti-Reform Resolution 08/16/2011
The Kansas Republican Party on Saturday passed a resolution that called for an immediate halt to efforts underway to link the state's Medicaid program with a health insurance exchange required by the federal health reform law. ... The resolution followed Gov. Sam Brownback's announcement last week that he and Lt. Gov. Jeff Colyer had decided to return a $31.5 million "early innovator" grant meant to help Kansas officials create an insurance purchasing exchange.
http://www.khi.org/news/2011/aug/15/gop-leaders-resolve-oppose-exchange-formation/

Minnesota:

Commerce Commissioner Rothman issues statement on health insurance exchange grant 08/16/2011
Last week, Gov. Mark Dayton announced the state received a $4.2 million grant to further the planning and establishment of a Minnesota-made health insurance exchange. The following is a statement from Commerce Commissioner Mike Rothman concerning ongoing collaborative efforts to establish a Minnesota-made health insurance exchange that will drive market competition and reduce health care costs for Minnesota consumers and businesses.
http://hometownsource.com/2011/08/16/commerce-commissioner-rothman-issues-statement-on-health-insurance-exchange-grant/

Health care law action draws GOP criticism 08/16/2011
A group of GOP legislators are criticizing Gov. Mark Dayton's administration for what they call its "go-it-alone" approach to building a pillar of last year's federal health care act. The criticism comes days after the Minnesota Department of Commerce announced it's getting federal funds to design Minnesota's health-insurance exchange, a pivotal provision of the health care act. The federal act requires states to have insurance exchanges operating by 2014. Under the act, millions of Americans — especially individuals and small businesses — would use the exchanges to compare coverage and obtain subsidies to purchase insurance.
http://www.sctimes.com/article/20110817/NEWS01/108160045/Health-care-law-action-draws-GOP-criticism

GOP blasts health exchange moves 08/16/2011
Some Republican legislators are claiming that Democratic Gov. Mark Dayton is exceeding his authority by setting up a state health insurance exchange without their input. Minnesota received a $4.2 million federal grant last week to help establish the exchange, which is a key piece of the federal health care law. GOP lawmakers fundamentally oppose the law. Sen. David Hann, R-Eden Prairie, the chair of the Senate health and human services committee, said today that the administration is wrong to move forward on its own. "We believe that they do not have the authority, and we are going to pursue every means available to us as a Legislature to prevent that from occuring," Hann said. "They should not be taking Minnesota down the path to enacting this law in the way that they're doing it without the counsel of the Legislature, without the input of the stakeholders in the health care community."
http://minnesota.publicradio.org/collections/special/columns/polinaut/archive/2011/08/gop_blasts_heal.shtml

Missouri:

Senate Committee Kicks Off Health Exchange Hearings in KC 08/16/2011

A Missouri Senate committee is kicking off a series of statewide hearings in Kansas City today on whether and how to set up a state health insurance exchange. The meeting comes just days after Missouri received a $21 million federal grant to start setting up the online infrastructure for an exchange, and just days after a federal appeals court struck down part of the federal health law. Senator Scott Rupp is chair of the insurance committee holding the hearings. He says some key issues must first be addressed before delving into the details of an actual exchange.
http://www.publicbroadcasting.net/kcur/news.newsmain/article/1/0/1840741/KCUR.News/Senate.Committee.Kicks.Off.Health.Exchange.Hearings.in.KC

Nebraska:

Insurance exchanges face unknowns 08/16/2011
Nebraska officials raised concerns Monday about the state's ability to meet upcoming federal health care reform deadlines. At a briefing for state lawmakers, the officials said they face challenges with the amount of work to be done and the lack of answers on key matters. Nebraska Insurance Commissioner Bruce Ramge said the federal law gives states until Jan. 1, 2013, to develop plans for a health insurance exchange. A state that decides against running its own exchange will have one created for it by the federal government.
http://www.omaha.com/article/20110816/LIVEWELL03/708169902/1161

Nevada:

State moving on health care exchanges 08/19/2011
While Nevada remains at the bottom of states for the provision of health care to its uninsured and underinsured population, the state is proceeding with plans for the implementation of SB 440, which sets up the exchanges mandated under the 2010 health care reform law. During a recent presentation sponsored by the Northern Nevada League of Women Voters, Marilyn Wills, director of the Office for Consumer Health Assistance, said the state has been on track with implementing the many reforms that have already gone into effect, and preparing for those that will be phasing in over the next several years.
http://www.nevadaappeal.com/article/20110819/NEWS/110819722/1006&parentprofile=1058

Oregon:

HHS Officials Arrive in Portland Next Week to Discuss Health Insurance Exchange 08/19/2011
Oregon's health insurance exchange is off to a quick pace with the announcement that national policymakers are coming to Portland next week for a listening session on the exchange involving advocates, health plan executives, business leaders and state officials. At this multi-state event hosted by the U.S. Department of Health and Human Services, the participants will look at the framework behind the insurance exchanges which will create competitive marketplaces so that individuals and small employers can compare private health insurance options on the basis of price, quality and other factors.
http://www.thelundreport.org/resource/hhs_officials_arrive_in_portland_next_week_to_discuss_health_insurance_exchange

Wyoming:

Should Wyo. develop its own health insurance exchange? 08/17/2011
A deadline is fast approaching for a state committee to decide if Wyoming should develop its own health insurance exchange. The Wyoming Health Benefits Exchange Steering Committee will meet today in Riverton to further discuss the options. It must submit a draft of its proposals by Oct. 1. there is a general consensus among Gov. Matt Mead and the legislators of the need for the state to create its own exchange rather than having the federal government design the program. "Governor Mead has made it pretty clear that the federal government should not be running our health care," she said. "We can do it better, and we need to craft a state-specific solution."
http://www.wyomingnews.com/articles/2011/08/18/news/19local_08-18-11.txt

New proposed exchange regulations released! HHS releases proposed regulations on eligibility determinations for Medicaid, exchange functions in the individual market (eligibility determinations and exchange standards for employers), and premium tax credits.

- HHS announces establishment grant awards. The following states were awarded Level One Grants: CA ($38.4 mil), CT ($6.6 mil), DC ($8.2 mil), IL ($5.1 mil), KY ($7.6 mil), MD ($27.1 mil), MN ($4.1 mil), MS ($20.1 mil), MO ($20.8 mil), NV ($4.0 mil), NY ($10.7 mil), NC ($12.3 mil), OR ($8.9 mil), WV ($9.6 mil).
- Like Oklahoma, Kansas will return its Early Innovator Grant ($31.5 million). Kansas Insurance Commissioner Sandy Praeger had been moving forward with setting up the exchange despite strong opposition from Gov. Brownback and the state legislature.
- Two reports released this week highlight the differences in health care costs across the country. A report by the Kaiser Family Foundation shows the variations in health insurance premiums, while a report from Thomson Reuters focuses on regional differences in medical spending for enrollees with employer-sponsored health insurance.
- A legislative oversight committee will be formed in New Hampshire later this month to address how the state will move forward on an exchange and use the rest of its exchange planning grant (a bill was passed earlier this month which calls on the state to send back two-thirds of the $1 million exchange planning grant).

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 08/05/2011 – 08/12/2011

Leavitt Partners Blog Posts

If you don't Like the Way you look… Blame the Mirror 08/11/2011

The Standard & Poor's rating agency announced Friday that it has downgraded the U.S. credit rating to AA+ from its top rank of AAA. Leavitt Partners Andrew Croshaw shares his thoughts." Since credit ratings simply reflect the likelihood of default for an issuer of debt, the recent downgrade simply means that it is now slightly more likely that the U.S. could default on its debt obligations in the future. Instead of being frustrated with mirror for reflecting the image we see, let's get busy confronting the portrait.

http://www.leavittpartnersblog.com/if-you-don%E2%80%99t-like-the-way-you-look%E2%80%A6-blame-the-mirror-10003079

Will Health Reform's Newly Insured Overcrowd the Health Care System? 08/04/2011

The Congressional Budget Office (CBO) estimates that under the Patient Protection and Affordable Care Act (PPACA) 21 million people will become newly insured by 2014, growing to 34 million by 2021. Millions will gain insurance through the expansion of state Medicaid programs and millions more will purchase federally subsidized insurance on the state health insurance exchanges. With claims that the health care system is already unable to adequately provide for the future needs of the existing population, the common gut reaction is that these newly insured will severely tax and potentially overburden the current system. While this gut response seems likely on face value, it doesn't hold up to closer evaluation.

http://www.leavittpartnersblog.com/will-health-reforms-newly-insured-overcrowd-the-health-care-system-10003040

Federal News

HHS, Treasury take new steps to help states build Affordable Insurance Exchanges 08/12/2011

The Departments of Health and Human Services and Treasury today took the next steps to establish Affordable Insurance Exchanges – one-stop marketplaces where consumers can choose a private health insurance plan that fits their health needs and have the same kind of insurance choices as members of Congress. Among other policies, the proposed rules describe how middle-class families will gain access to unprecedented tax relief that will dramatically reduce the cost of coverage.
http://www.hhs.gov/news/press/2011pres/08/20110812a.html

New Round of Level One Grants Announced 08/12/2011

The Exchange Establishment grants recognize that states are making progress toward establishing Exchanges but are doing so at different paces. States can choose when to apply for grant funding based on their needs and planned expenditures and states will have multiple opportunities to apply for funding in the years ahead. The following grantees applied by the June 30, 2011 deadline. Grants were awarded on August 12, 2011: CA ($38.4 mil), CT ($6.6 mil), DC ($8.2 mil), IL ($5.1 mil), KY ($7.6 mil), MD ($27.1 mil), MN ($4.1 mil), MS ($20.1 mil), MO ($20.8 mil), NV ($4.0 mil), NY ($10.7 mil), NC ($12.3 mil), OR ($8.9 mil), WV ($9.6 mil).
http://www.healthcare.gov/news/factsheets/exchanges05232011a.html

Secretary Sebelius Answers Your Questions on Health Insurance Exchanges 08/11/2011

By 2014, the health insurance market will be flooded with 30 million more Americans purchasing plans through "health insurance exchanges." To find out more, PBS spoke with Julie Appleby of Kaiser Health News for a Health Exchange 101 and looked at the exchange experiment already underway in Utah. Then we turned it over to you to ask Sebelius -- the top Obama administration official charged with overseeing the implementation of the exchanges -- your own questions about the big changes coming to the insurance marketplace.
http://www.pbs.org/newshour/rundown/2011/08/sec-sebelius-takes-your-questions-on-health-insurance-exchanges.html

Health Insurance Premiums Vary Widely, Report Says 08/10/2011

How much does health insurance cost? It's a deceptively simple question to ask, but a notoriously difficult one to answer, especially for people who buy their own coverage because they don't get it through their jobs. A report released today adds to what has so far been a limited data pool attempting to answer the question. Average costs ranged widely, from about $136 a month in Alabama to more than $400 in Vermont and Massachusetts, according to the report from the Kaiser Family Foundation (KHN is an editorially independent program of the foundation). The national average was $215. Unlike a few other reports on costs, this one looks at actual revenue insurers are bringing in and the number of people enrolling.
http://capsules.kaiserhealthnews.org/index.php/2011/08/health-insurance-premiums-vary-widely-report-says/

High Medical Spending Found In Unexpected Places, Says Study 08/10/2011

Where do insured Americans spend the most on health care? Miami? Los Angeles? Nope. It's Anderson, Ind., where people with employer-provided insurance spent an average of $7,231 on medical treatments. That's according to an analysis of 382 metropolitan areas examined by Thomson Reuters, a consulting firm that has one of the biggest databases of insurance claims from employers. Anderson's spending level in 2009 was 76 percent above the national average of $4,104 per person, according to the analysis.
http://capsules.kaiserhealthnews.org/index.php/2011/08/high-medical-spending-found-in-unexpected-places-says-study/

Walgreens plans to sell you health insurance 08/09/2011

Walgreens, the nation's largest drugstore chain, is planning to start selling health insurance to customers this fall. It will sell health insurance products with different price ranges and coverage levels from coast-to-coast through a private health insurance exchange, according to people familiar with the matter. Walgreens neither confirmed nor denied the move. "As always, we're looking at a number of options in light of health care reform as we continue to seek ways to help our customers better navigate today's health care system," a Walgreens spokesman said.
http://money.cnn.com/2011/08/09/news/companies/walgreens_health_insurance/

CCIIO Plans Exchange Sessions 08/09/2011

After the exchange rule came out CCIIO announced they'd be holding listening sessions around the country to get comments. PULSE has learned the agency is now gearing up to hold meetings in five or six of their regional offices starting at the end of August and running through September. While the dates and times haven't been made official yet, the sessions will include a morning meeting with state officials and an afternoon session with consumer groups, insurers and providers.
Politico

ObamaCare Opponents Differ Sharply Over Strategy at ALEC Conference 08/08/2011

A dispute over the merits and potential defects of health care exchange systems continued to rage last week at the American Legislative Exchange Council's (ALEC) annual meeting in New Orleans as state officials expressed concern over ObamaCare's Medicaid mandates. While it may be politically appealing to resist setting up an exchange system, governors and legislators who adopt this policy stance would actually open the way to greater federal interference, Edmund Haislmaier, the Heritage Foundation's Senior Research Fellow of Health Policy Studies, explained in a panel discussion.
http://www.thepelicanpost.org/2011/08/08/obamacare-opponents-differ-sharply-over-strategy-at-alec-conference/

U.S. employer health plan enrollment up 2% under PPACA's dependent eligibility rule 08/01/2011

On August 1st Mercer, a subsidiary of Marsh & McLennan Companies, Inc. released findings from a survey they conducted of 894 employers which found that U.S. employer health plan enrollment has increased an average of 2 percent among respondents. Despite concerns over costs, only 2 percent of the survey respondents said they are "very likely" to terminate medical plans after the health insurance exchanges become operational in 2014.
http://www.mercer.com/press-releases/1421820

State News

Colorado:

A 'healthy' discourse over our health care 08/08/2011

A committee charged with keeping watch over Colorado's health care insurance exchange board held its first meeting on Monday, airing concerns about an imbalance of power by industry members over consumers on the board. Securing a steady funding stream for the exchange program was also discussed.
http://coloradostatesman.com/content/992967-healthy-discourse-over-our-health-care

District of Columbia:

Resident input sought on DC's health insurance exchange 08/11/2011

The Mayor's Health Reform Implementation Committee (HRIC) is seeking public input on planning for a Health Insurance Exchange for District residents. The HRIC has held numerous meetings in the community and is now seeking input via this survey. The deadline for participating in this survey is August 31. More surveys will be available in the future.
http://healthreform.dc.gov/DC/Health+Reform

Illinois:

Illinois Appoints Board 08/11/2011

Twelve legislators have been appointed to the state's Health Benefits Exchange Legislative Study Committee, which is mandated to report recommendations on implementation by Sept. 30. The committee is bipartisan, with six legislators from each chamber appointed by the leadership, and will host a series of meetings with stakeholders and the public this summer, Rep. Greg Harris, one of the appointees, told POLITICO yesterday. "It's a very complicated issue," the Chicago Democrat said. "One of the things I want to work on is to make it as user friendly as we can."

Politico

Kansas:

Kansas returns $31.5M exchange grant 08/09/2011

Brownback, who met with key legislators Tuesday morning before making the announcement, may have telegraphed the move in May when he directed Insurance Commissioner Sandy Praeger to slow down the implementation timelines she proposed in the state's Early Innovator Grant application. Brownback asked Praeger to delay a RFP for vendors to build parts of the health exchange, scheduled to go out in July. Kansas had already spent $500,000 of the Early Innovator Grant money, but the governor's office says the state plans to pay HHS back the cash in full.

http://www.politico.com/news/stories/0811/60967.html

Maine:

Panel to tackle health exchanges 08/10/2011

Gov. Paul LePage has named nine members to an advisory group tasked with developing a state health insurance exchange in line with federal health care reforms. The group, comprised primarily of members with ties to the health care industry, is scheduled to make recommendations to the Legislature by Sept. 1 about the exchanges.

http://www.mainebiz.biz/news48319.html

Nebraska:

Coalitions at odds on health reform 08/12/2011

Two new Nebraska coalitions are pushing conflicting ideas about how best to carry out federal health care reform in the state. But both say Nebraska should run its own health insurance exchange rather than leave the job to the federal government. On one side of the debate are eight consumer organizations, among which are AARP, the Center for Rural Affairs and the Appleseed Center for Law in the Public Interest. The group released a paper Thursday calling for an independent, consumer-driven board to govern the exchange. On the other side is the Nebraska Health Care Alliance, a newly formed group of health care providers and insurers. Among alliance members are Blue Cross Blue Shield of Nebraska, the Nebraska Medical Association and the Nebraska Hospital Association. They say the state exchange board should include health insurers and others with experience providing insurance

http://www.omaha.com/article/20110812/LIVEWELL03/708129931/1161

New Hampshire:

N.H. to Make Planning Grant Decision 08/10/2011

New Hampshire's exchange is very much up in the air after last month's passage of House Bill 601, which calls on the state to send back two-thirds of the $1 million exchange planning grant. Democratic Gov. John Lynch allowed the bill to become law without his signature as a compromise. He wants the state to set up its own exchange and he's afraid this law hurts that effort. However, he let the bill pass because it allows the state to implement other parts of the ACA. A legislative oversight committee will be formed this month to address how the state handles the rest of the exchange planning grant and how the state should move forward on an exchange.

Politico

North Dakota:

North Dakota Deadline Looming 08/09/2011

North Dakota passed exchange legislation earlier this year, but it isn't yet committed to running an exchange. The state last month issued an RFP for a consultant to recommend a viable plan for how North Dakota could build and sustain a health exchange, and the deadline for proposals is Aug. 10. The state's insurance department will issue a notice of intent to award around Aug. 18.

Politico

Hamm: ND could let feds change insurance exchange 08/05/2011

North Dakota's top insurance regulator told lawmakers Friday that it might be wise to let the federal government take the lead in establishing a new health insurance. Insurance Commissioner Adam Hamm told an interim legislative committee that the federal government would allow states to later assume control of the exchanges, online marketplaces intended to make it easier for consumers to shop for coverage. "The feds would take all the risk," Hamm told members of the Legislature's Health Care Reform Review Committee, meeting in Fargo. But the reaction to that idea from Rep. George Keiser, R-Bismarck, chairman of the health review committee, was cool.
http://www.inforum.com/event/article/id/329571/group/News/

Wisconsin:

Wisconsin Keeping Innovator Grant 08/12/2011

***N**ow that two Republican governors have returned hefty Early Innovator Grants to build a health exchange, the logical question is if Wisconsin will follow suit. Not likely, though. Wisconsin "remains committed" to using the Early Innovator Grant, a spokesman for Gov. Scott Walker told PULSE today. That news may come as a surprise, given the attorney general's opposition to health reform and Walker's role as a national tea party figure. However, the state plans to use the grant to build a "free market" and "consumer driven" exchange, an idea that's traceable to the one created in Utah.*
Politico

Will Wisconsin's Scott Walker implement health-care reform? 08/11/2011

Cullen Werwie, a spokesman for Walker, said in an e-mailed statement: "Wisconsin's award was for a total of $49 million, which includes enhanced funding from CMS to upgrade Wisconsin's BadgerCare Plus [the state's Medicaid program] eligibility and enrollment systems and integrate with the new health insurance exchange. Wisconsin remains committed to using these dollars for this purpose."
http://www.washingtonpost.com/blogs/ezra-klein/post/will-wisconsins-scott-walker-implement-health-care-reform/2011/07/11/gIQALBOb8I_blog.html

- Joel Ario, the director of the Office of Health Insurance Exchanges at CCIIO, announced he will be leaving the department Sept. 23rd. He will be replaced by Steve Larsen, who runs the health reform office that includes exchanges planning, and Tim Hill, a deputy director of the health reform office.
- State Recap: Of the 10 states that enacted legislation in 2011 to establish an exchange (CA, CO, CT, HI, MD, NV, OR, VT, WA, WV), eight are planning for a quasi-governmental structure, one is planning on a non-profit structure (HI), and one will be operated by the state (VT).
- New Hampshire Gov. John Lynch, who wants the state to set up its own exchange, allowed a law to pass in July without his signature requiring the state to decline $666,000 in exchange planning grant funds.
- Several states are currently using legislative committees and stakeholder workgroups to study the feasibility of establishing an exchange. Some of these states include AL, AR, GA, ID, KS, ME, MI, MO, MT, NE, OK, PA, SC and WY.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 07/29/2011 – 08/05/2011

Leavitt Partners Blog Posts

Will Health Reform's Newly Insured Overcrowd the Health Care System? 08/04/2011

The Congressional Budget Office (CBO) estimates that under the Patient Protection and Affordable Care Act (PPACA) 21 million people will become newly insured by 2014, growing to 34 million by 2021. Millions will gain insurance through the expansion of state Medicaid programs and millions more will purchase federally subsidized insurance on the state health insurance exchanges. With claims that the health care system is already unable to adequately provide for the future needs of the existing population, the common gut reaction is that these newly insured will severely tax and potentially overburden the current system. While this gut response seems likely on face value, it doesn't hold up to closer evaluation.
http://www.leavittpartnersblog.com/will-health-reforms-newly-insured-overcrowd-the-health-care-system-10003040

Core Components of a Health Insurance Exchange 07/21/2011

In this video demonstration, Dan Schuyler discusses the core components of an exchange, a point of sale portal, a true health insurance exchange, and the components of a PPACA compliant exchange. Mr. Schuyler brings to the firm applied experience in the development and implementation of Health Insurance Exchanges, having played a central role in Utah's health insurance exchange, one of only two functioning state health insurance exchanges in the country. He combines this functional knowledge and experience with a notable background in information technology.
http://www.leavittpartnersblog.com/core-components-of-a-health-insurance-exchange-10003023

Governors Must Lead on Health Reform 07/19/2011

States must lead, not follow. Ground zero for these budget problems is the explosive growth of health entitlements. Medicaid (health insurance for low income Americans) expenditures have quintupled in the past two decades. One in six U.S. citizens is covered by Medicaid. It already makes up more the 20 percent of state budgets. Recently passed health-care reform legislation will add more than 20 million more people in years to come. In time, Medicaid will clearly become a bigger economic weight than Medicare.

http://www.leavittpartnersblog.com/governors-must-lead-on-health-reform-10003015

Federal News

Get Ready for Some External Review 08/04/2011

New rules in the health care law allow consumers to apply for an external appeals process if they're turned down for an insurance claim and HHS quietly released the preliminary list of states who they feel meet and don't meet the "strict standards" of consumer protections for an external appeals process. Twenty-three states currently have laws on the books that meet the minimum 16 protections for people who need to appeal an insurance claim, and 10 states have been told they have "similar" protections that insurance companies have to abide by. Appeals processes for insurance companies in the rest of the states and five territories will be conducted by HHS, or the company will have to "contract with accredited independent review organizations to review external appeals on their behalf." Those states are Alabama, Alaska, D.C., Florida, Georgia, Louisiana, Massachusetts, Mississippi, Montana, Nebraska, New Hampshire, North Dakota, Ohio, Pennsylvania, Texas, W. Virginia and Wisconsin. Companies in all states have until Jan. 1, 2012 to transition into the new rules, though insurance industry reps say companies have already been complying.
Politico

States Unlikely To Go For Regional Exchanges 08/04/2011

HHS is providing a pathway for states to build multistate exchanges, but the dominating message from local health reform leaders is that they're not interested in teaming up — for now, anyway. Ultimately, regional exchanges could allow states to share IT burdens while expanding the power of their purchasing pools. Still, the regional exchanges face significant policy challenges, such as who has governance responsibility and how differing insurance markets could be aligned. Further complicating things is the fact that states are struggling to build their own exchanges. Just 13 states have passed legislation enabling exchanges, while other efforts face legislative hurdles and ardent GOP opposition at the state level.
Politico

15 States Enacting Legislation around Health Insurance Exchanges 08/02/2011

Under the Patient Protection and Affordable Care Act, states must establish health insurance exchanges by Jan. 2014 or invite the federal government to step in and take over implementation. The exchanges, which would function as a marketplace for individuals and small businesses, are intended to help consumers negotiate for cheaper rates and lower insurance costs overall. Here are 15 states that have enacted legislation to establish, plan for or examine the feasibility of health insurance exchanges.
http://www.beckersasc.com/asc-coding-billing-and-collections/15-states-enacting-legislation-around-health-insurance-exchanges.html

Top HHS officials to take over exchanges office 08/02/2011

The Health and Human Services Department will split up the workload of overseeing insurance exchanges after its top exchanges official leaves the department this month. Steve Larsen, who runs the health reform office that includes exchanges planning and many other functions, said in an e-mail to agency employees that he and another HHS official will take over planning for the exchanges — a cornerstone of the new health law. Larsen will share the task with Tim Hill, a deputy director of the health reform office who has also held several other positions within HHS. Larsen and Hill are planning to recruit a state liaison to serve as the direct contact for states on exchange implementation. Ario is leaving Washington on Aug. 26, but he will continue to lead exchange implementation through Sept. 23.
http://thehill.com/blogs/healthwatch/health-reform-implementation/175137-top-hhs-officials-to-take-over-exchanges-office

Head of HHS exchanges office stepping down 07/29/2011

Joel Ario, the director of the Office of Health Insurance Exchanges at CCIIO, will be leaving the Obama administration. His unexpected departure comes in the middle of HHS's rollout of the rules that will determine how states should run their exchanges, and it is unclear whether this will disrupt the process.
Politico

State News

California:

SHOP Lessons from California 08/03/2011

A new paper looks at California's experience in small group exchanges and what the states and feds can learn from it. The paper, from the Pacific Business Group on Health (the group ran California's small business exchange PacAdvantage for eight years before it shut down), says that one of the biggest problems with PacAdvantage was "adverse selection both against the exchange and among plans within the exchange. For SHOP Exchanges to be successful, they must learn from this experience and remain vigilant and adaptable in combating risk." Fortunately, the authors write, the ACA has more protections against adverse selection and the financial incentives "may attract a reasonably large core population with relatively younger enrollees to SHOP Exchanges." But there is still plenty to watch out for.

http://www.pbgh.org/storage/documents/PBGH_SHOP_05.pdf

Maine:

Members announced for Maine's health insurance exchange panel 08/04/2011

Gov. Paul LePage announced appointments to the Advisory Committee on Maine's Health Insurance Exchange on Thursday. The committee was established through a resolve by the 125th Legislature. LePage has appointed nine members, according to a release from his office. Members will include Dan McCormack, CEO of Intermed; Steven Michaud, president of the Maine Hospital Association; Kristine Ossenfort, director of government relations at Anthem Blue Cross Blue Shield; Joel Allumbaugh, CEO of the National Worksite Benefit Group; lawyer Daniel J. Bernier; Jamie Bissonette Lewey, chairman of the Maine Indian Tribal State Commission; Edward Kane, vice president for Maine at Harvard Pilgrim Health Care; David R. Clough, Maine state director of the National Federation of Independent Business; and Joseph Bruno, chairman of the Dirigo Health Agency board of trustees. Bruno will serve as committee chairman.

http://bangordailynews.com/2011/08/04/politics/members-announced-for-maine%E2%80%99s-health-insurance-exchange-panel/?ref=latest

Michigan:

Michigan Creeps Closer to Obamacare 'Exchange' 08/03/2011

Gov.Snyder has not made a decision on whether to create an exchange, or alternatively, join a handful of other GOP governors who have refused to establish one. Kelly Niebel, a spokesperson for the Michigan Department of Community Health, told CapCon, "Governor Snyder has said we will follow the law, adapt accordingly as it changes and act in the best interest of Michigan. Nevertheless, MDCH has undertaken a number of actions paving the way for a Michigan exchange. For example, the Michigan Department of Community Health has been holding a series of stakeholder workgroups. A list of all the workgroup members is included in the following link:

http://www.mackinac.org/15501

Michigan Taking Some Time 08/02/2011

The Michigan health department was planning to deliver exchange recommendations to Republican Gov. Rick Snyder by the end of July, but it looks like it's going to need more time. The department is still reviewing the dozens of recommendations from state workgroups, according to a source in the state. It "seems likely" that Snyder will now get the recommendations around the end of August, the source said.

Politico

Minnesota:

Proposals Submitted to Build up State's Health Exchange 08/02/2011

Fourteen groups have submitted proposals to build the infrastructure for the state's health insurance exchange, a key part of the

new federal health care law. ... The state of Minnesota put out requests for design proposals in mid-June. The Commerce Department received 14 proposals by this week's deadline.
http://minnesota.publicradio.org/display/web/2011/08/02/health-insurance-exchange/

New Hampshire:

N.H. Will Send Back Exchange Planning Grant 07/29/2011

It was recently brought to PULSE's attention that New Hampshire passed a law requiring the state to decline $666,000 in exchange planning grant funds. Republican Gov. John Lynch, who wants the state to set up its own exchange, allowed the law to pass July 14 without his signature. Lynch said he's concerned that declining the funds will hurt the state's ability to build its own exchange, but he allowed the bill to become law because it specifically allows New Hampshire to implement ACA provisions the state wants to control, like rate review. In a statement, Lynch said he'll continue to work with state leaders "to identify the most effective way to access available federal funds so that New Hampshire is able to implement its own health insurance exchange."
Politico

Oklahoma:

Oklahoma Schedules Health Hearing 08/04/2011

A special Oklahoma legislative committee has scheduled its first hearing to examine implementation. It is planned for Sept. 14. The committee was put together after conservatives convinced the state to turn down its exchange grant. Among the panel's members are six Tulsa-area legislators, including several with special expertise on health-care issues: Two Tulsa Republicans, Rep. Glen Mulready and Sen. Gary Stanislawski, will lead the committee, and they will be joined by Sen. Bill Brown, R-Broken Arrow; Sen. Sean Burrage, D-Claremore; Sen. Brian Crain, R-Tulsa; and Rep. Jeannie McDaniel, D-Tulsa. Also on the committee is Rep. Doug Cox, R-Grove, who is a physician.
http://www.tulsaworld.com/news/article.aspx?subjectid=11&articleid=20110803_16_A9_OKLAHO71665

Rhode Island:

Koller announces 2012 commercial health insurer rate decisions 08/02/2011

"OHIC's decision on rate factor increases for small and large group insurance simply underscores the dire need to transform delivery and payment of health care. We must reverse the trend of spiraling medical costs to make health care affordable and sustainable for Rhode Island businesses and families," said Lt. Gov. Elizabeth H. Roberts. "I am confident that implementing reforms such as the health benefits exchange, a competitive online marketplace for purchasing health insurance, will begin to bring cost savings in the form of rate relief to Rhode Islanders," she said.
http://www.pbn.com/Koller-insurance-rates-need-to-be-more-affordable,60183

Utah:

Why Utah's Health Exchange is a Free-Market Model 08/03/2011

However, even without a concerted marketing effort, the Exchange continues to grow at a steady pace, enrolling new businesses and employees each month. Currently, over 4,000 people are getting the advantages of participating in a defined contribution health arrangement through the Exchange. Once the technology is refined to the point of being able to handle the pressure of large volumes, the Exchange will work with the private sector to create more public awareness and volume will likely accelerate and provide increased value to more Utah citizens.
http://blogs.forbes.com/aroy/2011/08/03/why-utahs-health-exchange-is-a-free-market-model/

Utah's Health Insurance Experiment Built Around Small Businesses 08/02/2011

Under the federal health care reform law, all states will be required to set up a health insurance exchange starting in 2014. Betty Ann Bowser reports on one state that is ahead of the game, and how the new system is helping small businesses.
http://www.pbs.org/newshour/bb/health/july-dec11/utahhealth_08-02.html

Vermont:

Single-Payor Healthcare in Vermont: Q&A with Tom Huebner of Vermont's Rutland Regional Medical Center 08/03/2011

Tom Huebner, president and CEO of Rutland (Vt.) Regional Medical Center, Vermont's second-largest hospital, shares some thoughts on the single-payor legislation, what it means to his hospital and what it means for the long haul. "By 2014, in Vermont, I believe we're going to see about 30 percent of the population in the exchange. I think small employers will give up their insurance and provide some financial help to their employees to go into the exchange. The state employees will automatically be going to the exchange. A few large employers may give up their health insurance, but I don't see that happening much. They still will be able to do it cheaper themselves. Medicaid and Medicare will not be through the exchange at that point."

http://www.beckershospitalreview.com/hospital-financial-and-business-news/single-payor-healthcare-in-vermont-qaa-with-tom-huebner-of-vermonts-rutland-regional-medical-center.html?A_with_Tom_Huebner_of_Vermont%5C%5C%5C%5C%5C%5C%5C's_Rutland_Regional_Medical_Center=

- In a video demonstration, Dan Schuyler, a Director at Leavitt Partners, discusses the core components of a health insurance exchange.
- A new report by the consulting firm Accenture found almost half of insurance customers would be willing to pay more for health insurance that caters to their needs; the latest national survey from Rasmussen Reports shows 82% of likely voters believe that workers should be allowed to pick their own health insurance plan.
- The California Health Benefit Exchange board voted to oppose a bill that would establish a basic health plan and to urge lawmakers to exempt the exchange from a law that regulates rate increases by insurers.
- Idaho's exchange decision is delayed, the Kansas Insurance Department teams up with the NFIB and the Kansas Chamber to hold exchange information sessions, and Pennsylvania begins its exchange planning.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 07/22/2011 – 07/29/2011

Leavitt Partners Blog Posts

Core Components of a Health Insurance Exchange 07/21/2011

In this video demonstration, Dan Schuyler discusses the core components of an exchange, a point of sale portal, a true health insurance exchange, and the components of a PPACA compliant exchange. Mr. Schuyler brings to the firm applied experience in the development and implementation of Health Insurance Exchanges, having played a central role in Utah's health insurance exchange, one of only two functioning state health insurance exchanges in the country. He combines this functional knowledge and experience with a notable background in information technology.

http://www.leavittpartnersblog.com/core-components-of-a-health-insurance-exchange-10003023

Leavitt Partners health insurance exchange expertise continues to grow 06/14/2011

In the 14 months since the Affordable Care Act became law, interest in exchanges has soared. Dozens of companies have remade themselves and added new capabilities touting themselves as the exchange experts. As decision makers quickly advance through the steps toward building exchanges, one of the most important decisions that they will make is who to partner with. Compressed timelines make this decision more important than ever. Reflecting on the experience of earlier efforts, there are several lessons learned that can be applied when selecting partners.

http://feeds.feedburner.com/LPHealthInsExch

Health Insurance Exchanges: Select the "Right" Team 07/02/2011

Several different types of teams will be used during the exchange establishment process: the exchange implementation team, technical workgroups, financial planning groups, the exchange governance board, etc. The composition of each of these teams is a key factor in determining how successfully the exchange will operate and, perhaps more importantly, how successfully it is perceived by the public. While the purpose and objectives of each group widely differ, the principles discussed in this blog apply to all of the teams. Leavitt Partners believes three basic principles should be followed when selecting the "right team."

http://feeds.feedburner.com/LPHealthInsExch

Federal News

Health Insurance Exchange Development: Innovation in the States 07/27/2011

Under health reform, state-based health insurance exchanges are a mechanism to buy private insurance beginning in 2014. Through panel discussions with state leaders and stakeholders, this briefing, jointly sponsored by the Bipartisan Policy Center (BPC), the Kaiser Family Foundation and the University of Virginia's Batten School of Leadership, explored states' progress on the exchanges and identified next steps.
http://www.kff.org/healthreform/health_insurance_exchange_states.cfm

Top 10 sectors that will benefit from health insurance exchanges 07/12/2011
Industry research firm IBISWorld has forecast the top 10 sectors that will benefit from the creation of state health insurance exchanges under the new rules released this week by the U.S. Department of Health and Human Services.
http://www.healthcarepayernews.com/content/top-10-sectors-will-benefit-health-insurance-exchanges

Establishing Health Insurance Exchanges: An Update on State Efforts 07/27/2011
This issue brief examines states' progress in setting up the state-based health insurance exchanges through which millions of Americans are expected to purchase coverage under the ACA beginning in 2014.
http://www.kff.org/healthreform/8213.cfm

HHS Releases Funding Announcement for Co-Op Plans 07/28/2011
The Health and Human Services Department formally released a funding opportunity Thursday to create health insurance cooperatives, a new type of plan authorized under the healthcare reform law. Co-ops must be nonprofit entities that reinvest extra revenues into either lowering premiums or improving the quality of care. Although they were originally pitched as an alternative to the controversial public option, co-ops cannot be run by a government entity.
http://thehill.com/blogs/healthwatch/health-reform-implementation/174225-hhs-releases-rules-for-co-op-plans

Eligibility and Enrollment Next Exchange Rule 07/28/2011
CMS's Cindy Mann strongly hinted Wednesday that HHS will next tackle eligibility and enrollment rules. "Our next set of guidance coming out in terms of regulations will be on some of the rules of the road in terms of eligibility and enrollment." Mann, who said some of the administration's vision on enrollment and eligibility requirements has already been seen through the Early Innovator and exchange establishment grants, laid out four major principles for the upcoming guidance: 1) ***Flexibility*** — HHS has boasted that the first exchange rule leaves major decisions up to the states, such as who can sell on the exchange, the exchange governance model and how the plans can be marketed. Mann said to expect more of the same. 2) ***Coordination*** — Health reform requires the exchange to be a one-stop shop for determining eligibility in either the exchange, Medicaid or the Children's Health Insurance Program. Providing a consumer-friendly and workable enrollment process requires coordination, Mann said. 3) ***Aligning rules*** — There are different eligibility rules for Medicaid, CHIP and the exchange subsidy, so aligning those rules and procedures — such as income definition and verification — is key. 4) ***Simplification*** — "If the rules are very complicated, even if they're aligned, it's still going to be hard" for consumers to understand, states to manage and health plans to anticipate enrollment and eligibility, Mann said. That puts pressure on the administration to simplify the income definition and verification process by using a using as much data as possible.
Politico

Report: Customers ready to pay more for customized health plans 07/26/2011
Almost half of insurance customers would be willing to pay more for health insurance that caters to their needs, according to a new report from the consulting firm Accenture. The firm

surveyed 1,000 insured people and found that nearly 50 percent were ready to pay more for better customer service. And nearly 80 percent said they expected customer service to be easier and more convenient. The findings are crucial for insurers competing for business as the healthcare reform law prepares to add 40 million people to the insurance rolls, according to the firm.
http://thehill.com/blogs/healthwatch/health-insurance/173549-report-customers-ready-to-pay-more-for-customized-health-plans

Experts say state health exchanges are an opportunity for vendors 07/28/2011
State health insurance exchanges may prove to be good for vendors who provide consulting services on how to make customer service available on health plan websites, experts say. However, Greg DeBor, a partner at Falls Church-Virginia-based CSC Healthcare Group said the health IT industry is still trying to digest the proposed rule to determine whether there's a role in it for them. In the individual health plan market today, very few health plans have advanced-enough service to offer a consumer the ability to purchase insurance directly online, according to DeBor. Jordan Battani, a principal with Global Institute for Emerging Healthcare Technologies at CSC said some of the confusion about what the exchanges will do is leaving it unclear to vendors as to what kind of services and products will be needed.
http://www.healthcareitnews.com/news/experts-say-state-health-exchanges-are-opportunity-vendors

82% Say Workers Should Be Allowed To Choose Their Own Insurance 07/27/2011
Though a majority of voters believe the system of employers providing health insurance to their workers is a good one, most believe employees should be allowed to pick their own. The latest Rasmussen Reports national telephone survey of Likely Voters shows that 82% believe that, if it didn't cost the employer any extra money, a worker should be allowed to pick his or her own health insurance plan if they didn't like the one provided by the employer. Only eight percent (8%) say the worker should not have this option.
http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/july_2011/82_say_workers_should_be_allowed_to_choose_their_own_insurance

States may get substantial power over health insurance exchanges 07/25/2011
States will have leeway in determining who operates their health insurance exchanges and which health plans qualify for sale in the exchanges, among other state powers outlined in proposed guidelines unveiled July 11 by the Dept. of Health and Human Services.
http://www.ama-assn.org/amednews/2011/07/25/gvl10725.htm

Larsen Mum on Timing of HHS 'Active Purchaser' Decision 07/22/2011
It's one of the biggest decisions they have to make under the health law — but Health and Human Services officials are remaining resolutely mum about whether Uncle Sam will deny insurers access to the health benefit exchanges it runs if they give consumers a lousy deal. Steve Larsen, director of the Center for Consumer Information and Insurance Oversight, declined to tell reporters Thursday when that decision would be announced. Larsen wouldn't even say whether it would be announced this year.
CQ Healthbeat

Exchange Deadline May Be a Soft One 07/21/2011
The Obama administration official overseeing the establishment of state health insurance exchanges left open the possibility Thursday that no states will establish such marketplaces by the 2014 statutory deadline. Steve Larsen, deputy administrator and director of the Center for Consumer Information and Insurance Oversight at the CMS, described at a news briefing in Washington the various activities that some states have undertaken to establish their own. However, even the states furthest along in the process have multiple complex steps left to undertake before the deadline
http://www.modernhealthcare.com/article/20110721/NEWS/307219984/

State News

Arkansas:

Exchange Watch 07/25/2011

The state failed to pass exchange legislation this year, but it continues to study the topic. The Arkansas Insurance Department on Tuesday hosts a meeting of the Health Benefits Exchange Steering Committee, a group of about two dozen stakeholders from industry and state government. In its most recent June meeting, the exchange committee reviewed a 10-point plan on how to market the idea of an exchange to the public.

Politico

California:

Public Agency Takes Up Political Hammer 07/27/2011

The board of the California Health Benefit Exchange voted last week to oppose a bill that would establish a basic health plan and to urge the lawmakers behind AB 52, which would regulate rate increases by insurers, to exempt the exchange from that law. The board also voted to direct staff to work with legislators on four other bills that deal with the exchange -- including two laws that directly refer to the exchange in their identifying titles.

http://www.californiahealthline.org/capitol-desk/2011/7/exchange-board-gets-political.aspx

Colorado:

State health exchange chief explains program 07/27/2011

Health insurance exchanges are tied to the federal Affordable Care Act and to perhaps the most controversial part of that law, the mandate that all Americans have health insurance. To make that happen for the people not already covered by employers' plans or government programs, the states have been asked to set up health insurance exchanges where people can shop for insurance on what Henneberry called a "level playing field." "This is not an entitlement program. This is not a new federal bureaucracy. This is a marketplace," she said.

http://www.chieftain.com/news/local/state-health-exchange-chief-explains-program/article_a1288396-b813-11e0-839c-001cc4c002e0.html

Idaho:

Idaho's Exchange Decision Delayed 07/29/2011

Members of Idaho's exchange governance workgroup were expecting to learn next week whether Republican Gov. Butch Otter would endorse the panel's recommendation that the state create its own exchange, but they're going to have to wait a little longer. The members were informed this week that the meeting was canceled to allow Otter time to review the panel's recommendations with legislative leaders. Otter earlier this year issued an executive order banning the state from implementing the ACA, but he ordered the state to explore its exchange options.

Politico

Kansas:

NFIB, Kansas Chamber Team Up with Insurance Department 07/27/2011

The Kansas Insurance Department, in a precarious position because of a multimillion dollar early innovator grant and an anti-ACA Legislature, has reached out to the NFIB and the Kansas Chamber to hold information sessions around the state to hear from the business community. "As a business community we are on the record saying we support the repeal of Obamacare," Kansas Chamber's Eric Stafford said. "But in the event it is not repealed we want to make sure we have a seat at the table and Kansans are in control." The meetings will be held in cities throughout the month of August and will have three main components: information from a potential vendor on the technical aspect of the exchange, information from insurance commissioner Sandy Praeger and a question and answer session.

Politico

Michigan:

Exchange Watch 07/25/2011

The state's health department is expected to send exchange recommendations to Republican Gov. Rick Snyder by the end of the week. Snyder, still undecided on whether to set up an exchange, is then expected to make his recommendations to the Legislature in September.
Politico

Missouri:

Missouri Scraps Show-Me Health Insurance Exchange Act 07/25/2011
A bill called the Show-Me Health Insurance Exchange Act was introduced late in the session, passing the House by a unanimous 157 to 0. It stalled, however, upon reaching the Senate. One key reason was the opposition of State Sen. Jane Cunningham (R-West County), who fought against the Act when it was introduced in her chamber.
http://www.heartland.org/healthpolicy-news.org/article/30456/Missouri_Scraps_ShowMe_Health_Insurance_Exchange_Act.html

Ohio:

Ohio puts challenge to health care reform on the ballot 07/27/2011
Ohio residents will be allowed to vote for a measure that would create an amendment to the state constitution blocking federal health care reform in the state. The measure will be on the November 8 ballot after a successful petition drive by state residents who oppose health care reform. The proposed amendment would constitutionally prohibit the state from complying with the requirements of federal health care reform passed earlier this year.
http://civsourceonline.com/2011/07/27/ohio-puts-challenge-to-health-care-reform-on-the-ballot/

Pennsylvania:

Commonwealth to Host Meeting to Discuss Statewide Health Information Exchange 07/25/2011
Pennsylvania was awarded $17 million under the American Reinvestment and Recovery Act (ARRA) to help establish the exchange. ARRA also provides incentives to doctors and hospitals to adopt electronic health records.
http://www.prnewswire.com/news-releases/commonwealth-to-host-meeting-to-discuss-statewide-health-information-exchange-126114448.html

New York:

Health Exchanges a High Priority on Albany's To-Do List 07/25/2011
New York lawmakers are expected to return to Albany for a special session next month, and high on their agenda is hashing out a new health insurance exchange.
http://www.wnyc.org/articles/wnyc-news/2011/jul/25/health-exchanges-slowly-materializing-albany/

Wyoming:

Wyoming Finally Making Exchange Moves 07/25/2011
The Wyoming Health Insurance Exchange Steering Committee has tapped PCG Health and Human Services to study the feasibility of creating an exchange. The state has so far made little progress on the exchange front — the steering committee was the only exchange bill to go through the legislature in this year's session — but Massachusetts-based PCG will have to turn around some recommendations quickly. The first draft is due to the steering committee Sept. 1, and a final copy, by Oct. 1.
Politico

- Former Secretary of Health and Human Services Mike Leavitt told governors they need to take the lead in creating health insurance exchanges. “This is a profoundly important moment for states. States need to lead. Too often, we have just deferred this to the federal government, and the federal government needs guidance [from the states] to do it.”
- Connecticut will soon pick a board and staff members to oversee the development of a state exchange; Illinois establishes a study committee to make recommendations by the end of September for how to set up an exchange; and Maryland issues RFPs, due July 25, to study market rules and risk selection, the small-business exchange, and the role of navigators.
- Ohio moves forward to create an exchange. Gov. Kasich said the state has received federal money to plan for building an exchange and will soon apply for a second round of federal cash.
- The executive committee of the Rhode Island Healthcare Reform Commission voted to urge Governor Chafee to issue an executive order to create the exchange. The committee also recommended the exchange become the responsibility of an existing state agency.
- Also attached is Leavitt Partners’ four-page briefer on the proposed exchange rules released last Monday.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 07/15/2011 – 07/22/2011

Federal News

Exchanges: HHS Official Offers Insights on State Deadline, Insurer Roles 07/22/2011

During a news briefing in Washington, D.C., Steve Larsen, deputy administrator and director of the Center for Consumer Information and Insurance Oversight at the CMS, discussed certain issues related to the establishment of state health exchanges.

http://www.kaiserhealthnews.org/Daily-Reports/2011/July/22/health-exchanges.aspx

Questions Plague State Health Exchange Program 07/20/2011

In a new report, Milliman Inc. identified a series of considerations for states, health plans, and employers as they look toward the 2014 state exchange implementation deadline. "The exchange regulations provide clarification on some points while leaving many questions open," said Cathy Murphy-Barron, Milliman principal and consulting actuary. "The possibility that exchanges could serve a larger role in the rate review process introduces questions about interaction between state insurance departments and exchanges. Perhaps most importantly from an actuarial perspective, we are still awaiting regulations on essential benefits and other key aspects of pricing, which will be pivotal in dictating the design of plans in the exchange. So while we know more

today than we did last week, there are still many unknowns and various questions for states, plans, and employers to consider as they plan for the exchange paradigm."
http://www.milliman.com/home/index.php

Is a Federal Exchange Viable? 07/19/2011

Will there really be a strong federal health insurance exchange to take over for states that don't build their own? Or is it a paper tiger? That question is nagging at some policy experts. The law does not give HHS the power to regulate insurance sold outside the exchanges — which would basically require it to take over the job of the state insurance commissioners. And it doesn't give HHS the power to take over a state's Medicaid program, even though the exchanges are supposed to handle enrollment when Medicaid is expanded to new populations in 2014. "It could be a real problem to set up an exchange that's even viable," mused Norm Thurston, health reform implementation coordinator for Utah. "It's a question that's come up with a lot of state people." The reality, he said, is that "nobody knows" if a federal exchange can work.
http://www.politico.com/news/stories/0711/59267.html

Leavitt: States must lead on health exchanges 07/16/2011

Former Secretary of Health and Human Services Mike Leavitt said Saturday that governors need to take the lead in creating health insurance exchanges or the federal government will dictate how the exchanges should be run. "This is a profoundly important moment for states," the former Utah governor said. "States need to lead. Too often, we have just deferred this to the federal government, and the federal government needs guidance [from the states] to do it."
http://www.sltrib.com/sltrib/news/52203503-78/health-states-federal-utah.html.csp

Romney Adviser Backs Obama Health Exchanges 07/16/2011

Former Utah Gov. Mike Leavitt, a top supporter and adviser of Republican White House hopeful Mitt Romney, strenuously backed the core piece of President Barack Obama's health-care law and urged the states to move forward together in adopting health insurance exchanges. Speaking to a bipartisan group of governors at the National Governors Association, the former Republican governor who served as secretary of health and human services in the Bush administration, called the exchanges where individuals and small businesses can purchase health plans "a very practical solution to a problem that needs to be solved." He warned governors who are reluctant to move forward with their state-level exchanges that their intransigence will only empower federal regulators.
http://blogs.wsj.com/washwire/2011/07/16/romney-adviser-backs-obama-health-exchanges/?mod=google_news_blog

State News

Connecticut:

Connecticut Will Soon Pick A Board To Oversee State Health Insurance Exchange 07/15/2011

Connecticut will soon pick a board and staff members to oversee the development of a state health insurance exchange. The 14-person board includes 11 voting members -- two appointed by the governor, six appointed by the legislature, the Special Advisor to the Governor on Health Care Reform, the secretary of Connecticut's Office of Policy and Management and the Connecticut Department of Social Services commissioner.
http://blogs.courant.com/connecticut_insurance/2011/07/connecticut-will-soon-pick-a-b.html

Idaho:

Idaho Gov. Says Ok to Grants 07/20/2011

Idaho Gov. Otter has approved 10 ACA grants totaling $18.9 million, even though he signed an executive order blocking implementation of the health reform law. Most of the money went toward things like public health and prevention, smoking cessation and a planning grant for a state proposal on how to lower costs for chronically ill patients on Medicaid.
Politico

Illinois:

Illinois Exchange Study due Sept. 30 07/18/2011

The bill Gov. Pat Quinn signed into law on Friday requires a study committee of six state senators and six representatives to make its recommendations for how to set up an exchange by the end of September. The committee, which must be appointed within 30 days, will grapple with issues including the operating model of the exchange, the size of employers to be offered coverage, coverage pools and standards for coverage of full- and part-time employees and their dependents. The Illinois Health Benefits Exchange must be open for business by Oct. 1, 2013.

Politico

Kansas:

States-Eye View for Creating Insurance Exchanges: Sandy Praeger 07/18/2011

The U.S. Department of Health and Human Services published last week its long-awaited rules for the health-insurance exchanges. There are many key things I had hoped this document would address, but doesn't, including which benefits the participating insurers should be required to cover and how Medicaid and other federal subsidies will be coordinated with the exchanges. But for the most part the new regulations are useful. They give officials like me the direction we need to establish an insurance exchange that's right for our states.

http://www.bloomberg.com/news/2011-07-19/states-eye-view-for-creating-insurance-exchanges-sandy-praeger.html

Maryland:

Maryland Moving Quickly to Study Exchange 07/21/2011

Even though Maryland is considered one of the leading states on exchange implementation, the law that passed through the state Legislature delays some major decisions until next year and puts the onus on the exchange board to come up those recommendations. So, the exchange board has quickly put out three RFPs to help it understand some of the key issues. The RFPs, due July 25, study market rules and risk selection, the small-business exchange and the role of navigators.

Politico

Michigan:

Health insurance exchange must focus on Michigan needs 07/17/2011

The Michigan Association of Health Plans envisions the exchange as a "market organizer," somewhat like an "Expedia" for health insurance, a place where consumers can come, see various products at various prices and then select the one that meets the consumer's specific needs. It would provide an important — but not the only — venue for individuals and businesses to come to find the right insurance product for their needs, at a price they can afford. A white paper developed by MAHP (available at http://www.mahp.org/whitepapers.html) recommends that Gov. Snyder and the Legislature move forward to establish a "minimalist" exchange operation, providing a flexible framework that regulators, consumers and health insurers can work together to improve and adapt as conditions change.

http://theoaklandpress.com/articles/2011/07/17/opinion/doc4e1cf8baa6b78722797519.txt

Insurance Exchanges Aim to Lower Costs of Health Coverage for Small Businesses, Individuals 07/16/2011

Work groups are recommending that Michigan create a single exchange as an independent, public authority, among other recommendations. The Michigan Department of Community Health plans to submit its suggestions by the end of the month to Gov. Rick Snyder, who will then make his own recommendations to the Legislature.

http://www.ahealthiermichigan.org/2011/07/16/insurance-exchanges-aim-to-lower-costs-of-health-coverage-for-small-businesses-individuals/

New York:

A New York Bill Revised? 07/19/2011

It's unclear just when the New York State Legislature will come back for a special session to take up the unfinished business of the health care exchange legislation, which was pulled off the Senate floor at the last minute. But when it does, the Legislature will now have to go back to its previously agreed upon bill and make sure it all stacks up against the new exchange rule. "[W]e have to take a hard look at the new rules from the federal government and see if any of these rules directly impact the bill we've negotiated," said Sen. Kemp Hannon, who co-wrote a version of the bill.
Politico

Ohio:

Ohioans will get a health exchange 07/19/2011

Gov. John Kasich said yesterday that plans are moving forward to create a statewide marketplace or exchange for health insurance, as mandated by the Affordable Care Act championed by President Barack Obama. Kasich said the state has received federal money to plan for building an exchange, in which individuals and small businesses that don't have insurance could find coverage beginning in 2014. He said Taylor, who also heads Ohio's Department of Insurance, is to apply soon for a second round of federal cash.
http://www.dispatch.com/live/content/local_news/stories/2011/07/19/ohioans-will-get-a-health-exchange.html?sid=101

Rhode Island:

Chafee asked to step in, create health-benefits exchange 07/19/2011

Rhode Island took a step forward Monday in the effort to establish a health-benefits exchange, the insurance marketplace that is the cornerstone of the federal health-care law. The executive committee of the Rhode Island Healthcare Reform Commission voted to urge Governor Chafee to issue an executive order to create the exchange. The committee also recommended the exchange become the responsibility of an existing state agency, although it did not specify which one.
http://www.projo.com/news/content/EXECUTIVE_ORDER_HEALTH_EXCHANGE_07-19-11_FEP8_v12.3880a.html

South Carolina:

South Carolina health care overhaul panel to meet 07/18/2011

A panel reviewing high-deductible health insurance policies for a proposed South Carolina health care exchange is planning to meet. The panel meeting Monday is part of the South Carolina Health Planning Committee that Gov. Nikki Haley established earlier this year. It will make policy recommendations about whether it is feasible for the state to create its own health exchange under federal health care laws. If the committee recommends against creating a state-run exchange, it will suggest alternate strategies in a report due on Oct. 28.
http://www.thestate.com/2011/07/18/1901984/south-carolina-health-care-overhaul.html

Vermont:

Larson to leave Legislature for job in government 07/19/2011

Mark Larson, a Democratic legislator for the past decade and one of the architects of the state's health care reform law, now will have a hand in implementing some of those reforms as commissioner of the Department of Vermont Health Access. Gov. Peter Shumlin announced Tuesday that he had chosen Larson, 41, of Burlington to fill the post being vacated by Susan Besio, who retired July 1.
http://www.burlingtonfreepress.com/article/20110719/NEWS03/110719020/Shumlin-picks-House-chairman-health-job-?odyssey=tab%7Ctopnews%7Ctext%7CFRONTPAGE

- HHS releases exchange rules. The following is Leavitt Partners' initial thoughts on the regulations:
    - There was nothing particularly unexpected in the proposed rules
    - The concept of "conditional approval" not only makes political sense; it makes practical sense
    - Any time HHS talks about increased state flexibility, it's a good thing
    - There are many more regulations yet to be written and states will inevitably exert influence on HHS in that regard; thus, early mover states have a clear advantage
    - HHS is continuing planning efforts for a federal fallback for those states who fail to establish an exchange
- HHS officials also released a proposed rule designed to minimize the impact on insurance companies of covering sick, expensive patients. The 103-page regulation includes three components that would encourage insurers to cover high-risk policy holders: 1) a permanent risk adjustment formula; 2) a three-year reinsurance program; and 3) a three-year risk corridor program.
- A recent survey by PricewaterhouseCoopers found about half of surveyed insurance executives have decided to try to participate in the exchange system. However, the company executives are worried about the risk of adverse selection and about the possibility that some exchanges will use an "active purchaser" carrier selection approach to keep higher cost carriers off the exchange.
- Hawaii Gov. Neil Abercrombie signed the Hawaii Health Connector into law, making Hawaii the 12th state to have a governor's signature on an exchange bill.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 07/08/2011 – 07/15/2011

Federal News

PricewaterhouseCoopers: PPACA Exchanges May Add Sales, Headaches 07/12/2011

Only about one-sixth of health insurance company executives polled told PricewaterhouseCoopers that they are certain their companies will stay out of the exchange system. One-third of the executives said their companies are still deciding whether to try to participate, and about half have decided to try to participate. PricewaterhouseCoopers found health insurance company executives are worried about the risk of adverse selection, and about the possibility that some exchanges will use an "active purchaser" carrier selection approach to keep higher cost carriers off the exchange.
http://www.lifeandhealthinsurancenews.com/News/2011/7/Pages/PricewaterhouseCoopers-PPACA-Exchanges-May-Add-Sales-Headaches.aspx?page=2

Health Exchange Risk Programs Would Protect Insurers Against Losses, Consumers Against Adverse Selection 07/11/2011

Health and Human Services Department officials coupled the health exchange regulation with a proposed rule designed to minimize the impact of covering sick, expensive patients on insurance companies. The 103-page regulation includes three components that would encourage insurers to cover high-risk policy holders just as they would those who are healthy: 1) A permanent risk adjustment formula that would pay insurers higher rates for sicker patients. The adjustment would apply to those in the individual and small group markets inside and outside of the exchanges. 2) A three-year reinsurance program that would establish a nonprofit to handle temporary payments for insurers that cover patients with high medical claims in the individual market. 3) A three-year risk corridor program that would give insurers inside the exchanges more certainty by limiting losses and gains. Insurers whose claims are at least 3% higher than projected would get more federal funding, while those whose costs are at least 3% less than projected would get fewer federal dollars.
CQ Healthbeat News

Private exchanges offer alternative 07/11/2011

Like the exchanges in the law, the private versions are supposed to give consumers a wide selection of health plans. But there are two big differences. Rather than operating with public subsidies, these new private marketplaces have companies ponying up a "defined contribution" — a set amount that employees can use to buy a plan, with the option to add in some of their own money to get a richer benefit package.

http://www.politico.com/news/stories/0711/58700.html

US offers states new insurance exchanges timetable 07/11/2011

The Obama administration offered U.S. states more flexibility in setting up new health insurance exchanges, an apparent effort to bring local authorities on board with a key part of a healthcare overhaul. The U.S. Department of Health and Human Services proposed on Monday a sliding deadline for states to set up the exchanges, relaxing a previously strict 2013 date to commit to a plan and be ready start by 2014.

http://www.reuters.com/article/2011/07/11/health-insurance-exchanges-idUSN1E76A0UG20110711

After Much Scrutiny, HHS Releases Health Insurance Exchange Rules 07/11/2011

The rules released Monday are less prescriptive than some consumer advocates desired, but grant states' requests that they be given broad leeway to design and regulate the marketplaces, called exchanges. Under the proposed rules, the marketplaces will have to post information online about price and quality, offer specific standardized plans and set an annual open enrollment period. Despite lobbying from consumer groups, insurers will be allowed to hold seats on exchange oversight boards and states will not be required to negotiate with plans on price or benefit offerings.

http://www.kaiserhealthnews.org/Stories/2011/July/11/Health-Insurance-Exchange-Regulations-Released.aspx

Giving Americans Better Health Insurance Choices - By Sec. Sebelius 07/10/2011

"Exchanges will give Americans competition, choice, and clout in the health insurance market. They share some key features. First, they will serve as a one-stop shop where you can easily see your private insurance options, compare prices and benefits, and pick the plan that's right for you and your family. Second, Exchanges will set conditions to ensure that insurers compete only on price and quality. Third, they'll ensure a basic level of coverage. All plans sold in the marketplaces will offer a minimum package of benefits similar to those offered by employers today, so you can be confident the plan you buy will protect you if you get sick."

http://www.huffingtonpost.com/sec-kathleen-sebelius/health-insurance-exchange-_b_894252.html

State News

Colorado:

Trouble Brewing in Colorado 07/13/2011

Consumer advocates took over the inaugural meeting of Colorado's exchange board on Monday afternoon, demanding that at least one board member with ties to the insurance industry resign. The advocates, upset that five of the board's nine members have ties to insurance and health technology companies, argue that the insurance representation violates the state's exchange law. The advocates say they may go to the state attorney general or ask the exchange's legislative oversight committee to step in. According to the governor's policy director for health reform, the state has no plans to replace any board members, saying that they're all committed to the success of the exchange.

Politico

Hawaii:

Aloha, Hawaii Exchange 07/12/2011

Hawaii Gov. Abercrombie signed the Hawaii Health Connector into law, making it the 12th state to have a governor's signature on an exchange bill. The bill directs the state to spend $750,000 on the Connector's operations, and Abercrombie is expected to name Connector board members by August.

Politico

Massachusetts:

Consultant advising state on aligning health exchange with new federal rules 07/15/2011

There was lots of buzz around the proposed rules for state health insurance exchanges released Monday by HHS. Massachusetts already has a state exchange. That means that policymakers can sit out this policy conundrum, right? Not quite. The state's insurance marketplace does not fit perfectly with the requirements of the Affordable Care Act. For one thing, the federal plan provides assistance in purchasing insurance to more people. Anyone who makes up to 400 percent of the federal poverty level would receive a subsidy, while the state's level is at 300 percent. The federal plan allows for some to receive tax credits not included at the state level now.
http://www.boston.com/Boston/whitecoatnotes/2011/07/consultant-advising-state-aligning-health-exchange-with-new-federal-rules/UN3N3P9FuFnYwm2GbVX19M/index.html

New Hampshire:

Health bills become law without Lynch signature 07/15/2011

A bill to exert state control over federal health-care reform became law without Gov. John Lynch's signature Thursday. House Bill 601 gives Insurance Commissioner Roger Sevigny power to continue work on implementing some provisions of the Patient Protection and Affordable Care Act, which will require everyone to have insurance by 2014. The bill also directs Sevigny to decline $666,000 in federal planning grant funds and tell the federal government to use it to lower the deficit.
http://www.unionleader.com/article/20110715/NEWS06/707159989

New York:

Exchange advocates hopeful of Senate return 07/11/2011

Elisabeth Benjamin, a vice president of the Community Service Society and an advocate of setting up a health insurance exchange, said she's confident Senators will pass a bill that has already cleared the Assembly to do so. "I honestly feel the Senate leadership, as well as senators Seward and Hannon, get it…The exchange bill just became a victim of the chaos at the end of session. It's not dead. Cooler heads will look at this, and say the negotiated bill is much better than having the federal government come in and run an exchange."
http://blog.timesunion.com/capitol/archives/74297/exchange-advocates-hopeful-of-senate-return/

Oregon:

Governor Urges OEBB to Cooperate in Exchange and Transformation Efforts 07/13/2011

The Oregon Educators Benefit Board (OEBB) is going to be part of the state's new insurance exchange, and will have to change the way its health plans deliver care to school district employees, according to Governor John Kitzhaber. The governor wants the board to develop a three-year strategy by September outlining how its health plans can complement the state's efforts to overhaul the Oregon Health Plan and transform the state's healthcare system.
http://www.thelundreport.org/resource/governor_urges_oebb_to_cooperate_in_exchange_and_transformation_efforts

Pennsylvania:

State isn't sure about insurance exchanges 07/12/2011

As the federal government this week rolled out the framework for states to establish their own health insurance exchanges, officials in Harrisburg were still trying to determine if they will set up an exchange at all. Gov. Tom Corbett has been an opponent of the law — as attorney general, he joined a multistate suit to fight the law in federal court — and a spokeswoman from the state Insurance Department says officials haven't decided whether they'll recommend developing an exchange for Pennsylvania. The department intends to hold public meetings throughout the rest of the summer to get feedback on a state exchange. The dates and sites of the meetings have not been set.
http://www.mcall.com/news/nationworld/pennsylvania/mc-pennsylvania-insurance-exchange-20110712,0,3491410.story

Utah:

Utah: We Can't Do Everything HHS Wants 07/14/2011

One of the most closely watched states on health care reform says it will pick and choose what pieces of ACA exchange requirements it will implement, regardless of federal rules. Norm Thurston, the state's health reform implementation coordinator, said in an interview Wednesday that the new federal requirements for exchanges are not going to drive Utah's policymaking. "We're just trying to do what's right for Utah," Thurston said. Given the short time frame for reform implementation, "we can't do everything that [federal officials] want us to do anyway, so we're just trying to pick and choose the things that are important to us"
Politico

Texas:

Texas refuses to launch health insurance exchange 07/15/2011

Gov. Rick Perry strongly opposes the health system reform law and threatened to veto any legislation that would help implement the law's health insurance exchanges. Perry did not want to be seen as aiding the implementation of the health reform law in any way, said Texas Rep. John Zerwas, MD, sponsor of the leading bill to create an exchange, and Texas Medical Assn. President Bruce Malone, MD, in separate interviews. Drs. Zerwas and Malone said Perry told them he can create a state insurance exchange administratively.
http://www.ama-assn.org/amednews/2011/07/11/gvse0715.htm

Wisconsin:

State of Wisconsin Selects Corticon's "No-Coding" Rules Engine for New Health Insurance Exchange System 07/13/2011

Corticon today announced that the State of Wisconsin has selected Corticon's "no-coding" rules engine for its new Health Insurance Exchange (HIX) system. Automating business rules with Corticon lets Wisconsin streamline citizen eligibility, increase productivity, and reduce costs. Unlike traditional systems that collect information and then determine eligibility later, Wisconsin's new system will determine eligibility upfront and then intelligently guide the information selection process, with little or no interaction with case workers.
http://www.marketwire.com/press-release/state-wisconsin-selects-corticons-no-coding-rules-engine-new-health-insurance-exchange-1537733.htm

- Gov. Dannel P. Malloy signs legislation establishing the framework for the Connecticut health insurance exchange; making a total of 11 states to enact exchange legislation this year.
- Rhode Island and Delaware consider establishing exchanges through executive order.
- Minnesota-based Bloom health's announcement that two large managed care companies in the state will start using its private health exchange highlights the growth in private exchanges and the gravitation of employers toward offering defined-contribution health benefits via a health exchange.
- The National Governors Association will feature a session on implementation of the health insurance exchanges at its annual meeting in Salt Lake City next week. Panelists will be Steven Larsen, Director, Office of Oversight, OCIIO; former HHS Secretary Michael O. Leavitt, who's now chairman of Leavitt Partners; and Cindy Gillespie, Managing Director, Public Policy and Regulatory Affairs, at McKenna Long & Aldridge.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 07/01/2011 – 07/08/2011

Federal News

How Many State Exchanges will HHS Run? 07/07/2011

It could be more than a few, according to Terry Gardiner of the Small Business Majority, one of the most vocal business supporters of the ACA. "I think HHS is going to have to switch gears here soon and say, 'It looks like a bunch of states aren't going to move forward," Gardiner said during a conference call sponsored by the Center for American Progress. The reality, Gardiner said, is that "if states do not move forward in 2011, it's going to be pretty tough for them to set up an exchange in 2014."

Politico

Governors to Discuss Health Exchanges in July Meeting 07/06/2011

The National Governors Association will feature a session on implementation of the health insurance exchanges at its annual meeting in Salt Lake City. Leading the July 16 session will be Wisconsin Gov. Scott Walker, chairman of the Health and Human Services Committee of the NGA, and Oregon Gov. John A. Kitzhaber, the vice chairman. Panelists will be Steven Larsen, Director, Office of Oversight, Office of Consumer Information and Insurance Oversight, U.S. Department of Health and Human Services; former HHS Secretary Michael O. Leavitt, who's now chairman of Leavitt Partners; and Cindy Gillespie, Managing Director, Public Policy and Regulatory Affairs, at McKenna Long & Aldridge.

CQ Healthbeat Staff

Private Exchanges Gain Traction 07/06/2011

Minnesota-based Bloom health will announce today that two large managed care companies in the state will start using its private health exchange platform. That includes the state's largest insurer, Blue Cross Blue Shield of Michigan ~~Minnesota~~ as well Medica, which has 1.66 million members in the Upper Midwest. Both are big gets for Bloom, which currently has about 50 employers with 25,000 members using its Private Exchange Platform. It also dovetails with what PULSE has been hearing a lot about lately: employers gravitating toward offering defined-contribution health benefits via a health exchange.

Politico

States slow in setting up central piece of Obama healthcare law 07/06/2011

State insurance exchanges are not being set up fast enough to meet the 2014 deadline set by the healthcare law, advocates and policy experts say. The delay means that a number of state legislatures are at risk of handing over the central component of the reform effort to the federal government, which will set up the exchanges for states that fail to do so.
http://thehill.com/blogs/healthwatch/health-reform-implementation/169761-states-lag-in-implementing-health-insurance-exchanges

How health insurance agents provide value in the new landscape of health care 07/05/2011

Health care reform may force a dramatic change in how health insurance is to be purchased. One facet being discussed is the health insurance exchange: national or state exchanges. If the Supreme Court ultimately decides on the insurance mandate, every individual will be required to obtain his or her own coverage. Employer-sponsored plans qualify. But to collect any subsidies, individuals must purchase coverage through an exchange. Can this be done effectively over the Internet without assistance?
http://www.sbnonline.com/2011/07/how-health-insurance-agents-provide-value-in-the-new-landscape-of-health-care/?full=1

Thanks to Insurance Commissioner Wayne Goodwin. No thanks to commissioners who voted to weaken health reform 07/01/2011

North Carolina Insurance Commissioner Wayne Goodwin was one of only four insurance commissioners on a key national task force who refused to endorse a plan that would weaken consumer protections in the new federal health care law. Yesterday this task force considered a proposal that requires insurance companies to spend a certain percentage of premiums on health care instead of on executive salaries, lobbying, marketing, and insurance agent commissions. Insurance commissioners from Florida, Arkansas, Louisiana, Mississippi, Montana, Nevada, North Dakota, New Hampshire, and Wisconsin all voted for the motion to weaken reform. Commissioners from West Virginia, Kansas, and Vermont voted against the proposal. Wayne Goodwin abstained.
http://pulse.ncpolicywatch.org/2011/07/01/thanks-to-insurance-commissioner-wayne-goodwin-no-thanks-to-commissioners-who-voted-to-weaken-health-reform/

State News

Arkansas:

Analysis: Health exchange faces steep odds in 2012 07/03/2011

Arkansas' top insurance official says he'll "go down fighting" in favor of the state setting up insurance exchanges under the federal health care overhaul. It's a fight he's entering as the clear underdog — with the odds stacked against him.
http://www.westport-news.com/news/article/Analysis-Health-exchange-faces-steep-odds-in-2012-1450453.php

Delaware:

Checking in with Delaware 07/07/2011

We haven't heard much from the tiny blue state. Democrats control the Assembly and the Senate, and Gov. Jack Markell is a Democrat. So it was kind of surprising they didn't even introduce exchange legislation. But members of the Delaware Health Care Commission, charged with designing the exchange, plan to ask for (and receive) an executive order from the governor in time for the September deadline for a Level One planning grant.
Politico

Colorado:

Health exchange starts from scratch 07/06/2011

Colorado's new health exchange board meets for the first time next week and must immediately get to work. Here's what is on deck for the new board and a summary of priorities for board members. Among the first agenda items: 1) Evaluating and interpreting the regulations that the federal government is slated to release on July 7. The rules are expected to stipulate how health exchanges must work. Colorado's board could decide to submit comments on the rules. 2) Hiring an executive director and staff for the new quasi-governmental organization. 3) Creating bylaws and policies. 4) Deciding whether to apply to the federal government by Sept. 30 for an operating grant. 5) Meeting with the legislative oversight committee in August and thereafter, five times a year. 6) Deciding by September whether additional legislation is necessary to create the exchange, and if so, starting to draft bills and build support for new measures. 7) Working with other states to consider joining forces on building necessary IT systems. All health exchanges must have robust computer systems that can generate real-time insurance quotes for customers.
http://www.healthpolicysolutions.org/2011/07/06/health-exchange-starts-from-scratch/

Many on health-insurance-exchange board closely tied to industry, each other 07/07/2011

The newly appointed health-insurance-exchange board includes a majority of members with a previously undisclosed series of connections, closely tying the board to the insurance and information-technology industries. Consumer advocates now question whether the board, meant to oversee a health care shopping site for the benefit of hundreds of thousands of state residents, can be independent, given its strong ties to existing industry players.
http://www.denverpost.com/news/ci_18424591

Connecticut:

Malloy signs bill to start CT's health insurance exchange 07/05/2011

Gov. Dannel P. Malloy has signed legislation establishing the framework for Connecticut health insurance exchange. The legislation creates a quasi-public agency, with a 14-member board that will manage the exchange, including an online marketplace where individuals and employers with up to 50 workers can compare and purchase health insurance plans that, starting in 2014, meet federal requirements, The Associated Press reports.
http://www.hartfordbusiness.com/news19310.html

Kentucky:

Kentucky Applies, but Still Undecided 07/05/2011

As expected, Kentucky went ahead and applied for a Level One exchange establishment grant late last week. However, the state hasn't made any firm decisions "in light of challenges to the Affordable Health Care Act (ACA), the lack of federal guidance and a tangible federal exchange model to consider," said Kentucky Cabinet for Health and Family Services spokeswoman Jill Midkiff. "The state is continuing its planning efforts "in the event that the ACA is not repealed."
Politico

Missouri:

Insurance exchange puts Mo. GOP in tough spot 07/05/2011

Last week, a Senate committee was established to study the health insurance exchange issue. The committee takes place because a bill establishing an exchange, sponsored by Rep. Molendorp, failed in the Senate. His bill would have established the framework for an exchange, leaving the heavy lifting to state agencies and a 17-member governing board. That means there would need to be some time after the bill passes in order to meet the federal deadline. "This can't be put together quickly," Molendorp said. Sen. Jane Cunningham, however, said Molendorp's bill is unworkable and the Senate committee will 'start from scratch." The committee will explore Missouri's options on the establishment of a health insurance exchange and to study the effect of existing state law regarding the issue.
http://www.stltoday.com/news/local/govt-and-politics/article_f21654de-edff-552c-b855-0170c452f18a.html

Ohio:

Anti-health law measure moves toward ballot in Ohio 07/08/2011

Opponents of the federal health care law in Ohio say they have enough signatures to place a measure on the 2012 ballot that would amend the state constitution to ban any requirement that people buy health insurance, as called for in the law. Supporters filed more than 546,000 signatures with Ohio Secretary of State Jon Husted on Wednesday (July 6). Arizona and Oklahoma voters already have approved similar measures, and Alabama, Florida and Wyoming plan to put a similar amendment on the ballot next year. North Dakota, Tennessee, Kansas and Indiana all have statutes barring enforcement of the federal law's so-called individual mandate.
http://www.stateline.org/live/details/story?contentId=586222

Rhode Island:

Rhode Island Explores Executive Order 07/07/2011

As expected, Rhode Island Gov. Lincoln Chafee's office is working quickly to explore alternative exchange options after the Legislature failed to pass an exchange bill before adjourning last week. The Rhode Island exchange workgroup will meet Monday to discuss options for the structure of an exchange established by executive order, according to an email from the lieutenant governor's office. "The legislation that did not pass was the consensus first choice for creating an exchange," Lt. Gov. Elizabeth Roberts wrote to members of the state's health care reform commission on Friday. "However, I am now working closely with the governor and my partners in the executive branch to examine all of the other options that are available."
Politico

Utah:

Utah Health Exchange Is Geared To Small Business Employees—The KHN Interview 07/07/2011

Utah has a head start in exchange development. But will it meet the new federal rules? The state, which had experimented with public programs to expand coverage to low-income adults, created its exchange in 2007 through state legislation signed by former Gov. John Huntsman, a Republican who is now seeking the party's nomination for president. The exchange was designed to insure small business employees, who make up the majority of Utah's workers. It launched to a limited group in 2009, and then opened to all small employers at the start of this year. It now provides coverage for about 3,583 people working for 139 employer groups.
http://www.kaiserhealthnews.org/Stories/2011/July/07/Connor-q-and-a-health-law-exchange-small-business.aspx

Wyoming:

Wyoming's insurance exchange committee 07/01/2011

The Wyoming Health Benefit Exchange Steering Committee is tasked with recommending whether the state should create its own exchange, partner with other states on a regional program or let the feds handle everything. More about the committee's work can be found here and the committee's roster is located at the below link.
http://trib.com/news/opinion/blogs/wolfjammies/article_66b88eb8-c1cc-5426-bad4-f8febf79bbed.html

Former HHS Secretary Michael O. Leavitt says time is running out for states to meet the federal deadline of building a health insurance exchange. He believes most states will need at least a couple legislative sessions to work out the details of running an exchange, and therefore "deadlines will end up being elongated."

- Another former HHS Secretary, Tommy Thompson, also supports exchange development. He believes states should see the exchanges as an opportunity for innovation and, more importantly, a way to keep the federal government out of Medicaid.
- New York's Senate fails to pass exchange legislation. The bill may be taken up again in a special session held in two weeks.
- Arkansas Insurance Commissioner Jay Bradford plans to ask the Legislature during its fiscal session to allow his department to start implementing a state health insurance exchange.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 06/24/2011 – 07/01/2011

Federal News

Former HHS Secretary Leavitt Says Most States Aren't On Track to Meet Exchange Deadline 06/27/2011

Most states are not on track to make the Jan. 1, 2014, deadline for building health insurance exchanges set by the federal overhaul law, said former Health and Human Services Secretary Michael O. Leavitt. "If you count back from 2014, the clock is running out," said the former Utah governor who served as HHS secretary in the George W. Bush administration and now runs a health care consulting company. Leavitt, whose home state already has a prototype of the exchange, said he believes most states will need at least a couple legislative sessions to work out the details of running an exchange, and therefore "deadlines will end up being elongated."
http://www.kaiserhealthnews.org/Stories/2011/June/24/Leavitt-Says-States-Not-On-Track-On-Exchanges-Deadline.aspx

Tommy Thompson: Health Exchanges Important 06/28/2011

Republicans might be opposed to the health care law but governors should move forward with the health insurance exchanges, former Health and Human Services Secretary Tommy Thompson says. In an opinion piece published in the Huffington Post on Monday, Thompson, who was HHS secretary from 2001 to 2005, wrote that the exchanges have the potential to be a market-based solution. States should see the exchanges as an opportunity for innovation and, more importantly, a way to keep the federal government out of Medicaid, according to Thompson.
http://nationaljournal.com/healthcare/tommy-thompson-health-exchanges-important-20110628

State News

Arkansas:

Ark. Insurance Commissioner Jay Bradford to try again on exchange 06/27/2011

Arkansas' insurance commissioner says he hopes to win approval to help implement part of the new federal health care law during next year's legislative session. Arkansas Insurance Commissioner Jay Bradford told reporters Monday that he plans to ask the Legislature during its fiscal session to allow his department to start implementing a state health insurance exchange. The

department has been planning for the exchange, but efforts to authorize its setup stalled in the Legislature this year over objections to the federal health care law.
http://www.todaysthv.com/news/article/162789/2/Ark-insurance-chief-to-try-again-on-exchange

Colorado:

9 Named To Board Overseeing Health-Insurance Exchange 06/30/2011
Colorado took another step Wednesday toward full compliance with the new federal health care law, naming a nine-member board to oversee a health-insurance exchange that is a key component of the law. The board members, the majority of whom cannot have "direct affiliation" with the insurance industry, will hire the exchange's executive director.
http://www.denverpost.com/search/ci_18381715

Delaware:

Delaware Wraps with No Bill 07/01/2011
Delaware wrapped up its legislative session yesterday with no exchange establishment legislation to be seen. Despite having a Democratic-controlled legislature and governor's office, no bill was ever introduced. Staff at the insurance department has told Pro it's likely that Gov. Jack Markell will use an executive order to accomplish the task of setting up the marketplace.
Politico

Idaho:

Governor explains his support of health insurance exchanges 06/29/2011
Gov. Butch Otter is opposed to federal health care legislation commonly called Obamacare, but he supports health insurance exchanges. That puts him at odds with some state legislators in his own party, plus a number of fellow GOP governors including Florida's Rick Scott and Louisiana's Bobby Jindal.
http://www.idahoreporter.com/2011/governor-explains-his-support-of-health-insurance-exchanges/

Idaho Hitting the Books 06/28/2011
Even though Gov. Butch Otter issued an April executive order blocking ACA implementation, the state's exchange group continues to study whether to build an exchange or let the feds step in. The exchange study group's governance committee holds a meeting today, and the group on Thursday held a conference call with CMS and CCIIO officials to get information on how the feds would act if they ran the exchange. The group has spent the last couple of weeks gathering stakeholder input on two possible exchange routes: an Idaho-controlled, federally funded exchange and an exchange funded and controlled by the feds. The group, which issued a report on a federal exchange Friday, holds a meeting today to discuss it.
Politico

Kansas:

Legislative Leaders Approve Interim Studies 06/30/2011
State legislative leaders today approved 13 topics for study by interim committees that will meet during the summer and fall, including a review of the options for a Kansas health insurance exchange and the potential cost-effectiveness of providing dental benefits to adult Medicaid beneficiaries.
http://www.khi.org/news/2011/jun/30/legislative-leaders-approve-interim-studies/

Health insurance exchange hinges on legislative support 06/22/2011
The federal health reform law requires that all 50 states have a health insurance exchange plan in place by Jan. 1, 2013 and an operational exchange by Jan. 1, 2014. Kansas may not make the deadlines. "We will know, obviously, by the end of the next legislative session whether it's feasible for us to continue working on this," Kansas Insurance Commissioner Sandy Praeger said, referring to her department's ongoing effort to design a Kansas exchange. "We need to keep moving forward." Praeger met Wednesday with more than 20 members of a steering committee charged with assembling the basic framework for a Kansas-specific exchange and a plan to present to the Kansas Legislature.

http://www.khi.org/news/2011/jun/22/exchange-dedsign-hinges-legislative-support/

Minnesota:

Minnesota Looks for Exchange Vendors 07/01/2011

A state exchange bill may not be seeing much movement, but that hasn't stopped the state from moving forward with planning. Via NASHP's State Reforum, the state has issued a Request for Proposal looking for vendors who can build a technical infrastructure for the state marketplace. "The ultimate goal of this project is to obtain prototypes and detailed cost, work plan and timeline proposals for evaluation of options and costs for possible Exchange implementation," the request says, with vendor proposal's due on July 20. The RFP http://politico.pro/iijs4i

Politico

Fewer families get health coverage from workplace 06/28/2011

The number of Minnesotans who get health insurance through employers has dropped 10 percentage points in the past decade, outpacing the decline nationwide, according to a study released Tuesday by the University of Minnesota.

http://www.startribune.com/local/124658533.html

Mississippi:

Mississippi's PR Campaign 06/29/2011

Mississippi is full steam ahead with plans to use the high-risk pool as an exchange and has begun an aggressive campaign to educate citizens about the plan. Last week, the insurance department did a 13-city, five-day tour of the state presenting their outline for the exchange. They took feedback on what people want, and do not want to see, in the program, but "overall the response was positive," Aaron Sisk of the Mississippi Insurance Department said. "We were really able to educate people that this complies with the ACA but is not the ACA and would benefit Mississippi. There was a lot of misinformation out there." Sisk says the "tools" for the exchange will be developed over the next few months and the department will do another tour in the early fall so people can have a "hands-on experience" with an online product that would be a portal to gain insurance.

Politico

Mississippi health insurance exchange introduced at town hall meetings 06/25/2011

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.

http://blog.gulflive.com/mississippi-press-news/2011/06/mississippi_health_insurance_e.html

Input sought on health insurance options 06/24/2011

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 formulate an exchange that will serve as a marketplace where individuals and businesses can compare and shop for health insurance.

http://www.hattiesburgamerican.com/article/20110625/NEWS01/106250322/Input-sought-health-insurance-options?odyssey=tab%7Ctopnews%7Ctext%7CFRONTPAGE

Nebraska:

State conducting online survey of Nebraskans on health insurance exchange 06/29/2011

The Nebraska Department of Insurance is conducting an online survey so Nebraskans can share their reactions and suggestions about the state's health insurance exchange. The survey is designed to get reaction to several policy and program choices state policymakers will face. The survey site says comments will be considered confidential but may be used in the executive summary or analyst's reports without attribution: http://www.surveymonkey.com/s/HIX_Nebraska.

http://www.therepublic.com/view/story/b44b4c0496ea4fd9a69c63a0cf031857/NE--Health-Insurance-Survey/

New York:

NY Senate Majority Leader Dean Skelos: State Health Exchange Tantamount To "ObamaCare" – Updated 06/27/2011

Senate Majority Leader Dean Skelos said his chamber left Albany without passing legislation to create a state health care exchange because his members didn't want to buy into "ObamaCare." Skelos, on WOR-AM's John Gambling show, didn't say when and if his members will deal with the issue. "There's some discussions on it, he said. "It's not necessary to be passed, I believe, for almost another year." The bill could be taken up when the Senate returns sometime in the next few weeks to "tie up some loose ends" and ratify any labor contracts that are agreed on, Skelos said.
http://origin.nydailynews.com/blogs/dailypolitics/2011/06/ny-senate-majority-leader-dean-skelos-state-health-exchange-tantamount-to-obam

Pennsylvania:

Pennsylvania Lawmakers Get a Lesson on Massachusetts' Health Insurance Exchange 06/24/2011

Members of the Pennsylvania House Insurance Committee heard from a national expert today on Massachusetts' experience structuring a health insurance exchange. States have until 2014 to create state-based health insurance exchanges that meet the criteria set forth in the Affordable Care Act. If they do not create a satisfactory exchange by then, the federal government will establish one for them. While emphasizing that there is no "one size fits all" approach for states as they structure insurance exchanges, Dr. Jon Kingsdale said Pennsylvania can learn a thing or two from the Massachusetts experience.
http://youngphillypolitics.com/pennsylvania_lawmakers_get_lesson_massachusetts039_health_insurance_exchange

Rhode Island:

Exchange Bill Dies in Rhode Island 07/01/2011

Despite being one of the first states to receive a CCIIO exchange establishment grant, the Legislature failed to get an exchange bill passed before adjourning late Thursday night. After intense negotiations over the past few days, House and Senate leadership couldn't find a compromise on abortion language included in the Senate version of the bill. Gov. Lincoln Chafee's office is now giving serious consideration to establishing an exchange through an executive order, according to a source close to the negotiations.
Politico

South Carolina:

Haley to shun federal funds for state health insurance exchange 07/01/2011

Gov. Nikki Haley has decided South Carolina won't pursue any more grant money from the federal health care overhaul to fund a possible state-run health insurance exchange. "The governor has said she's going to evaluate these opportunities as they come as to what's best for South Carolina," said Tony Keck, the director of the state Department of Health and Human Services. "The one decision she's already made is that there is no reason for South Carolina to apply for additional money related to health insurance exchanges."
http://www.goupstate.com/article/20110701/ARTICLES/110709990/1083/ARTICLES?Title=Haley-to-shun-federal-funds-for-state-health-insurance-exchange-

Vermont:

Vermont Enacts Nation's First Single-Payer Healthcare System amid Controversy 06/27/2011

In classic cart-before-the-horse thinking, Vermont enacted a law to institute a single-payer universal-coverage healthcare system within the state, starting in 2017. However, this law does not specify how the new healthcare system will be funded. That is the next challenge for the Vermont legislature.
http://www.darkdaily.com/vermont-enacts-nations-first-single-payer-healthcare-system-amid-controversy-062711

West Virginia:

Who Will Foot the Exchange Bill? 07/01/2011

With little notice or fanfare, the state of West Virginia will hit a health reform milestone today: It is the only state with explicit authority to tax all insurance carriers in the state in order to finance its new health exchange — independent of whether they plan to use the new marketplace or not. West Virginia won't be lonely for long though. Four other states — Connecticut, Hawaii, Maryland and West Virginia — have given the exchange authority to assess a fee on insurers, according to a POLITICO analysis of the 13 bills that have passed, either establishing an exchange or legislating a state's intent to do so.

Politico

- Gov. Brian Sandoval of Nevada and Gov. John Kitzhaber of Oregon sign exchange legislation.
- D.C. and Mississippi hold stakeholder meetings discussing the implementation of exchanges.
- Maryland applies for $50M in Exchange Establishment Grant funds; Missouri announces the formation of the Senate Interim Committee on Health Insurance Exchanges.
- The New York Assembly, the Senate, and Gov. Andrew Cuomo worked together to develop one combined exchange establishment bill. The exchange bill passed the Assembly and is likely to pass the Senate.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 06/17/2011 – 06/24/2011

Federal News

Which State Provides the Best Health Care? 06/23/2011

A study by the Commonwealth Fund ranked the 50 U.S. States as to the quality of their health care in 2009. Recently, U.S. States have signaled increasingly divergent approaches to health care, moving in opposite directions in the type and quality of health care systems they seek to make available to their citizens. This has renewed the question, which states and which health care systems provide the best health care? Which are ranked highest in quality?
http://www.helpingyoucare.com/13703/which-state-provides-the-best-health-care-3

Leavitt Partners Briefs RGA on Exchanges 06/21/2011

The Utah-based consulting firm Leavitt Partners, founded by former HHS Secretary Michael Leavitt, briefed senior level staff at a Republican Governors Association retreat last week on their options to move forward on health exchanges. Leavitt's Cheryl Smith and Brett Graham briefed staffers gathered at a retreat last Thursday and Friday in Coronado, Calif. They presented a 24-slide PowerPoint on subjects including "What States Face In the Wake of PPACA" and "Exchanges: A Look At State Actions." Their takeaway message: "Most states will initiate efforts to build an exchange, though largely on their own terms" but "fully functioning, PPACA compliant exchanges by 2014 [are] questionable."
Politico

Survey: Employer-Sponsored Insurance Market Will Remain Stable After ACA Goes Into Effect 06/21/2011

Avalere Health utilized microsimulation model estimates from various organizations and agencies — including RAND, the Urban Institute and the Congressional Budget Office — to determine net changes in the employer-sponsored insurance market. The research showed the changes to the employer-sponsored insurance market after 2014 is relatively insignificant. However, long-term erosion of the employer-sponsored insurance market — over the next 10-20 years — may be possible under certain circumstances. For instance, if a several large employers choose to stop health coverage for employees, others may follow suit.
http://www.beckershospitalreview.com/news-analysis/survey-employer-sponsored-insurance-market-will-remain-stable-after-aca-goes-into-effect.html

RILA Comments on Regulatory Impact of Important Health Reform Provision 06/18/2011

The Retail Industry Leaders Association issued the following news release: In comments submitted to the Department of Treasury, The Retail Industry Leaders Association (RILA) provided the agency with feedback on issues related to the employers shared responsibility provision in the Patient Protection and Affordable Care Act (PPACA). The Association provided input on employer mandate regulations relating to: the definition of a full-time employee, the 90-day waiting period, employer penalties, auto enrollment, communication between Exchanges and employers, and the affordability test and minimum valued standard.
http://www.tmcnet.com/usubmit/2011/06/18/5582062.htm

State Health Insurance Exchange Legislation: A Progress Report 06/16/2011

This state map in this blog provides a picture as of June 2011 of where states stand in establishing the legal authority for their insurance exchanges.

http://www.commonwealthfund.org/Content/Blog/2011/Jun/State-Health-Insurance-Exchange-Legislation.aspx

State News

Alabama:

Health insurance report due Dec. 1 06/19/2011

Members of Alabama's 14-member commission include Medicaid Commissioner Bob Mullins and Insurance Commissioner Jim Ridling. Others include physician representatives, legislators, for profit and nonprofit insurance providers, business, nursing homes and hospitals and insurance agents. Bentley named state Sen. Greg Reed, R-Jasper, as co-chairman of the commission.

http://www.tuscaloosanews.com/article/20110619/NEWS/110619698/1291/NEWS06?p=1&tc=pg

California:

Senate appoints Robert Ross to Health Benefit Exchange Board 06/22/2011

*The Senate Rules Committee today appointed the head of a large, statewide private health foundation to the **California Health Benefit Exchange Board.** The California Endowment President and CEO **Robert Ross,** will join the newly created oversight board, which is tasked with setting up a statewide health insurance marketplace to comply with the federal health care overhaul.*

http://blogs.sacbee.com/capitolalertlatest/2011/06/senate-appoints-robert-ross-to.html

District of Columbia:

District of Columbia 06/19/2011

The District of Columbia Department of Health Care Finance kicks off a series of stakeholder meetings across town for constituents to weigh in on the possibility of a D.C. exchange. B19-0002, establishing a health benefits exchange for the nation's capital, was introduced on Jan. 4 and currently sits in the D.C. Council's Health, Public Service and Consumer Affairs Committee. The stakeholder meetings get started Tuesday at the Cleveland Park Library, where the topic will be exchange governance.

Politico

Florida:

Online Health Insurance Market May Be Coming to Florida 06/23/2011

Lawmakers approved Florida Health Choices in 2008, billing it as a way to provide more choices to small businesses that were getting hammered by rising insurance costs. But after lengthy delays in carrying out the law, Chief Executive Officer Rose Naff said Wednesday the program could start operating this summer. Naff said she did not have a specific date. Scott signed two bills Tuesday designed to help the program, with one (HB 1473) providing public-records exemptions that Naff said were important to protecting confidential information about people and health plans in the program. Also, a broader bill (HB 1125) included a provision eliminating a restriction that Florida Health Choices would only be open to businesses with 50 or fewer employees.

http://www.wctv.tv/home/headlines/Online_Health_Insurance_Market_May_Be_Coming_to_Florida_124418294.html

Maryland:

Md. health care exchange applies for $50M in fed funds 06/21/2011

Organizers of a new health insurance marketplace for Maryland are applying for nearly $50 million in federal grants to set the system up. The board of trustees for the Maryland Health Benefit Exchange resolved to apply for federal health reform-funded grants at a special meeting Tuesday morning. Applications for the grants are due by the end of the month.
http://www.bizjournals.com/baltimore/news/2011/06/21/6-21-healthexchange.html

Mississippi:

Miss. examines creation of health insurance exchanges 06/23/2011

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.
http://www.clarionledger.com/article/20110624/BIZ/106240325/Miss-examines-creation-health-insurance-exchanges?odyssey=mod%7Cnewswell%7Ctext%7CHome%7Cp

Olive Branch town hall draws health care queries 06/22/2011

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.
http://www.commercialappeal.com/news/2011/jun/22/olive-branch-town-hall-draws-health-care-queries/

Health insurance town hall meeting held 06/21/2011

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.
http://www.wtva.com/news/local/story/Health-insurance-town-hall-meeting-held/ku0K9ZAyiUuQeJD7fdioiA.cspx

Missouri:

Missouri Senate panel examines creating health insurance exchange — legally 06/23/2011

The Missouri Senate has created a panel to debate whether the state should begin building a health insurance exchange despite it potentially violating state law. Senate Leader Robert Mayer, R-Dexter, on Wednesday announced the formation of the Senate Interim Committee on Health Insurance Exchanges.
http://www.bizjournals.com/kansascity/blog/2011/06/missouri-senate-panel-examines.html

Nevada:

Nevada Makes Nine 06/19/2011

With little fanfare or ceremony, Republican Gov. Brian Sandoval quietly signed a bill setting up the Silver State Health Insurance Exchange last Thursday. Senate Bill 440 probably had the smoothest path forward of all the exchange bills we've seen handled by a divided state-government, receiving relatively widespread approval from the Democratically-controlled legislature. Next up for the state: Sandoval must appoint two members of the exchange bill by July 1.
Politico

New Jersey:

Filling in the Details of NJ's Health Insurance Exchange 06/20/2011

Although it is not clear what elements of the exchange will require legislation, several members of the state Senate and Assembly have offered their own ideas. Sen. Joseph Vitale (D-Middlesex), a member of the health committee, is a sponsor of two measures; one calls for an exchange run by DOBI itself, while the other recommends the program operate through an independent, non-profit entity. Both bills encourage state officials to play an active role in screening the insurance policies so

that only high-quality plans would be offered for purchase. The measures were both introduced in December, but have received little attention since. Vitale said he plans to combine elements of both proposals into a final bill, at some point, with input from the healthcare coalition.
http://www.njspotlight.com/stories/11/0620/0037/

New York:

Over to Cuomo by Day's End 06/24/2011
Well it seems like it's finally going to happen for New York today! The exchange bill has passed the Assembly and looks like it will pass the Senate today without much ado. Then it's on the way to Gov. Cuomo's desk for a signature. The bill couldn't have come soon enough: The Legislature is hoping to wrap up its extended stay in Albany today. Consumer advocates like the bill because it protects New York's community rating and open enrollment rules and insurers will like it because it doesn't lock in too many heavy policy issues. The big decisions (essential benefits above the federal requirement, whether to merge markets, etc.) will be taken up over the course of the next year.
Politico

New York Update 06/23/2011
New York state lawmakers finally reached a deal on an exchange bill. The session had been extended to the end of the week — and the bill is now in the Senate Rules Committee. The bill, worked out between the Assembly, the Senate and Gov. Andrew Cuomo, is pretty standard: It establishes a governance board to set standards and guidance for health plans who wish to be on the exchange. But it does provide a bit of a safety net in case the law is overturned: Lawmakers must convene within 180 days if such an event takes place to plan for the next steps.
Politico

North Carolina:

North Carolina Withers 06/23/2011
While the North Carolina legislature will come back into special session next month, we're hearing that the prospects for the exchange bill (House Bill 115) are incredibly low. "It's unlikely that the exchange bill will see any movement" in a special session on redistricting, a source familiar with the bill says. However, since the bill came out of the House "it will be carried over the 2012 legislative session and could be taken up then."
Politico

North Carolina 06/19/2011
House Bill 115 has been sitting in the Senate Committee on Rules and Operations since May 31. Bill sponsor Jerry Dockham expects the Senate to take it up before the Legislature lets out later this month, but the exact timing is becoming increasingly unclear.
Politico

Oregon:

Oregon Makes 10 06/19/2011
Exchange bills are flying by us these days: fresh on the heels of Nevada, Oregon Gov. John Kitzhaber has signed Senate Bill 99 into law. Kitzhaber and the Oregon Legislature do not have a specific deadline by which they have to appoint members to the Oregon Health Insurance Exchange Corporation, but the body is responsible for producing a report to the legislature by Oct. 3, 2011.
Politico

- Maine pushes its two exchange bills into the 2012 session, deciding to study the issue in 2011 instead; Rhode Island's bill stalls because some state leaders oppose a restriction on abortion coverage outlined in the bill.
- New York Gov. Cuomo introduces his exchange bill, North Dakota begins crafting an exchange bill for a special legislative session in November, and Pennsylvania moves to hire an exchange planning consultant.
- In Iowa, Republican Gov. Terry Branstad is charging ahead on a health exchange, but some Democrats in the state are convinced that they'd rather have a federal exchange instead of leaving the task to a Republican governor who wants the reform law overturned.
- Even though Kansas doesn't have exchange legislation, as an Early Innovator Grant awardee the state is moving forward with implementing important pieces of the law, like setting up the technological infrastructure for the exchange.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 06/10/2011 – 06/17/2011

Federal News

W.H. bringing in states to talk fed exchange 06/16/2011

The White House will host a series of meetings next month with state legislators to discuss what the federal fallback exchange ought to look like. The Working Group of State Legislators for Health Care, a body organized by the White House two years ago, will come to town in mid-July for a series of meetings with White House and HHS officials. The big topics of discussion: what a federally run exchange will look like and what role states should play. State legislators requested the White House meetings to ensure they have an active role in the planning process.
Politico

CHOICE Administrators Exchange Services Issues Seven-Step Strategy to Help States Comply with Health Reform Mandates 06/15/2011

As America's 50 states grapple with how to comply with required elements of healthcare reform, CHOICE Administrators Exchange Services, the nation's leader in developing and administering health insurance exchange programs, has issued a white paper offering a seven-step strategy that states could potentially follow to craft measures that provide options unique to their citizens while fulfilling federal regulatory requirements.
http://insurancenewsnet.com/article.aspx?id=265450&type=newswires

State News

Connecticut:

State to hold public forum on health insurance exchange 06/13/2011

Connecticut will hold a public forum on the health insurance exchange development at City Council Chambers, 45 Lyon Terrace, on Wednesday, June 15, from 6:30 to 8 p.m. The purpose of the forum will be to provide Connecticut residents an opportunity to give feedback on exchange design, as well as learn about the purpose and functions of an Exchange.
http://www.acorn-online.com/joomla15/thebridgeportnews/community/96419-state-to-hold-public-forum-on-health-insurance-exchange.html

Georgia:

Georgia Weighing its Options 06/16/2011

While Georgia remains a highly anti-ACA state, Gov. Nathan Deal's administration has expressed interest in putting an exchange in place "whether the law is upheld or not," assistant insurance commissioner Ron Jackson said at the AHIP conference Wednesday. A committee ordered to study an exchange will be working quickly to decide if the state wants to move forward with the federal health law, but the governor has asked them to look at it "through the prism of a free market, and if it could make the market in Georgia better." Then, "the idea was posited maybe this is something that could work for Georgia regardless of the federal law," Jackson told PULSE, qualifying that he could not speak for directly for Deal and "no one was committed 100 percent to anything."
Politico

Iowa:

Health exchange turns tables in Iowa 06/16/2011

Iowa is a topsy-turvy state these days when it comes to health policy — with Republicans are pushing to establish a health exchange and Democrats not supporting that process. Republican Gov. Terry Branstad is charging ahead on a health exchange, with his state department of public health pursuing multimillion dollar grants that will enable the state to implement the Affordable Care Act. But Democrats in the state aren't so keen: after a bruising legislative battle over exchange legislation this session, some are convinced that they'd rather have the Obama administration take over the marketplace instead of leaving the task to a Republican governor who wants the reform law overturned.
Politico

Kansas:

States facing deadline pressure on exchanges back 06/16/2011

In Kansas, Linda Sheppard is the project manager for implementing the health care law. She said that even without exchange legislation and with a governor who dislikes the law, the state is moving forward with implementing important pieces of the law, like setting up the technological infrastructure for the exchange, because it has no other choice. Kansas was one of seven states to receive an Early Innovator Grant and has certain obligations to HHS. "We needed to move forward because of the timing," she said. "We're doing some different things to allow us to move forward. You make some assumptions and you proceed as much as you can."
Politico

Kentucky:

Health exchange turns tables in Iowa 06/16/2011

And still other Democratic governors are not ready to commit to pushing for an exchange in the first place. Under the leadership of Democratic Gov. Steve Beshear, Kentucky is still leaving its options open as to who will run the state's marketplace. The state did not pursue any legislation to authorize an exchange this year, nor does it have any imminent plans to do so. "In order to meet the timelines for implementation of an exchange, states will have to pursue legislation or other means available next year if a decision is made to operate a state exchange," Jill Midkiff, spokeswoman for the Kentucky Cabinet for Health and Family Services, wrote in an email.
Politico

Maine:

Deadline: Maine 06/15/2011

The state wraps up its legislative session today. No big surprises expected here: the state has pushed two exchange bills (LD1497 and LD1498) into its 2012 session, taking up instead a resolve to study the issue in 2011.
Politico

Mississippi:

Speak up on insurance 06/16/2011

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, that's open to all residents. Small business owners are especially invited.
http://www.clintonnews.com/apps/pbcs.dll/article?AID=/20110616/NEWS/106160302/Clinton-Briefs

Montana:

Montana Exchange Prospects Dim 06/15/2011

It was recently reported that Montana insurance commissioner Monica Lindeen was talking to HHS about what existing authorities the state had to set up a health exchange, with an exchange bill dead and the legislature not convening again until 2013. Now, we're hearing that the prospects for setting up an exchange via existing state authorities are pretty dim. The Center for Rural Affairs recently completed a legislative analysis to see if the state had any provisions that would allow exchange implementation to move forward — a la Mississippi working through its high risk pool — and couldn't turn up much. "Now Lindeen has pivoted to try and figure out how she could be of assistance to HHS if they setup the state's exchange," CFRA assistant director Brian Depew tells PULSE. "She can sort of effectively guide the process at this point.
Politico

Nebraska:

Advocates share principles to be used for health insurance exchange 06/12/2011

Consumer protection agencies in Nebraska are banding together to have a voice in the development of health insurance exchanges that are scheduled to be implemented in 2014 under the Affordable Care Act. Nine organizations in the state have drafted a set of principles outlining what they would like to see addressed by the state government when crafting the exchanges for Nebraska. Organizations include AARP Nebraska, American Cancer Society Cancer Action Network, Center for Rural Affairs, National Alliance on Mental Illness - Nebraska Chapter, National Association of Social Workers - Nebraska Chapter, Nebraska Appleseed, Nebraska Farmers Union, Public Health Association of Nebraska and Voices for Children.
http://www.hastingstribune.com/news0611health.php

New York:

Flexibility, competition called keys to success of insurance exchange 06/17/2011

The health insurance exchanges mandated by the federal reform law are supposed to help small business owners like Sanders, their employees and their families, by injecting some competition into the insurance market and bringing down costs. This is what small employers want.
http://www.bizjournals.com/albany/print-edition/2011/06/17/flexibility-competition-called-keys.html

Afternoon Exchange Watching 06/14/2011

New York Gov. Andrew Cuomo has just introduced "executive program bill No. 12" outlining his vision for the state's exchange. It's a bit fuller than the Senate bill that came out last week, and as the Albany Times Union writes, Cuomo's version "would have broader power to negotiate with insurance companies." Cuomo's legislation is the most specific: It calls for a seven-member board of directors, four with health industry expertise; ex-officio members that would include the state's health commissioner, Medicaid director and other state fiscal officials; and an 18-member advisory committee, including representatives from small business, health care and consumers.
Politico

New York Health Insurance Exchange Bill Preserves Agents' Role 06/10/2011

New York agents are cheering a new Senate bill that guarantees a role for producers in the state's health insurance exchange. This proposal calls for a public exchange overseen by an 11-member board who have different expertise in the health care field — among those areas: purchasing health coverage. The bill specifically mentions agents and brokers in this category and

requires agents and brokers be permitted to obtain coverage for individuals and businesses through the exchange. The exchange will also have eight regional advisory committees who will advise the exchange, and agents and brokers will be eligible to serve on these councils.
http://www.insurancejournal.com/news/east/2011/06/10/202150.htm

North Dakota:

ND lawmakers crafting health exchange bill 06/15/2011
Encouraged by a former federal health and human services secretary, a group of North Dakota lawmakers agreed Tuesday to support drafting legislation to broaden health insurance coverage in the state. The Legislature's interim Health Care Reform Review Committee will be preparing the measure for possible introduction during a special legislative session in November. The proposed bill would establish a North Dakota health insurance exchange.
http://www.forbes.com/feeds/ap/2011/06/15/business-us-health-exchanges-north-dakota_8517511.html

Pennsylvania:

Pennsylvania Weighs an Exchange 06/14/2011
Pennsylvania Insurance Commissioner Michael Consedine told Poltico, back at the last NAIC conference in March, that his state "want[ed] to get a better sense of what the courts say before we move forward." He now sends PULSE an update, noting that the pending court cases have not halted state action, and that Pennsylvania has used its planning grant to retain a consultant, to advise the governor on next best steps. "[We] will be using this summer to engage in a market analysis and stakeholder outreach to assist the Governor in making the policy decision."
Politico

Rhode Island:

Exchange hung up on abortion 06/13/2011
Rhode Island's effort to create a health-insurance "exchange" – a key part of the sweeping federal health care law – has stalled because some state leaders oppose a restriction on abortion coverage in a health-exchange bill already passed by the Senate. Both Gov. Lincoln D. Chafee and Lt. Gov. Elizabeth H. Roberts say they're against the language that prohibits health plans from covering abortions if the plans were purchased with public subsidies through the exchange.
http://www.pbn.com/Exchange-hung-up-on-abortion,58967

Wyoming:

Group examines Wyoming insurance exchange 06/13/2011
A committee studying options for a Wyoming health insurance exchange will meet Wednesday in Casper. The Wyoming Health Benefit Exchange Steering Committee is charged with recommending whether the state should create its own health exchange or partner with other states on a regional program. Wyoming could also let the federal government design the exchange, but committee members have so far shown little interest in that option. Gov. Matt Mead and the committee will have to find answers to several questions. It must, for example, decide whether Wyoming's population is large enough to support an exchange and whether the state has the technological capabilities to develop a program in a relatively short time. The committee is scheduled to discuss hiring a consultant to help with the effort.
http://billingsgazette.com/news/state-and-regional/wyoming/article_b19c0c20-c0c3-5904-a137-3016fdae006f.html

- Connecticut, Nevada, and Oregon send their exchange bills to the Governor to be signed.

- New York introduces exchange legislation, New Hampshire decides to hold its exchange bill until the 2012 legislative session, and Delaware considers establishing the exchange through executive order.
- More than 10 states have notified CCIIO of their intent to apply for an Establishment Grant by the June 30th deadline. Four of these states include California, the District of Columbia, Maryland, and Mississippi.
- Several states are looking to adopt a "work around" to passing exchange establishment legislation. For example, Indiana issued an executive order and Mississippi established the exchange through the state's high risk pool. Other states, such as Alabama and Georgia, created exchange study committees through executive order and Montana has been in discussion with the federal government about possible alternatives.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 06/03/2011 – 06/10/2011

Federal News

10-Plus States Eye June 30 Grants 06/08/2011

More than 10 states have submitted letters to CCIIO notifying the agency that they intend to apply for an Establishment Grant by this month's June 30 deadline. If all are approved, that would be a huge spike from the last round of Establishment Grants, when just three states — Indiana, Rhode Island and Washington — received awards. So far, Pro knows of four states will be hitting that deadline: California, the District of Columbia, Maryland and Mississippi.
Politico

WellPoint to Acquire CareMore Health Group 06/08/2011

WellPoint, Inc., the nation's largest health benefits provider in terms of medical membership, announced today that it has entered into an agreement to acquire CareMore, a senior focused health care delivery program that includes Medicare Advantage plans and clinics designed to deliver proactive, integrated, individualized health care in select California, Arizona and Nevada markets.
http://www.prnewswire.com/news-releases/wellpoint-to-acquire-caremore-health-group-123452059.html

Exchanges Rule to Cover Federal Fallback 06/08/2011

In a Tuesday conference call on state health exchanges organized by the Commonwealth Fund, HHS Director of Coverage Policy Chiquita Brooks-LaSure dropped many hints of what to expect from the agency's proposed rule on health exchanges, due out sometime this month. The regulation will focus largely on what the federally run marketplace will look like, how much states need to do to have their exchanges certified in 2013 and how they can adopt models being developed elsewhere in the country. One key question that probably won't get answered is what counts as part of health reform's "essential benefits" package — the set of medical procedures that all health insurers will be required to cover, with big implications for the cost of the plans offered in the exchanges.
Politico

Ceridian Joins Forces with Microsoft to Provide Health Insurance Exchange Solutions 06/07/2011

Ceridian Corporation, a leading provider of human resource, benefits administration, workforce management, payroll and health insurance exchange solutions, announced today it has signed a letter of intent with Microsoft to collaborate on providing small business exchange solutions. The joint effort will involve a variety of health insurance exchange marketing and selling efforts to governmental entities within the United States.
http://insurancenewsnet.com/article.aspx?id=264156&type=newswires

New Analysis Outlines "Active Purchaser" Options for Health Insurance Exchanges 06/03/2011

States have more options than policymakers may realize to create health insurance exchanges that promote competitive and affordable insurance markets, according to a new white paper that addresses the issue of exchanges as "active purchasers." The paper, released today by the National Academy of Social Insurance and the Georgetown University Health Policy Institute, notes the wide range of policies states can pursue, depending on local market conditions, to leverage higher quality, more affordable insurance for individuals and small businesses.
http://www.prnewswire.com/news-releases/new-analysis-outlines-active-purchaser-options-for-health-insurance-exchanges-123103433.html

NASCIO Issues IT Guidance on the Health Benefit Exchanges 06/03/2011

State chief information officers (CIOs) will play a variety of roles in health care reform, including providing sound leadership and delivering feedback to governors on IT gaps, according to a publication released today by the National Association of State Chief Information Officers (NASCIO). The publication, On the Fence: IT Implications of the Health Benefit Exchanges, is available for download at:
www.nascio.org/publications

State News

California:

California Sets the Agenda 06/10/2011

The state has put up an agenda for its June 15 exchange board meeting, which includes guest spots from CCIIO's Joel Ario and CMS's Cindy Mann. Also on the docket: a presentation on the state's Level One Establishment Grant application, which California plans to submit by June 30. Agenda http://bit.ly/k1KWmx
Politico

Cash-strapped states ask foundations for health-law help 06/06/2011

Nowhere do the ties between private health foundations and state government run deeper than in California, where Democratic Gov. Jerry Brown's administration is grappling with a projected $10.8 billion deficit in 2012, leaving little money to implement the law. Three major foundations - the California HealthCare Foundation, the Blue Shield of California Foundation and the California Endowment - have stepped into the breach with money for actuaries, economists and other consultants.
http://www.bostonherald.com/business/healthcare/view.bg?articleid=1343429&srvc=business&position=recent

Connecticut:

Connecticut Bill to Malloy 06/06/2011

*Whole lot of exchange action this weekend: The Connecticut House voted late Saturday to set up the Connecticut Health Insurance Exchange, sending it to the desk of Gov. Dan Malloy, a Democrat who has been a strong supporter of the health reform law (even as it's meant largely sidelining the state's public-option project, SustiNet). The House rejected a last minute amendment that, according to the Connecticut General Assembly Office of Fiscal Analysis, would have allowed the exchange to limit the number of plans selling. The bill **http://1.usa.gov/mpRoio**. The rejected amendment **http://1.usa.gov/m9eqPW**.*
Politico

Conn. House votes to set up state health agency 06/04/2011

The House of Representatives has passed legislation that moves Connecticut closer to complying with the federal health care reform law. House members on Saturday voted 108-to-30 to establish the Connecticut Health Insurance Exchange, a quasi-public agency that's required under the federal legislation. A 14-member board would manage the exchange, including an online marketplace where individuals and employers with up to 50 workers can compare and purchase health insurance plans, starting in 2014.

http://www.greenwichtime.com/news/article/Conn-House-votes-to-set-up-state-health-agency-1409817.php

Delaware:

Delaware Weighs Executive Order 06/09/2011

With the legislative session about to wrap up — and no bill in sight — Delaware Gov. Jack Markell is likely to use an executive order to move forward the state's insurance exchange, a source in the Delaware Insurance Department tells PULSE. "The legislative session is going to be ending and it would be difficult to get [an exchange bill] through at this point," the source says. An executive order will most likely happen so that the state can move forward with a Level One Planning Grant application by the September deadline. The Delaware Legislature adjourns on June 30.
Politico

Illinois:

Illinois takes slow approach on health exchange 06/08/2011

While Illinois joined a handful of states passing legislation to set up insurance exchanges, the bill that passed last week won out over a proposal for a more ambitious approach. That bill died without coming to a vote, along with another bill that would have given state regulators power to deny health insurance rate increases. The winning bill sets up a bipartisan study committee, made up of legislators, which must issue a report by Sept. 30. That would be enough time to introduce a more detailed bill in the fall veto session, Mautino said.
http://www.forbes.com/feeds/ap/2011/06/08/business-us-health-care-illinois_8505878.html

Massachusetts:

Connector Board Discusses Wellness, Operating Budgets, and Exchange Planning 06/09/2011

This morning, the Connector Board met to discuss four agenda items: Updates on the wellness initiative for Business Express, FY 2011 Administrative Budget and Audits, Voting on FY 2012 Administrative Budget Recommendation, and a vote on an exchange planning grant contract. Materials from the meeting are here.
http://blog.hcfama.org/2011/06/09/connector-board-discusses-wellness-operating-budgets-and-exchange-planning/

Minnesota:

Medica plan may be glimpse of future 06/06/2011

Medica is launching a new plan for businesses that it says will help them gain more control of health care costs, while giving employees more say in designing their insurance plans -- even as they're picking up more of the tab. The Minnetonka-based insurer's plan may provide a glimpse into how new health insurance exchanges could work, well ahead of the 2014 federal mandate. Called "My Plan," the employer sets aside a specific dollar amount for each employee to use for health care. Employees then go online and decide how they want to spend it by choosing among 20 Medica plans.
http://www.startribune.com/business/123290103.html

Montana:

Feds could step in to create health insurance exchange in Montana 06/03/2011

During an interim legislative meeting on Friday, lawmakers heard from the Insurance Commissioner's office about how it's moving forward with the exchange. The Insurance Commissioner's chief legal counsel, Jesse Laslovich, says that if Montana fails to act by January 1, 2012, the federal government will step in. "In fact they have already reached out to our office and said we are contacting those states we've identified have made it pretty clear that they are not going to do a state based exchange and said we need to get the ball rolling in those states." Montana State Senator Joe Balyeat sits on the Economic Affairs Interim Committee, charged with studying how the state should implement a health insurance exchange.
http://www.kxlh.com/news/feds-could-step-in-to-create-health-insurance-exchange-in-montana/

Nevada:

Nevada Sends Sandoval Bill 06/07/2011

The Nevada Legislature passed an exchange bill Monday, just hours before wrapping up its 2011 legislative session. Senate Bill 440, establishing the Silver State Health Insurance Exchange, now goes to Gov. Brian Sandoval, a Republican who opposes the health reform law but supports S.B. 440. He has 10 days to sign or veto the legislation. The Nevada bill http://bit.ly/jJyQTo
Politico

Nevada's Exchange Bill 06/06/2011

The exchange bill made a last minute sprint through the Nevada House this weekend, aiming for passage before the session adjourns today. The Nevada House passed Senate Bill 440 on Saturday but amended the bill ever so slightly, changing just two words, and sending it back to the Senate, which had already approved the legislation. The bill http://bit.ly/lnL4TS.
Politico

New Hampshire:

Fed Exchange Timeline Trips up States 06/07/2011

New Hampshire state Sen. Ray White started off 2011 looking to get a head start on health reform, but he backed off because regulations for state-run exchanges were not expected until June. White is now holding an exchange bill for the state's 2012 session, making New Hampshire one of a handful of states that has become publicly frustrated with HHS's timeline for exchange regulations. The POLITICO Pro story: http://politico.pro/jrqs7x
Politico

New York:

New York exchange bill introduced as clock ticks 06/09/2011

With only six days left in their legislative session, two New York Republican senators have introduced a long-awaited exchange bill. The bill would establish a governance board to move forward on planning an exchange for the state. The bill does not weigh in on specific policies, but it does establish regional authorities to make area-specific recommendations. "The bill establishes a solid foundation, adhering to all of the necessary requirements to receive federal funding, as we continue to craft the final details of a state exchange," said Sen. James Seward, one of the bill's co-sponsors. Seward chairs the Committee on Insurance, and the bill's co-sponsor Sen. Kemp Hannon chairs the Committee on Health.
Politico

Lawmakers introduce bill for single-payer health-care system 06/07/2011

Democratic lawmakers in both houses introduced a universal health-care bill today, under which publicly sponsored coverage would replace coverage by insurance companies. Instead of premiums, there would be broad-based public financing of health care based on people's ability to pay. It would be funded through a graduated income tax, and the system wouldn't have deductibles or co-payments. Delivery of care would remain primarily private.
http://polhudson.lohudblogs.com/2011/06/07/lawmakers-introduce-bill-for-single-payer-health-care-system/

Battle of the health plans 06/08/2011

Two proposals for a health insurance exchange are being floated around the state Capitol -- one that gives an exchange wide powers, and the other placing strong limits on its role. Neither plan has been officially introduced in either the GOP-controlled Senate or the Democrat-led Assembly. The governor's proposal would make the exchange a "public benefit corporation" with the power to regulate insurance plans and set minimum requirements for the plans offered through the exchange. This model also gives the exchange the authority to act as a buyer, putting the exchange in a position to negotiate discounted rates. The Senate proposal calls for a "public authority" that has no regulatory leverage unless empowered by the Legislature, and no power to act as a buyer.
http://www.timesunion.com/business/article/Battle-of-the-health-plans-1414295.php

Oregon:

State House approves health insurance exchange to cover all Oregonians 06/07/2011

A bill that will extend health insurance to nearly all Oregonians, a key part of state health care reform, won final passage in the Legislature on Tuesday. Senate Bill 99 will create a government regulated and subsidized health insurance marketplace called an exchange to make coverage affordable and mandatory. Within months, Oregon will establish the Oregon Health Insurance Exchange as a public corporation governed by a nine-member board. It will be charged with offering small businesses and individuals insurance plans in an exchange by Jan. 1, 2014.

http://www.oregonlive.com/health/index.ssf/2011/06/oregon_house_approves_health_i.html

Texas:

Behind the Scenes, Plans for Insurance Exchange 06/09/2011

Despite Mr. Perry's stated opposition to a federally-mandated health insurance exchange and the state's participation in lawsuits aimed at overturning federal health reform, officials at the Texas Department of Insurance acknowledge that since last fall, with the help of a $1 million grant from the United States Department of Health and Human Services, they have been working quietly to plan for a health insurance exchange.

http://www.nytimes.com/2011/06/10/us/10ttinsurance.html?_r=2&emc=tnt&tntemail0=y

- Gov. John Hickenlooper of Colorado signs the state's bill establishing health insurance exchanges. This makes 10 governors (including UT and MA) to sign exchange legislation.
- Illinois' legislature passes exchanges legislation and sends it to the Governor to be signed; Oregon's House Health Care Committee approves exchange legislation and sends it to the House floor for a final vote; Nevada's bill gets approval from the Senate and moves to the State Assembly.
- South Carolina's bill dies in committee and Maine's Committee on Insurance and Financial Services decided it will not take up either of the two pending exchange bills until it reconvenes for the second half of its two-year session in early 2012.
- Alabama's Gov. Robert Bentley is considering an executive order to allow for health reform implementation to move forward in his state.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 05/27/2011 – 06/03/2011

Federal News

Health Insurance Exchanges: Select the "Right" Team 06/02/2011

Over the coming weeks, Leavitt Partners is publishing a series of blogs with information and suggestions on the four basic components of implementing an exchange. The first component, the exchange team, is crucial to the successful implementation of an exchange. This team should be composed of state officials and policy leaders who understand the history and purpose of exchanges and have the knowledge to design an exchange that addresses a state's specific health and economic needs.
http://leavittpartnersblog.com/health-insurance-exchanges-select-the-%E2%80%9Cright%E2%80%9D-team-10002880

An assessment of the complexities and opportunities emanating from the ACA's public health insurance exchange concept 06/02/2011

Triple Tree, a mergers & acquisitions boutique specializing in health-care deals, has written a research note concluding that it will cost about $6 billion to establish exchanges, and $2 billion in annual operating costs thereafter.
http://www.triple-tree.com/Dynamic_Data/ResearchDocs/49_3.pdf

Feds cut rates for hard-to-insure Americans 06/01/2011

The Obama administration announced Tuesday that it is moving to reduce health insurance premiums in nearly two dozen states, by as much as 40 percent, to make it easier for people with pre-existing conditions to get coverage. The federal government also is relaxing restrictions on who qualifies for high-risk insurance pools, also known as health plans designed for people with medical problems. These are designed in the new health care law to serve as a bridge until 2014 for those who are sick; at that point, insurance companies can no longer deny coverage for pre-existing conditions. Tuesday's announcement by Health and Human Services Secretary Kathleen Sebelius means that prices for these high-risk plans will fall more in line with premiums paid by the average healthy person.
http://www.washingtonpost.com/blogs/federal-eye/post/feds-cut-rates-for-hard-to-insure-americans/2011/03/23/AGH4UuFH_blog.html

GOP Govs Move to Establish Health Insurance Exchanges 05/31/2011

A small but growing number of prominent, Republican governors — including Daniels and arbour — are taking the lead to shape a key component of the health care overhaul their party fought so hard to kill. It's a delicate balancing act for

Republicans who, on the one hand, oppose federal health reform, even challenging its constitutionality in federal court, and, on the other hand, are pragmatically trying to control as much of the implementation process as they can.
http://schealthcarevoices.org/2011/05/31/gop-govs-move-to-establish-health-insurance-exchanges/

Health reform's 'Early Innovators' running late 05/31/2011

Many of the seven states awarded Early Innovator grants, while still meeting HHS benchmarks, are struggling to move forward on other key aspects of implementation, especially passing legislation to set up the new online marketplaces for insurance. The challenges range from Oregon, where an exchange bill is stuck in a Republican-helmed committee, to Kansas, where a new directive from Republican Gov. Sam Brownback has thrown some elements of implementation into limbo. And Oklahoma, a state awarded a $54 million grant, has pulled out of the program altogether.
Politico

State News

Alabama:

Alabama governor creates commission to study health insurance exchange 06/02/2011

Gov. Robert Bentley is creating a commission to study how to establish a health insurance exchange in Alabama. Bentley said Thursday he had signed an executive order starting the Alabama Health Insurance Exchange Study Commission. He said the commission will address many issues, including the type of entity that should house the insurance exchange, the makeup of its governing board, and the resources needed for operating the exchange. The 14 members will include legislators, members of Bentley's Cabinet, health care professionals and insurance representatives.
http://www.greenfieldreporter.com/view/story/d73658cdd45a4f968b82811cd5c071ab/AL--Governor-Insurance-Exchange/

Alabama Eyes Executive Order For Exchange 06/01/2011

Alabama Gov. Robert Bentley, a Republican, is seriously eyeing an executive order to allow for health reform implementation to move forward in his state, Politico has learned. Bentley is "looking at" an executive order to set up a health exchange under the Affordable Care Act, his Medicaid director Bob Mullins said in an interview, a move he's likely to make by the end of the year.
Politico

California:

State-Based Coverage Solutions: The California Health Benefit Exchange 05/31/2011

This brief looks at the decisions health officials in California made while establishing the state's health insurance exchange program. California was the first state to implement a health care exchange after the federal health law was passed and its decisions may help guide other states. Several factors played a role in creating the state's exchange, the authors write, including: "minimizing adverse selection, promoting cost-conscious consumer choice, and seamlessly coordinating with public programs." But the brief suggests that "each state will have to design solutions tailored to its own political, demographic, and market characteristics. There are technical decisions each state will have to make"
http://www.commonwealthfund.org/Content/Publications/Issue-Briefs/2011/May/State-Based-Coverage-Solutions.aspx

Colorado:

Governor to sign health exchange bill 06/01/2011

Gov. John Hickenlooper is expected to sign a bill into law today that will set the course for establishing health insurance exchanges in Colorado. Hickenlooper is scheduled to hold a signing ceremony for SB200 at 10:30 a.m. at St. Anthony's Hospital in Lakewood. The bill would establish an online insurance marketplace enabling small businesses and individuals to unite and negotiate features of their health coverage as well as premium prices.
http://www.chieftain.com/news/local/governor-to-sign-health-exchange-bill/article_21f902d0-8c12-11e0-8e3e-001cc4c03286.html

Georgia:

Deal creates panel to study health care exchange 06/02/2011

Gov. Nathan Deal has signed an executive order creating a panel to determine whether Georgia should establish a state-based health care exchange under the new federal health care law. Georgia has joined 25 other states in a lawsuit declaring the law's individual mandate to have insurance - a key component of the legislation - unconstitutional. Deal says he wants Georgia to have time to thoroughly study the issue as the judicial process plays out. "It is my hope that this committee will construct the appropriate avenues for our state to implement our own exchange, based on delivering free market solutions for increasing the access and affordability of health insurance," Deal said in a statement released Thursday. "The exchange should also focus heavily on improving the economic viability of creating and expanding small business in Georgia."
http://www.ledger-enquirer.com/2011/06/02/1603381/deal-creates-panel-to-study-health.html

Illinois:

Illinois Bill to Quinn 06/01/2011

Illinois became the 10th state, over the weekend, to authorize a health exchange. The legislation, S.B. 1555, passed late Sunday and now heads to the desk of Gov. Patrick Quinn, a supporter of the health reform law, who has 60 days to sign or veto the legislation. One interesting provision here: the Illinois Health Benefits Exchange Act requires state agencies to offer their employees' Health Savings Accounts.
http://1.usa.gov/jVBtP8

Maine:

Maine Slows Down 06/02/2011

Despite the introduction of both a Democratic and a Republican sponsored exchange bill, don't expect the state legislature to move forward. Instead, the state's Joint Standing Committee on Insurance and Financial Services has decided to go ahead with legislation that will set up an Advisory Committee on Maine's Health Insurance Exchange. The committee will not take up either of the two pending exchange bills (L.D. 1498 and L.D. 1497) until it reconvenes for the second half of its two-year session in early 2012.
Politico

Nevada:

Nevada Legislation Gets Going 06/01/2011

As sources told PULSE last week, the Nevada legislation is gaining momentum before the session wraps up on June 6. After sitting in committee for months, S.B. 440 moved through committee on May 27 and just got the full Senate's approval yesterday. The exchange bill now heads to the State Assembly, where it is expected to pass.
http://bit.ly/lsbNzg

Oklahoma:

Oklahoma, RIP 05/27/2011

The Sooner State's legislative session wraps up today, and left on the cutting room floor will be S. 960, legislation that would have authorized a health exchange. The bill has sat in the Senate Retirement and Insurance Committee since mid-February. A bicameral committee will spend another year studying possible options on an exchange but will not take any concrete steps to set up an exchange.
Politico

Oregon:

House Health Care Committee passes bill to create Oregon Health Insurance Exchange 06/01/2011

A bill to create a marketplace known as an exchange for government-subsidized health insurance plans that would extend coverage to nearly all Oregonians was approved by the House Health Care Committee on Wednesday. Senate Bill 99 now heads

for a final vote on the House floor. The bill creates a public corporation that will be governed by a nine-member board and financed through fees from participating insurance companies.
http://www.oregonlive.com/politics/index.ssf/2011/06/house_health_care_committee_pa_1.html

South Carolina:

Deadline: South Carolina 06/02/2011
The South Carolina legislature adjourns at the end of today, and the state's exchange bill (H.B. 3738) is sitting in its Ways & Means Committee, unlikely to see the light of day.
Politico

Utah:

Utah Health Exchange growing as more small businesses sign on 05/30/2011
More than 100 small-business employers now use the Utah Health Exchange to allow their employees to access health insurance benefits, and state experts say they're hoping to have 10 times that many companies using it by the end of the year. It's attracting a lot of attention by states that are trying to figure out how to create their own health exchanges. The exchange now has 114 small-business employers enrolled, providing coverage to 1,035 employees and their dependents, a total of 2,985 people covered, according to Patty Conner, director of the Utah Office of Consumer Health Services.
http://www.deseretnews.com/mobile/article/700140212/Utah-Health-Exchange-growing-as-more-small-businesses-sign-on.html

Vermont:

The Vermont Health care Virus 05/30/2011
Vermont's H202 is a trial balloon that may theoretically work because Vermont is a small State. Other states are already copying this approach. But ultimately health care is a subset of the national entitlement discussion and closely related to the fact that most of us don't smoke and live longer, want lower taxes and more government services.
http://www.glgroup.com/News/The-Vermont-Health-care-Virus-54175.html

- Three states receive Level I Exchange Establishment Grants: Indiana ($6.9 million), Rhode Island ($5.2 million), and Washington ($22.9 million).
- Gov. Brownback (KS) calls for a delay in selecting a key exchange vendor. The administration asked Insurance Commissioner Sandy Praeger to delay that process until the 2012 Legislature has weighed in on the plan.
- Minnesota's exchange legislation dies in committee (although it may be considered in the upcoming special session), while Nevada's bill is expected to be pushed forward next week.
- Vermont Gov. Shumlin signed into law a plan to create the nation's first state-run "single-payer" health system. If fully implemented, every Vermont resident, including those on Medicare and Medicaid, would be entitled to enroll in the state's own insurance plan, Green Mountain Care. Private insurers would still be allowed to operate in the state.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 05/20/2011 – 05/27/2011

Health Insurance Exchange Level I Grants

Indiana

Administrator: Indiana Family and Social Services Administration
Award Amount: $6,895,126
Summary: Indiana will use resources from the Affordable Care Act to strengthen the health information technology systems that will be integral to its Exchange. Additional funding will support project management, legal, actuarial, and financial expertise and general policy support.

Rhode Island

Administrator: Rhode Island Department of Business Regulation
Intended Award Amount: $5,240,668
Summary: Rhode Island will use resources from the Affordable Care Act to strengthen health information technology systems, develop an integrated consumer support program to provide support to individuals and small businesses, and strengthen its business operations

Washington

Administrator: Washington State Health Care Authority
Intended Award Amount: $22,942,671
Summary: Washington will use resources from the Affordable Care Act to develop options and recommendations on policy decisions that will have a significant impact on the Exchange. The grant will also provide funds to develop a health information technology system that will support its Exchange.

Federal News

States should be allowed to implement key health reform law provisions early, experts say 05/23/2011

More than eight of 10 leaders in health and health care policy (82%) believe states should be allowed to implement key provisions of the Affordable Care Act early with full federal support, ahead of the timeline outlined in the law. Such key provisions include expanding Medicaid eligibility to cover more low-income families and creating insurance exchanges with premium subsidies. Findings are from the latest Commonwealth Fund/Modern Healthcare Health Care Opinion Leaders Survey, which asked respondents about the relative authority states and the federal government should have implementing health care reform. Other findings from the survey include that a majority of opinion leaders (61%) support or strongly support the creation of a federal health exchange, in addition to the state exchanges that will become operable in 2014.
http://www.eurekalert.org/pub_releases/2011-05/cf-ssb052311.php

Health Exchanges: Impact of health plan benefit changes on cost and utilization 05/20/2011

PPACA mandates changes to health insurance products if they are to be sold through an exchange starting in 2014. For products to be included inside the exchange, they must meet or exceed the minimum requirements for one of the bronze, silver, gold, or platinum plans. These benefit design changes will not only affect insurer costs because of changes in member cost sharing, but in fact may result in several other consequences, most notably changes in utilization by members as they respond to new plan designs.
http://publications.milliman.com/publications/healthreform/pdfs/health-exchange-impact-plan.pdf

State News

Kansas:

Insurance exchange planning group will slacken pace 05/23/2011

The steering committee that is developing the plan for a Kansas health insurance exchange will move at a slower pace after the administration of Gov. Sam Brownback called for delay in selecting a key exchange vendor. The initial plan, as spelled out earlier this year by Kansas Insurance Commissioner Sandy Praeger, had been to issue a request for proposal (RFP) for a vendor sometime in July. The administration, however, asked Praeger to delay that process until the 2012 Legislature has weighed in on the plan.
http://www.khi.org/news/2011/may/23/insurance-exchange-planning-group-will-slacken-pac/

Maryland:

Panel named to oversee health insurance exchange 05/27/2011

Gov. Martin O'Malley made his picks for the board that will oversee the state's new Health Benefit Exchange, The board will include: Dr. Georges Benjamin, executive director of the American Public Health Association; Lisa Dubay, an Urban Institute Senior Fellow; Darrell Gaskin, an associate professor and a health economist at the Johns Hopkins Bloomberg School of Public Health; Jennifer Goldberg, assistant director of Advocacy for Health Care at the Maryland Legal Aid Bureau; Enrique Martinez-Vidal, vice president at AcademyHealth and director of the Robert Wood Johnson Foundation's State Coverage Initiatives program; and Thomas Saquella, former President of the Maryland Retailers Association.
http://weblogs.baltimoresun.com/health/2011/05/panel_named_to_oversee_health.html

Maryland Pulls Ahead on Implementation 05/27/2011

The key takeaway from the launch of Maryland's exchange board here: This is one state to definitely keep an eye on. Maryland has, in some ways, flown under the radar on implementing the Affordable Care Act. It has always been a leader but hasn't racked up any first-in-the-nation accomplishments. It was the third to pass legislation enabling a health exchange, the second to set up an exchange board and one of six states participating in HHS's Early Innovator grant program, for states leading the way on exchange information technology
--Politico

Md. Health Secretary Sharfstein: Health Law Brings 'Fast And Furious' Opportunity – The KHN Interview 05/26/2011

When the health law moved from Congress last year to state capitals, where officials continue putting it into action, much of the controversy followed it. Not in Maryland, a Democratic bastion that welcomed the law. Without political baggage to

circumnavigate, Maryland is among a handful of states moving quickly to implement the law. Its work may serve as a guide for other states. "We haven't had major conflict at this point," said Dr. Joshua Sharfstein, the state's health secretary.
http://www.kaiserhealthnews.org/Stories/2011/May/26/sharfstein-q-and-a-maryland-health.aspx

Minnesota:

Minnesota Bill Doesn't Move 05/24/2011

The Minnesota legislature ended at midnight Monday, and two introduced exchange bills didn't even get a hearing this go-around. Gov. Mark Dayton's press secretary Katharine Tinucci said the legislature didn't agree on a budget either, so a special session will have to take place in the next few months and exchange legislation may be introduced again at that point. "We have until 2013, and we expect and hope that we will get something done by then," she said. But Democratic Rep. Erin Murphy tells PULSE that political pressure from the tea party stopped the bill in its tracks: "There is a sense of urgency and I think it's important for the state to have as much time as it can take to set up an exchange. There's strong support for an exchange from providers, consumers and small business groups. We may be able to introduce a bill in the special session — that all depends on the willingness of the Republican leadership to do what is right for Minnesota."
--Politico

Nevada:

Nevada Wraps Public Meetings, Pushes Bill 05/25/2011

If Las Vegas fixed odds on exchange legislation, we'd be betting that Nevada moves its bill before the legislative session wraps up on June 6. The state finishes today with a series of stakeholder meetings, financed by its exchange planning grant, and the action turns to Senate Bill 440, which would establish the Silver State Health Exchange. The bill has the endorsement of Republican Gov. Brian Sandoval, and his administration expects it to pass through the legislature. "The governor supports it, and we believe the Democratically-controlled legislature is in favor of it," says Gloria Macdonald, who works on health reform issues in the Nevada Division of Health Care Financing and Policy. A source in the Nevada State Legislature tells PULSE to watch for the bill to move next week.
--Politico

North Carolina:

NC health exchange creation gets approval by House 05/26/2011

The House voted 83-34 on Wednesday to create a North Carolina health benefit exchange. The 2010 federal health care overhaul requires all states to have an exchange. The federal government will create exchanges for states that don't have them by 2014. Bill co-sponsor Rep. Tom Murry of Morrisville calls the bill pro-consumer and says it preserves the insurance market outside the exchange. Rep. Verla Insko of Chapel Hill voted against the measure now heading to the Senate. She said the bill has no patient appeals process and would discourage healthier residents to participate.
http://www.businessweek.com/ap/financialnews/D9NF5P780.htm

Ohio:

Ohio starts work on its health insurance exchange and wants your input 05/23/2011

Ohio has started to work on its exchange. Ohio process is being tracked through ohioexchange.ohio.gov. The website will carry regular updates on Ohio's exchange and a lot more. People can see how other states are organizing their exchanges. And they can ask questions and comment on Ohio's plan. Cleveland State will be hosting two more forums on the subject. Both are free and open to the public.
http://www.cleveland.com/healthfit/index.ssf/2011/05/ohio_has_already_started_work.html

Oklahoma:

Tulsa Republican legislators to study health insurance exchange 05/23/2011

Two Tulsa Republican lawmakers have been chosen to deal with one of the hottest of political hot potatoes next fall. Sen. Gary Stanislawski and Rep. Glen Mulready are the leaders of a special joint legislative committee that will study how the state should respond to the federal mandate to create a state health insurance exchange.
http://newsok.com/tulsa-lawmakers-to-study-state-insurance-exchange/article/3570503

Rhode Island:

R.I. wins $5.2-million federal grant to build health-insurance exchange 05/24/2011

Rhode Island has received a $5.2-million federal grant to continue its work developing a health-insurance exchange, a cornerstone of the federal health-care law. But the state, which also received a $1-million planning grant in September, could lose out on future federal money if the General Assembly fails to approve legislation creating the exchange, a marketplace for health insurance. That bill has stalled, caught in a dispute over anti-abortion language. The one-year grant, announced Monday, will be used to develop the specifications for the complex computer systems needed to run the exchange, said Health Insurance Commissioner Christopher F. Koller. The grant will also be used to hire 2 to 10 staffers to work on the exchange — once the legislature provides the authorization.
http://www.projo.com/news/content/HEALTH_REFORM_GRANT_05-24-11_14O8PVD_v7.2e8b58b.html

Vermont:

Vermont has a plan for single-payer health care 05/26/2011

Vermont made history today when Governor Peter Shumlin, a Democrat, signed into law a plan to create the nation's first state-run "single-payer" health system. If fully implemented, every Vermont resident, including those on Medicare and Medicaid, would be entitled to enroll in the state's own insurance plan, Green Mountain Care. Private insurers would still be allowed to operate in the state.
http://news.consumerreports.org/health/2011/05/vermont-establishes-road-map-for-single-payer-health-care.html

Washington:

Washington gets $23m for health insurance exchange 05/24/2011

Washington has received a $23 million federal grant to create a new health insurance exchange through the state's Health Care Authority plan. The health insurance exchange is a key component of federal health care reform and builds on a series of recent legislative and funding moves designed to create a comprehensive response to health care in the state.to create a comprehensive response to health care in the state.
http://civsourceonline.com/2011/05/24/washington-gets-23m-for-health-insurance-exchange/

- Maine passes a health care overhaul bill that allows insurance companies to determine premium rates based on age, geographic location, and occupation. A legislator in California introduces a bill that would initiate single-payer universal health care for the state.
- The Greenville Tea Party urges that South Carolina opt out of Health Insurance Exchanges. Oklahoma Governor Mary Fallin signs the Healthcare Compact, making her the second governor to sign the compact.
- Gov. Andrew Cuomo has nominated his chief of staff, Benjamin Lawsky, to serve as commissioner of the new Department of Financial Services, which will regulate, and potentially operate, the exchange. West Virginia's Insurance Commissioner, Jane Cline, announced her retirement Wednesday.
- Eight states have passed exchange legislation, legislation is on the Governor's desk in three states, four states have vetoed or tabled their exchange legislation, and legislation has died in committee in six states. One state has established an exchange by executive order. Twenty-eight states to go!

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 05/13/2011 – 05/20/2011

Federal News

State Legislators Tussle over Health Benefit Exchanges as Adjournments Near 05/19/2011

As state legislatures near the end of their sessions, many lawmakers are still struggling with whether to approve measures to set up health-benefits exchanges created under the health care law — and it appears almost certain work in many states will extend into 2012. While a few states have enacted legislation and others may be nearing final action, many others are torn by differing opinions among politicians, health care providers and consumers about what an exchange should look like or how it should function

--CQ Healthbeat News

Affordable Care Act helps fight unreasonable health insurance premium increases 05/19/2011

Today, The Department of Health and Human Services (HHS) issued a final regulation to ensure that large health insurance premium increases will be thoroughly reviewed, and consumers will have access to clear information about those increases. Combined with other important protections from the Affordable Care Act, these new rules will help lower insurance costs by moderating premium hikes and provide consumers with greater value for their premium dollar. In 2011, this will mean rate increases of 10-percent or more must be reviewed by state or federal officials.

http://www.hhs.gov/news/press/2011pres/05/20110519a.html

CHOICE Administrators CEO Calls Brokers the Key to the Successful Implementation of Health Insurance Exchanges 05/19/2011

The architect of America's most successful health insurance exchange has recently advised brokers to "sharpen their skills" and "begin now in educating their clients about the many benefits that health insurance exchanges can bring. Healthcare reform is upon us, and health insurance exchanges are a key part of it," said Ron Goldstein, president and chief executive officer of CHOICE Administrators. "In this new world, brokers will be more important than ever in helping to successfully tackle the country's massive uninsured and underinsured challenges."

http://insurancenewsnet.com/article.aspx?id=261839

Leaders from the First Health Insurance Exchange, Jon Kingsdale and Patrick Holland, Form Alliance with Oliver Wyman 05/19/2011

Two central figures in U.S. healthcare reform have formed a strategic alliance with the consulting firm Oliver Wyman. Jon Kingsdale and Patrick Holland were founding executives in the Commonwealth Health Insurance Connector Authority, the Massachusetts health insurance exchange that was a key model for the Affordable Care Act of 2010, helping to define national healthcare reform. At Oliver Wyman, they will serve as strategic advisors and subject matter experts for clients of the firm's Health & Life Sciences practice, offering their deep perspective on reform, exchanges, and the current state and federal legislative environment.
http://insurancenewsnet.com/article.aspx?id=261842

MAXIMUS and Connecture Form Alliance to Provide Robust Government Health Insurance Exchange Solution 05/17/2011

MAXIMUS, Inc., a provider of government services worldwide, and Connecture, the leader in Web-based marketplaces and administration solutions for health insurance distribution, announced today that the two companies have entered into a strategic alliance. This alliance will deliver a proven, comprehensive government Health Insurance Exchange (Exchange) solution blending the expertise in eligibility and enrollment for state Medicaid and CHIP programs provided by MAXIMUS with Connecture's established Web-based health insurance shopping, enrollment and administration solution.
http://insurancenewsnet.com/article.aspx?id=261238

State News

Alabama:

Keep an Eye on Alabama 05/19/2011

Exchange legislation in Alabama (H.B. 401) has sat dormant since March, but it'll get moving next week. Bill sponsor Rep. Greg Wren (R), says he's gotten a guarantee from Alabama legislature leadership to move his bill before the session wraps up mid-June. The body has taken a two week break to deal with re-districting and is set to come back into session next Tuesday, May 24. "I have every reason to believe we'll move House Bill 401 out of the health committee as soon as Thursday," he tells PULSE. "There will be a couple of changes but the core of the bill will be the same." Wren has a strong ally in Gov. Robert Bentley, who was among the first Republican governors to support running his own health exchange.
--Politico

California:

California health care bill would initiate single-payer reform 05/18/2011

The national debate over health care can be summed up in a bill being debated in Sacramento. Supporters of Senate Bill 810 say the legislation would be the only way to provide medical coverage for every Californian. Opponents deride the measure as socialized medicine. The California Universal Healthcare Act was introduced by Sen. Mark Leno, D-San Francisco. The bill would initiate single-payer universal health care for the state of California, Leno said. "What that means in short is Medicare for all," he said.
http://www.kaiserhealthnews.org/Daily-Reports/2011/May/19/state-health-roundup.aspx

Is Affordable Healthcare Within Reach? 05/18/2011

Unlike the premiums for auto and homeowners policies, the price of health insurance is not regulated in California. That means health insurers can basically raise rates at will. A bill to give regulators veto power over health insurance rates is moving through the state legislature. Consumer advocates say without it, the exchange can't guarantee premiums will be reasonably priced.
http://www.kpbs.org/news/2011/may/18/promise-affordability/

Colorado:

Colorado business sees big wins in legislative session 05/15/2011

Business advocates across the state hailed the passage of Senate Bill 200, which will create a health-benefit exchange. The exchange, which will be run by a nine-member board and a legislative oversight committee, addresses the cost and availability of health insurance, which has been the top issue for small businesses.

http://www.denverpost.com/business/ci_18062605

Connecticut:

Connecticut Bill Drops Basic Health Plan 05/17/2011

A Connecticut health exchange bill (S.B. 1204) is heading to the Senate floor soon with a pretty significant change: the Appropriations Committee has stripped the bill of the Basic Health Program. The provision — originally sections 18 and 19 of the bill — would have opted the state into the Affordable Care Act provision creating a state-run plan, likely a Medicaid-look-alike, for those between 133 and 200 percent of the federal poverty line.

http://www.cga.ct.gov/2011/TOB/S/2011SB-01204-R02-SB.htm

Kansas:

Kansas foundations establish health reform grant fund 05/19/2011

Five Kansas health foundations have formed a $450,000 fund to help various organizations and government agencies compete for billions of dollars in federal health reform grants. "Our goal in setting up this fund is to ensure that Kansas and its citizens are well positioned to take advantage of federal programs, technical assistance and grants that are becoming available as part of federal implementation of health reform," said Brenda Sharpe, president and CEO of the REACH Healthcare Foundation. "It is our intent that Kansans receive the full benefit of opportunities related to the law."

http://www.khi.org/news/2011/may/19/kansas-foundations-establish-health-reform-grant-f/

Passing exchange legislation will be a challenge, former speaker says 05/19/2011

In a few months, the Kansas Insurance Department is expected to release a blueprint for how a health insurance exchange might work. "We still have a lot of work to do but, so far, the process has been going really, really well," said Linda Sheppard, head of the insurance department's accident and health accident and health division. However, whether the proposed framework will have enough support to survive the state's legislative process remains to be seen. Doug Mays, a former Speaker of the House who is working to help craft the legislation and to help educate lawmakers about it, is hedging his bets. "It will not be an easy sell, no matter what it looks like," he said.

http://www.khi.org/news/2011/may/19/health-insurance-exchanges-legislative-future-unce/

Landwehr to lead exchange work group 05/18/2011

A legislator who's been outspoken in her criticism of the federal health care reform law has agreed to lead one of eight work groups charged with designing a health insurance exchange for Kansas. Rep. Brenda Landwehr, said Kansas Insurance Commissioner Sandy Praeger approached her about leading the group a couple weeks ago. ... "Just about everybody knows that Sandy and I are somewhat opposite in our politics," Landwehr said. "But I have to say that I think I bring something to the table and that's -- if we're going to have to move forward on this, then let's do it in a manner that's right for Kansas"

http://www.khi.org/news/2011/may/18/landwehr-lead-exchange-work-group/

Maine:

Maine insurance law could conflict with new federal rules 05/17/2011

Several states have passed or considered bills that explicitly disapprove of the federal healthcare reform law, but Maine's new statute isn't simply a political statement — it makes substantive policy changes to the state insurance market that a leading opponent says will have to be revisited in just two years. For example, the new Maine law allows insurers to charge older customers up to five times more than younger ones. The state's health care overhaul would allow for interstate insurance sales and allow insurance companies to determine premium rates based on age, geographical location, and occupation.

http://thehill.com/blogs/healthwatch/health-insurance/161727-maine-insurance-law-may-conflict-with-new-federal-rules

Minnesota:

Minnesota GOP between a Rock and Hard Place on Health Exchange Options 05/17/2011

Minnesota state Rep. Steve Gottwalt, a three-term Republican with 10 years experience in the health care industry, is no fan of last year's health care law -- or its requirement that states set up insurance exchanges. But as chairman of the Health and Human Services Reform Committee, he decided he needed to weigh in on the exchange. He wrote a Republican exchange bill that tries to temper the government's role. He said he hoped the bill would be taken seriously by Dayton and not used as "the beginning of Obamacare." Minnesota "should implement an exchange and define it for ourselves," he said. "I could not absolve myself if I did nothing."
http://www.kaiserhealthnews.org/Stories/2011/May/17/minnesota-health-exchange.aspx

States grapple with health insurance exchanges 05/16/2011

Minnesota is struggling to develop the state-based health insurance exchange mandated by the federal health reform law. Republicans are feeling pressure to refuse to implement the exchange and hope that the U.S. Supreme Court eventually rules the overhaul unconstitutional. Meanwhile, Gov. Mark Dayton (D) -- who supports the reform law -- could offer his own proposal for an exchange. Republicans are concerned about what an exchange implemented by Dayton would include, but also are worried that the state would get a plan from the federal government if it does not create its own exchange.
http://www.californiahealthline.org/road-to-reform/2011/why-nursing-homes-want-to-waive-goodbye-to-reform-law.aspx

New Hampshire:

Insurance Dept. health exchange bid actions questioned 05/19/2011

The New Hampshire Insurance Department has disciplined Leslie Ludtke - its health-care policy analyst -- for what it calls "behavior issues," but for what Ludtke says was her refusal to go along with bidding procedures that might be illegal. When Ludtke heard that the Executive Council might refuse the contract with Wakely Consulting Group Inc., she voiced her concerns to Sevigny and Feldvebel that "NHID could be accused of improperly using the competitive bidding process to achieve a politically palatable result." After she gave that advice, Ludtke wrote, she was frozen out of an April 5 meeting, and found the result "profoundly upsetting."
http://www.nhbr.com/businessnewsstatenews/919881-257/insurance-dept.-health-exchange-bid-practices-questioned.html

New York:

Forum at MCC addresses health exchange concerns 05/19/2011

A forum in New York was looking to answer questions such as: Should there be regional exchanges or just one for the whole state; should individuals and small businesses have separate exchanges; how many plans should be offered; and how do you make sure all the sick people don't end up in an expensive plan while healthy people are in another. Jodie Perry, president and CEO of the Greece Chamber of Commerce, talked about the need for small businesses to have access to good, affordable plans. She also said that chambers can be conduits to the business community.
http://www.democratandchronicle.com/article/20110520/NEWS01/105200348

Push for early action on insurance exchange 05/16/2011

Health Care for All New York, an advocacy group comprised of more than 100 organizations, conducted a press conference last Wednesday, urging lawmakers to introduce a bill before the end of session that would establish a health insurance exchange program in New York.
http://www.legislativegazette.com/Articles-c-2011-05-16-77350.113122-Push-for-early-action-on-insurance-exchange.html

Cuomo picks Lawsky to head Financial Services 05/16/2011

*Gov. **Andrew Cuomo** has nominated his chief of staff to head the state's new banking and insurance regulator. **Benjamin Lawsky** is Cuomo's pick to serve as commissioner of the new Department of Financial Services, created in the budget that was finalized last month. The new department will regulate, and potentially operate, a health insurance exchange for small businesses and consumers that is being set up as part of the federal health care overhaul approved last year.*
http://www.bizjournals.com/buffalo/news/2011/05/16/cuomo-picks-lawsky-to-head-financial.html

Oklahoma:

Oklahoma legislators to study federal health care law 05/19/2011

Legislative leaders announced Wednesday they formed a special joint legislative committee to determine how the federal legislation will affect Oklahoma. "Studying this issue in more depth makes for healthy legislative process," said House Speaker Kris Steele. Steele said last week that legislators would not take up this session a measure that would develop a system where Oklahomans could shop for health insurance — an idea that is required by the federal law and has drawn the ire of many state Republicans.

http://newsok.com/article/3569235

Oregon:

Oregon Can't Afford to Pass Health Insurance Exchange 05/17/2011

SB 99 preserves the complex maze we currently have by keeping an "external" or "dual" marketplace. Insurance companies will use "free" market tactics to weaken the exchange's purchasing power so they can peddle their lemons to cherry-picked consumers. This bill offers no advantages over the state's fallback plan, which is to defer to the federal government to design and implement the exchange. Rather than codify this insurance giveaway, lawmakers should use the intersession to rewrite the bill.

http://www.thelundreport.org/resource/oregon_can%E2%80%99t_afford_to_pass_health_insurance_exchange

South Carolina:

Greenville SC Tea Party Letter to Nikki Haley 05/13/2011

The Greenville Tea Party of South Carolina urges that South Carolina opt out of Health Insurance Exchanges that are part of the Affordable Care Act. The one million dollar Federal Grant to set up a state managed exchange should be rejected and returned. A state-level insurance exchange that is obligated to enforce Federal rules is not managed at the state level.

http://www.fitsnews.com/2011/05/13/greenville-sc-tea-party-letter-to-nikki-haley/

Utah:

Utah's uninsured rate holding steady 05/18/2011

There was little change last year in the number of Utahns who went without health insurance. The state's ranks of uninsured included 301,700 people in 2010, about 10.6 percent of the population, according to an annual census by the Utah Department of Health. That's a slight improvement over the 314,300 Utahns who went without coverage in 2009, but statistically insignificant, say health officials. At Wednesday's monthly meeting of the legislative health reform task, the governor's health adviser, Norm Thurston, said Utah isn't interested in using its exchange to connect Utahns to these tax credits, which family advocates say is disappointing.

http://www.sltrib.com/sltrib/news/51840998-78/health-utah-uninsured-insurance.html.csp

Governor Hosts Officials from 30 States at Symposium 05/15/2011

As one of the first operational health exchanges in the nation, the Utah Health Exchange has garnered a lot of interest from other states. So much so that Governor Gary R. Herbert welcomed 79 top policy officials from 30 other states and Puerto Rico this week who came to Utah for a two-day symposium to learn more. Joined by a few federal officials and various private providers, symposium attendees heard about exchange development process, technology, operations, and future direction. "Utah is a national model for other states who are interested in building their own exchanges, either to comply with new federal laws or as a way of making insurance more accessible," said Utah Health Exchange Director Patty Conner.

http://www.utahbusiness.com/issues/articles/11048/2011/05/governor_hosts_officials_from_30_states_at_symposium

Vermont:

Vermont approves universal health program 05/16/2011

Vermont Gov. Peter Shumlin has pledged to sign a bill that paves the way for the state to launch a health system approaching a single-payer model later in the decade and to create a state health insurance exchange within the next several years.
http://www.ama-assn.org/amednews/2011/05/16/gvsa0516.htm

West Virginia:

State insurance commissioner to retire 05/18/2011

An official tasked with shepherding West Virginia through the intricacies of national health care reform announced her retirement Wednesday. West Virginia Insurance Commissioner Jane Cline plans to retire at the end of June, the Governor's Office announced. Perry Bryant, the executive director of West Virginians for Affordable Health Care, said the logical choices to replace Cline are Deputy Insurance Commissioner Bill Kenny or Jeremiah Samples, an official tasked with helping oversee the creation of a state health insurance exchange.
http://www.dailymail.com/News/statehouse/201105180674

- North Dakota Governor Jack Dalrymple and Washington Governor **Chris Gregoire** sign exchange legislation.
- North Carolina's bill passes the House Insurance Committee; New York and Nevada continue to hold stakeholder meetings.
- Minnesota GOP lawmakers rally against a Republican bill to establish an exchange and legislation is introduced in the Senate that prohibits the creation, operation, or existence of a health insurance exchange.
- The Robert Wood Johnson Foundation announced the launch of a new initiative designed to help states implement health insurance coverage provisions. Initially, the foundation will focus on ten states — Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island, and Virginia.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 05/06/2011 – 05/13/2011

Federal News

Cúram Software Announces Health Care Reform Solution to Enable States to Meet 2014 Mandates 05/10/2011

Cúram Software, the leading provider of Social Enterprise Management (SEM) software solutions, today announced Cúram for Health Care Reform, a commercial off-the-shelf solution that leverages a common system of record for enrollment and eligibility in order to provide critical functionality for families shopping for and enrolling in health care coverage.
http://insurancenewsnet.com/article.aspx?id=260193

Risk Adjustment Software to Support Health Care Reform 05/10/2011

Developed in 1991, the ACG System is an industry standard risk adjustment and predictive modeling software originally developed by a team of researchers from the Bloomberg School. The updated "ACG-HIE" software will be distributed to the newly formed state Health Insurance Exchanges (HIEs) and to health plans currently under contract with these Exchanges. This innovative technology will be distributed at no cost to facilitate health care insurance reform and encourage equitable care.
http://finchannel.com/Main_News/B_Schools/86449_Risk_Adjustment_Software_to_Support_Health_Care_Reform/

RWJF to help states expand coverage to uninsured 05/07/2011

The Princeton, N.J.-based healthcare foundation said it will support technical assistance, research, consumer engagement, online networking and leadership development to help extend coverage to millions more Americans. Starting with 10 states, the foundation will provide technical assistance to help set up insurance exchanges, make insurance market changes, expand Medicaid and streamline eligibility and enrollment in programs. Heather Howard, former New Jersey commissioner of Health and Senior Services, is leading this initiative.
http://www.modernhealthcare.com/article/20110507/NEWS/305079999/

State News

California:

California Scales Back Exchange Grant Ambitions 05/12/2011

One key nugget from the California Health Exchange board meeting yesterday: California will only be pursuing Level 1 exchange grant funding, rather than the Level 2 grant they'd committed to at last month's meeting. The Level 1 grant shores up funding

for the next year, whereas Level 2 — a more extensive application — would have secured funding through 2015. It's an interesting turnaround from just last week, when California Exchange Board member Kim Belshe told us that California was going "Level 2 or bust."
--Politico

Letter from California: Exchange Board Has Daunting Task 05/10/2011

California, which has had a long, sometimes-tortured history of trying to overhaul its health care markets, beat every other state last year when it passed a law creating a health insurance exchange – an online marketplace where millions of uninsured residents will be able to get insurance. Now the board overseeing the exchange must ensure that coverage on the exchange, which must be up and running in 2014, is affordable and easy to buy. It also must figure out how to administer federal subsidies to help lower-income people buy policies and make sure that the exchange attracts healthy as well as sick people. All in a state with very limited resources.
http://www.kaiserhealthnews.org/Stories/2011/May/10/california-health-care-exchange.aspx

Small firms unaware of health care perks 05/08/2011

Numerous studies conducted in California have revealed that small-business owners, including those in the Central Valley, don't know what they're missing with the federal health care law. Some 57 percent of small businesses statewide are unfamiliar with the tax credits, and 62 percent haven't heard of the health benefits exchange the state is establishing. That's according to a 2011 survey conducted by Pacific Community Ventures, an organization that helps businesses to create jobs in low-income communities.
http://www.modbee.com/2011/05/07/1678985/small-firms-unaware-of-health.html

Minnesota:

Minnesota rally highlights rift within GOP on bill to create state health insurance exchange 05/12/2011

Several GOP lawmakers spoke against a Republican bill to establish a state health insurance exchange. The federal law requires states to start exchanges for consumers to buy insurance starting in 2014. The exchange bill has nine Republican sponsors including Reps. Steve Gottwalt, Joe Hoppe, and Joyce Peppin. Supporters including business groups want Minnesota to set up the exchange instead of letting the federal government do it. GOP Sen. Gretchen Hoffman says opponents of the health care overhaul should fight the health insurance exchanges. She and several other Republican lawmakers are backing legislation to prohibit an exchange in Minnesota.
http://www.therepublic.com/view/story/5118146b043545f5884d53a7f3fb7b29/MN-XGR--Health-Care-Exchange/

Capitol Review: Gambling, Health Insurance and the Cedar Avenue Bridge 05/10/2011

***SF1343 was** introduced on May 2 to the Commerce and Consumer Protection Committee. The bill prohibits the creation, operation, or existence of a health insurance exchange in Minnesota. A health insurance exchange is defined as a selection of HMOs, PPOs and fee-for-service plans operating within a network and administered by private insurance companies.*
http://burnsville.patch.com/articles/capitol-review-gambling-taxes-health-insurance-and-the-old-cedar-avenue-bridge

Nevada:

Nevada insurers told new health care system won't spark client exodus 05/09/2011

While Nevada Department of Health and Human Services representatives asked for cooperation and patience, those pleas sometimes seemed to fall on deaf ears, as brokers worried that the creation of the Silver State Health Insurance Exchange would hurt their bottom lines.
http://www.lvbusinesspress.com/articles/2011/05/09/news/iq_44076286.txt

New Mexico:

Group holding meetings for public input on health care 05/11/2011

With the deadline for President Barack Obama's Affordable Care Act approaching in January of 2013, state organizations and officials are taking a look at health care possibilities for New Mexico. New Mexico First is holding community meetings in various locations around the state to get public input on whether a Health Insurance Exchange is right for New Mexico and if so, what kind of exchange will be right for state residents.
http://www.cnjonline.com/news/care-43279-meetings-deadline.html

New York:

New York Keeps Ball Rolling 05/12/2011
After the governor's office hosted a stakeholder meeting and the legislature held a hearing, the New York Insurance Department is kicking off its first round of public meetings on the health exchange. They'll host five meetings across the state, starting next Monday in Albany.
http://www.ins.state.ny.us/press/2011/p1105101.htm

North Carolina:

Industry bill on NC health exchange sails through committee; new taxes coming 05/10/2011
Today the bill pushed by NC Blue Cross that would take over the new health marketplace in NC created by the national health reform law passed the House Insurance Committee easily. Representative Verla Insko tried to eliminate new taxes on small businesses and individuals who buy health plans through the marketplace but was rebuffed. The bill passed easily despite a public hearing in the committee last month where not one person spoke in favor of the legislation.
http://pulse.ncpolicywatch.org/2011/05/10/industry-bill-on-nc-health-exchange-sails-through-committee-new-taxes-coming/

Oklahoma:

Legislators aiming for early adjournment 05/12/2011
The House is planning to adjourn a week early even though it means punting on developing a system where Oklahomans could shop for health insurance — an idea that has drawn the ire of many state Republicans, House Speaker Kris Steele said Wednesday. "I'm not sure we're going to see a piece of legislation coming through this year on the health insurance exchange network," said Republican Gov. Mary Fallin, who last month returned a $54.6 million federal grant to help set up the system. "We're frankly running out of time."
http://newsok.com/legislators-aim-for-early-adjournment/article/3567159

Oregon:

Insurance exchange bill on hold in Oregon House 05/13/2011
An Oregon lawmaker says the state House has reached an impasse on a health-insurance exchange bill because of disagreement over whether to allow it to negotiate for lower rates. The bill, which easily passed the Senate, included language prohibiting the exchange from negotiating for lower rates from insurance companies. State Rep Mitch Greenlick, the Democratic co-chair of the House Health Care Committee, said Thursday Democrats want to remove that language.
http://www.forbes.com/feeds/ap/2011/05/13/business-or-xgr-insurance-exchange_8465153.html

Oregon Rolls up its Sleeves 05/10/2011
Keep an eye on the Oregon House this week, where the Health Committee gets down to business working through Senate Bill 99, which cleared the Oregon Senate last month. The committee is so far mulling one change: an amendment that came up in a Friday hearing would bar the health exchange from limiting "the number of qualified health plans that may be offered through the exchange as long as the same limit applies to all insurers." Under the Senate version of the bill, the exchange would retain such power.
--Politico

Rhode Island:
R.I. gets aid in developing health-insurance exchange 05/12/2011

Rhode Island has been selected as one of 10 states that will receive specialized help in implementing the federal health-care law. The Robert Wood Johnson Foundation will provide research and technical assistance, valued at more than $1 million, starting in July and continuing through 2014. Rhode Island was selected through a competitive process to become part of the foundation's State Health Reform Assistance Network, which will help states expand insurance coverage and also share lessons learned with policymakers around the country.
http://www.projo.com/news/content/a10_fill_12_05-12-11_3PO1V5H_v6.2cd0c9f.html

Texas:

Kathleen Sebelius: The TT Interview 05/06/2011
In an exclusive on-camera interview with The Texas Tribune on Friday, U.S. Health and Human Services Secretary Kathleen Sebelius discussed the federal government's efforts to cooperate with a state like Texas, where GOP leaders have been hostile to the Affordable Care Act.
http://www.texastribune.org/texas-legislature/82nd-legislative-session/kathleen-sebelius-the-tt-interview/

Vermont:

Vermont moves toward single-payer 05/12/2011
When State House Bill 202 is signed by Vermont Governor Peter Shumlin on May 26th, it will be a big deal for Vermont's residents (who stand to benefit from a single-payer system), a big deal for insurance companies that have fought against the legislation and pharmaceutical companies that would be affected. But it will also be a big deal for the rest of us.
http://www.healthinsurance.org/blog/2011/05/12/vermont-moves-toward-single-payer/

Sanders to introduce single-payer bill 05/09/2011
Sen. Bernie Sanders (I-Vt.) and Rep. Jim McDermott (D-Wash.) will introduce a bill Tuesday to establish a single-payer health care system. The bill would establish state-based programs to administer coverage and set payment rates for providers. A federal board would set criteria for those offices. The new system would replace Medicare, Medicaid, CHIP and insurance exchanges established under the Obama administration's health care reform law.
http://www.kaiserhealthnews.org/Daily-Reports/2011/May/10/single-payer-bill.aspx

Washington:

Pro Exchange Watch: Washington Makes Six 05/12/2011
Washington state Gov. Chris Gregoire signs off on the state's exchange bill (H.B. 5445) and that will make the state the sixth, by Pro's count, to authorize a health exchange (North Dakota's exchange bill became law on Monday, after it sat on the governor's desk for 15 days without a signature).
--Politico

Exchange bills in Colorado, Hawaii, and Vermont prepare to go to the Governor to be signed.

- Oklahoma drafts a new bill "to allow Oklahoma to establish and operate its own Health Insurance Private Enterprise Network to facilitate access to health insurance and enhance competition in the individual and small employer health insurance markets." The "network" will be paid for with state and private funds; however, some conservatives are still wary of establishing any type of exchange.
- At least half of the states where exchange legislation has failed are now putting all options on the table, including expanding existing agencies and using executive orders to establish exchanges.
- Measures opposing the health care law are pending in more than 30 states. Twenty-six states have signed on to the Florida lawsuit and about 12 states have introduced legislation to enter into interstate compacts.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 04/29/2011 – 05/06/2011

Federal News

More States Trying to Get Around Implementation of Health Law 05/04/2011

While the U.S. House works to defund the health care law, more states are attempting to avoid implementing it. Challenges to or measures opposing the health care law are pending in more than 30 states, according to the National Conference of State Legislatures. Twenty-six states have signed on to the Florida lawsuit questioning the constitutionality of the law. About 12 states have introduced legislation to enter into interstate compacts as a way to circumvent it.
http://nationaljournal.com/healthcare/more-states-trying-to-get-around-implementation-of-health-law-20110504

Treasury, IRS Seek Public Input on Certain Employer Provisions of the Affordable Care Act 05/03/2011

The Treasury Department and Internal Revenue Service today requested public comment on issues relating to the shared responsibility provisions included in the Affordable Care Act that will apply to certain employers starting in 2014. Under the Affordable Care Act, employers with 50 or more full-time employees that do not offer affordable health coverage to their full-time employees may be required to make a shared responsibility payment. The law specifically exempts small firms that have fewer than 50 full-time employees. This provision takes effect in 2014.
http://www.irs.gov/newsroom/article/0,,id=239023,00.html

House acts to cut money for key part of health law 05/03/2011

The House Republican drive to dismantle the new health care law piece by piece advanced Tuesday with a vote to disrupt the flow of federal dollars for health insurance exchanges, an integral part of the law's goal of expanding insurance coverage. The bill is mainly a vehicle for Republicans to restate their case against the health care law enacted last year, since the Democratic-led Senate is likely to ignore it and the White House issued a veto threat in the event it passed.
http://news.yahoo.com/s/ap/20110503/ap_on_go_co/us_congress_health_care_law_2

States look for options as health exchange laws fail 05/02/2011

At least half of the states where exchange legislation has failed are now putting all options on the table, including expanding existing agencies and using executive orders, which would allow them to establish the health reform centerpiece without the support of their state legislatures. Other states are eyeing executive orders as a means of accomplishing what their legislatures could not. Both Arkansas and Georgia are looking at potentially establishing an exchange via executive order. Other states are in discussions with HHS about what options might be available to them. Montana Insurance Commissioner Monica Lindeen has

discussed with the federal government possible alternative plans after multiple health exchange bills died in the Republican-controlled Legislature.
--POLITICO

Psilos Group's New Healthcare Outlook Report Predicts Health Reform Will Radically Transform the Relationship between Consumers and Insurers 05/03/2011

The HIX purchasing model is already taking hold in the retiree healthcare market, where many private companies are successfully migrating retirees over the age of 65 from group model Medicare supplemental plans to individual Medicare supplemental and Medicare Advantage policies subsidized by an employer-funded defined contribution. More than 200,000 retirees today buy policies on the private health insurance exchange developed by San Mateo-based Extend Health, Inc., the largest of its kind so far.
http://www.sys-con.com/node/1816345

State News

California:

"LEVEL 2 OR BUST" 05/03/2011

California is strongly committed to pursuing the more extensive health exchange grant that would provide funding for the marketplace up until 2015, California Health Exchange Board member Kim Belshe told reporters in California on Monday. That "Level Two" funding for a health exchange is the more extensive — and more labor-intensive — health exchange grant that states can pursue and commits the state to establishing a health exchange. The other option: "Level One" funding for another, single year of health exchange planning. Belshe says California is aiming to have the application, which can come in between March of this year through June of 2012, by September.
--POLITICO

Colorado:

'Amycare?' 'Bettycare?' Colorado's health exchange headed for final passage 05/04/2011

An unprecedented bipartisan coalition of business advocates, health industry leaders and consumer representatives showed up in droves at the Capitol on Tuesday to support SB 11-200. Lawmakers approved the measure in the health committee by a 9-to-4 vote. Later in the full House the measure was approved on a voice vote. In the end, Stephens dropped the "opt-out" amendment and attached language Tuesday that asserts states' rights, but creates no roadblocks for Democratic support. Proponent's steamrolled Tea Party activists and some traditional conservatives who believe establishing a health exchange means Colorado is capitulating to the federal government. The bill will need final approval in both the House and Senate.
http://www.healthpolicysolutions.org/2011/05/04/%e2%80%98amycare%e2%80%99-%e2%80%98bettycare%e2%80%99-colorado%e2%80%99s-health-exchange-headed-for-final-passage/

Hawaii:

Hawaii Sends Bill to Gov 05/03/2011

Both bodies of the Hawaii Legislature voted Tuesday afternoon to send an exchange bill to Gov. Neil Abercrombie, a Democrat expected to sign off on the bill. It might not be soon, though; he has 45 days to weigh in on the legislation after it hits his desk. Still, the state wants to move quickly on health reform. As insurance commissioner Gordon Ito told PULSE when we caught him at NAIC in March, "Our issue isn't slowing down. It's that we can't move fast enough."
--POLITICO

Maryland:

Health Plan Comparison Web Portal Launched With Benefitfocus Technology 05/03/2011

Benefitfocus and the Maryland Health Care Commission (MHCC), today announced the launch of an information only health plan comparison portal, named VIRTUAL COMPARE. Using technology developed by Benefitfocus, the portal allows small businesses throughout the State of Maryland to research and compare health plans online, in the same way consumers shop and research other products online. Aetna, CareFirst BlueCross BlueShield, Coventry Health Care, Kaiser Permanente and UnitedHealthcare offer various insurance products on the VIRTUAL COMPARE site. Using a Software as a Service (SaaS) model, Benefitfocus hosts, updates and manages the configuration and presentation of health plans on the VIRTUAL COMPARE portal.
http://www.prnewswire.com/news-releases/health-plan-comparison-web-portal-launched-with-benefitfocus-technology-121153424.html

Missouri:

Conflicts of interest could doom 'Show Me"' health insurance exchange 05/02/2011
Molendorp, R-Belton, has done the seemingly impossible. He has crafted and advanced legislation that would authorize the creation of the "Show-Me Health Insurance Exchange." Mr. Molendorp has won the confidence of his House colleagues and the trust of advocates for the uninsured. The bill passed on a vote of 157-0 in the House and is expected to be heard in the Senate later this week.
http://www.stltoday.com/news/opinion/columns/the-platform/article_d3045438-f598-578b-b02b-70bb88881ee7.html

New Hampshire:

NH House votes to send health care funds back 05/04/2011
The New Hampshire House voted Wednesday to send back to the federal government any money the state receives to implement the federal health care reform law. Lawmakers also directed the attorney general to join states suing to block the federal law. Meanwhile, the Senate voted Wednesday to ask the state Supreme Court if lawmakers have the constitutional power to order the attorney general to join the states suing to block the Affordable Care Act.
http://www.boston.com/news/local/new_hampshire/articles/2011/05/04/nh_house_votes_to_send_health_care_funds_back/

Oklahoma:

Health Care Authority on exchange: 'all grant activities have ceased' 05/04/2011
Senate Bill 971 will be sponsored in the upper chamber by Sens. David Myers and Clark Jolley. Language in the new bill tracks closely with the outline of provisions provided at the April 14 press conference where Governor Mary Fallin announced the state would reject the $54.6 million federal grant. The new bill's purpose, according to its current draft, is "to allow Oklahoma to establish and operate its own Health Insurance Private Enterprise Network to facilitate access to health insurance and enhance competition in the individual and small employer health insurance markets. The measure would create a "Health Insurance Private Enterprise Network" designed as "a state-beneficiary public trust."
http://www.tulsatoday.com/index.php?option=com_content&view=article&id=2556:health-care-authority-on-exchange-all-grant-activities-have-ceased&catid=60:state&Itemid=108

Washington:

Health insurance exchange draws praise, ridicule 05/01/2011
Intended to improve access to affordable health insurance coverage for individuals and small employers, the state's new health insurance exchange has six goals: 1) Reduce the number of uninsured and increase access to care. 2) Ensure greater accountability and transparency. 3) Increase the portability and continuity of coverage. 4) Simplify the health insurance purchase. 5) Increase competition in the health insurance marketplace. 6) Drive quality improvement and cost containment.
http://www.spokesman.com/stories/2011/may/01/a-healthy-exchange/

West Virginia:

Working people get health-care break 04/30/2011

Working people who earn less than $43,000 a year can still sign up for almost-free, nonhospital medical care through the state's West Virginia Connect program. Since December, about 7,100 have enrolled in the 10,000-person demonstration program, operated by the state Department of Health and Human Resources through seven community health centers. There are 2,900 slots left. The federally funded program is a trial run for health-care reform, said Rick Brennan, project director. "Connect will help us find out what happens when large numbers of people get care from a true medical home, with follow-up, health screening and dietary help."
http://sundaygazettemail.com/News/201104301564

Vermont:

Vermont lawmakers reach agreement on health care 05/03/2011

Major health reform legislation working its way through the Vermont Legislature has won final approval in the Senate, with the House expected to follow suit. It's expected to be at least next week, if not the week after, before Gov. Peter Shumlin signs the bill into law.
http://www.boston.com/news/local/vermont/articles/2011/05/03/vermont_lawmakers_reach_agreement_on_health_care/

Vt. lawmakers resolve immigrant health care issue 05/03/2011

Vermont Senate negotiators dropped an amendment to bar illegal immigrants from coverage under a new state health care program, delivering a victory Monday evening to human rights activists who had rallied repeatedly at the Statehouse to demand the change.
http://www.forbes.com/feeds/ap/2011/05/03/business-us-vt-health-care-immigrants_8446801.html

Illegal immigrants may find Vt. health care bill not quite 'universal' 04/29/2011

As proposed by the Shumlin administration and passed by both House and Senate, the sections of the bill dealing with the exchange say a person qualified to be in the exchange "is reasonably expected to be during the time of enrollment, a citizen or national of the United States or a lawfully present immigrant in the United States as defined by federal law."
http://www.dailyjournal.net/view/story/a536271571394a9bb171b446fbc03970/VT--Health-Care-Immigrants/

- Colorado, Oregon, and Vermont's exchange bills pass the Senate, while North Dakota's bill goes to the Governor to be signed.
- Minnesota introduces a bill banning the establishment of health care exchange and the Colorado House advances a bill to opt out of federal health reform.
- Montana's Commissioner of Securities and Insurance asks the legislature to grant her the authority to build the exchange without a bill.
- A CBO report shows Congress could save $14B by repealing exchange implementation grants, but the total effect of eliminating those grants is higher because doing so could lead to delays and challenges in establishing the exchanges, making them less attractive to potential customers.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 04/22/2011 – 04/29/2011

Federal News

Some Employers Already Sending Workers to Exchanges to Buy Health Insurance 04/29/2011

Fed up with the unpredictable cost of health insurance for his small business, Mike Sarafolean last year made a dramatic change: Instead of picking a plan to offer workers, he now sends them to a "private exchange" or marketplace where they compare and choose their own insurance. The amount his company pays for coverage is capped. The private exchanges, mainly run by former insurance executives and employee benefit consulting firms, operate in more than 20 states.
http://www.kaiserhealthnews.org/Stories/2011/April/29/private-health-exchanges.aspx

AAFP Releases Principles for Health Insurance Exchanges 04/27/2011

As states move forward with creating the individual state health insurance exchanges called for in the Patient Protection and Affordable Care Act, the AAFP has created a set of eight principles designed to help its constituent chapters address insurance exchange issues with state legislators and regulators.
http://www.aafp.org/online/en/home/publications/news/news-now/government-medicine/20110427exchangeguidance.html

CBO: Repealing health law's exchange grants would save $14B 04/27/2011

Congress could save roughly $14 billion over the next decade by repealing grants to help states set up the health insurance exchanges established by healthcare reform, according to the Congressional Budget Office. CBO also said eliminating the planning grants would lead fewer people to enroll in the exchanges. The House Energy and Commerce Committee passed a bill earlier this month to repeal the planning grants.
http://thehill.com/blogs/healthwatch/health-reform-implementation/158081-cbo-cutting-exchange-grants-saves-14b

Aon Hewitt Establishes a Health Care Exchange for Corporate Clients 04/27/2011

Aon Hewitt, the global human resource consulting and outsourcing business of Aon Corporation, announced plans to offer a corporate health care exchange to employers nationwide, targeting 1,000 or more full-time employees, beginning as early as 2012. Aon Hewitt has been providing and administering retiree medical exchanges for several years. In anticipation of changes to the insurance market, the organization is extending its exchange model as a viable option for active employees.
http://www.prnewswire.com/news-releases/aon-hewitt-establishes-a-health-care-exchange-for-corporate-clients-120771919.html

Small business owners tussle with health care reform decisions 04/25/2011

Small business owners across the country are trying to figure out their best financial options in how to provide their employees with health insurance, come the health care reform mandates in 2014.

http://marketplace.publicradio.org/display/web/2011/04/25/am-small-business-owners-tussle-with-health-care-reform-decisions/

State News

California:

State commissioner seeks ability to regulate health insurance rates 04/29/2011

A law that took effect Jan. 1 gives the commissioner the ability to review health insurers' rate proposals. But if the California Department of Insurance finds a proposed increase to be excessive or unwarranted, Commissioner Dave Jones cannot modify the proposal. Rather, he says, his recourse with health insurance companies is "to sentence them to my website." Now Jones is backing legislation that would give him the teeth to do something more than simply offering an online warning to consumers.

http://www.vcstar.com/news/2011/apr/28/state-commissioner-seeks-ability-to-regulate/

Colorado:

Colorado small-business leader urges GOP to pass health-exchanges bill 04/29/2011

In a blunt open letter, the state's leading group for small businesses called upon Republicans on Thursday to stand up to Tea Party activists who oppose a bill that would set up health insurance exchanges. In the letter, titled "Time for Republicans to Vote for What They Believe In," Tony Gagliardi, state director for the National Federation of Independent Businesses, said Republicans need to line up behind Senate Bill 200. He said passage of the bill is "the largest issue facing Colorado small business in at least a decade."

http://www.denverpost.com/legislature/ci_17954752

Insurance exchange clears Colorado Senate 04/27/2011

The Democratic Senate gave final approval Wednesday to a bill that would set up a state exchange. Democrats overruled the GOP and passed the exchange 20-15 in a party-line vote. That sets up an interesting second act for the health exchange bill in the House. The House is ruled by Republicans, and GOP leader Amy Stephens is a co-sponsor of the proposal. Stephens later said she would support the exchange plan only if Colorado also seeks a waiver from other provisions of the health care act. She says she is working to come up with an exchange plan both parties accept. But the Republicans' slim one-vote majority in the House means the exchange measure doesn't need every Republican there to agree.

http://www.forbes.com/feeds/ap/2011/04/27/business-us-health-exchange-colorado_8437838.html

House panel advances bill to opt Colorado out of federal health law 04/27/2011

A Republican-backed bill allowing Colorado to opt out of the federal health law moved forward Tuesday after a hearing that featured division among Tea Party activists and talk of "death lists" and "microchips." The House Health and Environment Committee approved House Bill 1273 on a 7-6, party- line vote, sending it to the House Appropriations Committee, which must approve it before it can go to the full Republican-led House.

http://www.denverpost.com/legislature/ci_17935807

Montana, North Dakota and Colorado move forward on health exchanges 04/26/2011

In Colorado, a measure that would establish a nine member board to develop the exchange has preliminary approval but faces Republican opposition in the House. Two amendments requiring Gov. John Hickenlooper to receive a federal waiver from health care reform before the exchanges would go into place and banning the state from taking any federal money for the exchange failed along party lines. These amendments may come up again as the bill moves through the house.

http://civsourceonline.com/2011/04/26/montana-north-dakota-and-colorado-move-forward-on-health-exchanges/

Georgia:

Georgia's legislative session: Lawmakers leave plenty for next time 04/22/2011
A common-sense proposal offered this year would have enabled a health insurance exchange. GOP leaders agreed to pull back the legislation under pressure from tea party activists who saw the measure as giving ground in the fight against federal health care legislation. That's a short-sighted, unfortunate decision that will hit hardworking Georgians squarely in their pocketbooks. Lawmakers should work hard to explain this point to their constituents before next session. Georgia should be leading the nation in establishing insurance pools, an idea long advocated by fiscal conservatives.
http://www.ajc.com/opinion/georgias-legislative-session-lawmakers-921820.html?cxtype=rss_news_128746

Minnesota:

GOP legislators introduce bill banning establishment of health care exchange 04/26/2011
Republican House members have introduced legislation that would prohibit creation of a health insurance exchange as proscribed by the 2010 federal health care overhaul. Rep. Doug Wardlow, R-Eagan, is the chief author of the bill. Eight other Republican legislators are co-sponsors.
http://politicsinminnesota.com/blog/2011/04/gop-legislators-introduce-bill-banning-establishment-of-health-care-exchange/

Missouri:

Open Forum on Health Care Bill to be Held at Town Hall Meeting on Tuesday 04/24/2011
In a town hall meeting at Benton High School on Tuesday, the Missouri Foundation will answer questions residents have about the Affordable Care Act that was signed into law last year. Since May of last year, the Missouri Foundation for Health has done 85 of these presentations in an effort to clear up any questions people have on the law that has been unofficially coined "Obamacare".
http://topnews.us/content/239058-open-forum-health-care-bill-be-held-town-hall-meeting-tuesday

Montana:

Montana, North Dakota and Colorado move forward on health exchanges 04/26/2011
In Montana, Republicans in the state legislature oppose the implementation of the exchange through federal money leading the state insurance commissioner to apply for authority to move forward on her own. Montana has received a $1 million grant from the federal government to set up its exchange but Republicans in the statehouse sent a measure to the Governor that would prohibit the state from using those funds or from setting up an exchange. The Governor vetoed the measure creating a deadlock in terms of what the state can do. Yesterday, Monica Lindeen, the MT Commissioner of Securities and Insurance, asked the legislature to grant her the authority to build the exchange on her own without a bill.
http://civsourceonline.com/2011/04/26/montana-north-dakota-and-colorado-move-forward-on-health-exchanges/

New York:

New York Agents Want Say in State Health Exchange 04/29/2011
Jack Smith, executive vice-president of William A. Smith & Son Insurance in Newburgh, a board member of the Independent Insurance Agents and Brokers of New York (IIABNY), told lawmakers that consumers need agents' help in evaluating coverage. "What we would really like to see is a continued role for an advisor like an insurance agent or broker in the exchange," Smith said. "Consumers need a trusted advisor, a licensed advocate who understands the laws and markets in New York State."
http://www.insurancejournal.com/news/east/2011/04/29/196639.htm

Designing an insurance exchange 04/28/2011
Creating a new public authority to oversee a state health insurance exchange appears to have widespread support among stakeholders in New York. A public authority has "more advantages than disadvantages," said Peter Newell, co-director of the Health Insurance Project at the United Hospital Fund. Newell wrote an analysis of the options that includes running the exchange through a state agency, nonprofit or public authority. A public authority is independent, has a public board, more flexibility than a state agency, and is subject -- with some exemptions -- to open meeting and Freedom of Information laws.

http://www.timesunion.com/default/article/Designing-an-insurance-exchange-1355681.php

North Carolina:

Advocates question timing, seats on state health insurance board 04/22/2011

A state advocacy group is questioning the candor surrounding a House bill that gives the state authority to regulate the health insurance market by establishing the North Carolina Benefit Exchange. Democracy North Carolina, a self-proclaimed nonpartisan organization, objects to the bill's top two sponsors. One, Rep. Jerry Dockham, R-Davidson, is a former insurance professional, and both were large recipients of hefty political campaign contributions from health insurers as well as other institutions that will be represented on the exchange.

http://www.the-dispatch.com/article/20110422/NEWS/304229989/-1/NEWS?Title=Critics-call-health-insurance-bill-a-conflict-of-interest-for-those-debating-it

North Dakota:

Legislators move health care exchange forward 04/25/2011

The Senate passed legislation Monday that, while not committing North Dakota to running the program, puts in place a framework for creating the health insurance exchange required under federal health care reform. It now goes to the governor to be signed. Under House Bill 1126, the state Insurance Department will work with the state Human Services Department to plan the exchange, which serves as a cost and quality of coverage comparison tool. The program also should serve as a portal for people to check their eligibility for public programs like Medicaid and then enroll.

http://www.bismarcktribune.com/news/local/govt-and-politics/2011_session/article_a19026dc-6f83-11e0-94fe-001cc4c03286.html

Montana, North Dakota and Colorado move forward on health exchanges 04/26/2011

In North Dakota, a measure is set to go to the Governor for his signature that will establish the framework for a health exchange in line with federal health care reform requirements. North Dakota is eligible for $27 million in grants from the federal government for exchange development, but not unless a plan is approved. The measure slated to go to the Governor does not put North Dakota in charge of running the exchange but it does establish a framework to create one. However, a competing bill in the legislature would prohibit the state from setting it up.

http://civsourceonline.com/2011/04/26/montana-north-dakota-and-colorado-move-forward-on-health-exchanges/

Oregon:

Oregon Politics Roundup: Senate passes health care exchange; two governors agree on Columbia River bridge design; David Wu and more 04/26/2011

The Oregon Senate approved a bill aimed at offering health insurance to all Oregonians through an "exchange" or marketplace of coverage choices. The bill allows the state to use $48 million in federal grants meant to expand health coverage to more people.

http://www.oregonlive.com/politics/index.ssf/2011/04/oregon_politics_roundup_senate.html

GOP agrees to advance grant application to develop infrastructure for Oregon health exchange 04/26/2011

Republicans in the Oregon House have agreed to advance a bill that would allow the state to accept a $48 million grant to create the computer infrastructure for a health insurance exchange. Republican state Rep. Dennis Richardson said Tuesday the bill will get a committee hearing on Friday. The bill had been caught up in a key budget committee over GOP concerns about the state's record on managing large information technology projects

http://www.dailyjournal.net/view/story/70d098b5e0d14839964976cdc3502966/OR-XGR--Health-Exchange/

Oregon's consumer health insurance exchange 04/23/2011

Under the proposed health insurance exchange for Oregon - Senate Bill 99 - some 350,000 people will have access to affordable, quality health care through a central marketplace where carriers will have to compete on quality and value. For the first time,

we will have apples-to-apples information about health insurance and will know exactly what we are buying. Oregon small businesses will be able to give their employees a set amount of money to buy coverage on the exchange, giving them more choices. And people who leave their jobs will have the option to keep their coverage. ***By Mike Bonetto, Governor Kitzhaber's health policy advisor and a member of the Oregon Health Policy Board.***
http://www.blueoregon.com/2011/04/oregons-consumer-health-insurance-exchange/

Utah:

A Closer Look: Utah's Health Insurance Exchange 04/26/2011
In most states, responsibility for designing health insurance exchanges is vested in departments of health and human services. Not in Utah. Its exchange, which was created in 2007, resides in the governor's Office of Economic Development. That's because Utah views insurance for small businesses as a key economic development driver. Not surprisingly, Utah Gov. Gary Herbert turned to the private sector to recruit former Ceridian executive Patty Conner. Since last December, Conner has served as the new director of Utah's health exchange. With a budget of $600,000 and a staff of just two, it's her job to roll out what has emerged as the model exchange for conservatives. I recently spoke with Conner and the Office of Economic Development communications director Michael Sullivan about how Utah's exchange is progressing.
http://www.governing.com/topics/health-human-services/closer-look-utah-health-insurance-exchange.html

Vermont:

Vermont 'Single-Payer' Gateway Bill Passes Senate 04/27/2011
The Vermont Senate brought the state close to beginning work on a single-payer health system with a 21-9 vote on a bill establishing a health insurance exchange. The bill, H. 202, will go back to the House, which approved a previous version in a 92-49 vote. Supporters praised the April 26 Senate vote, saying the changes made did not weaken the legislation and even included changes preferred by key House lawmakers. The Senate vote was mostly along party lines, with one Republican joining the majority Democrats in support.
http://insurancenewsnet.com/article.aspx?id=258049

Wisconsin:

State weighing Medicaid shift 04/29/2011
Wisconsin's new Office of Free Market Health Care, created by Gov. Scott Walker to set up the health insurance exchange required by the federal health care law, is considering moving Medicaid recipients into private plans offered on the exchange. Such a move could reduce state costs and expand options for Medicaid recipients, but one critic questions what protections would remain for patients under such a "privatized" system.
http://www.milwaukeenewsbuzz.com/?p=586891

California will share data with Early Innovator states, taking Oklahoma's place; Colorado's bill clears a procedural Senate committee; and Minnesota's Chamber of Commerce supports the establishment of an exchange.

- Connecticut and New York hold stakeholder meetings, while Wisconsin gathers feedback from an online survey.
- Idaho Gov. Butch Otter vetoed a bill that would have nullified federal health care reform in the state because he was concerned it would prevent the state from setting up its own exchange.
- Gov. Deal of Georgia signs the interstate health care compact into law, while the House of Representatives in Texas give the compact their initial approval.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 04/15/2011 – 04/22/2011

State News

California:

Here, Take Oklahoma's Seat 04/21/2011

The federal government has asked California to share information with the six Early Innovator states (seven until Oklahoma dropped out last week). California did not apply for the program but state Health and Human Services Secretary Diana Dooley announced Wednesday that the state will share that data. The state will apply for the next round of exchange grants by September 2011, a move the California HHS staff roundly recommended.
--Politico

State Health Benefit Exchange Has First Meeting 04/20/2011

The state's new Health Benefit Exchange, which will sell health insurance to individuals and small business owners starting in 2014, had its first meeting Wednesday in Sacramento. On the agenda for the four-member board: applying for federal grants that will pay for operation of the exchange. The board members include Susan Kennedy and Kim Belshe, both former aides to former Gov. Schwarzenegger; Diana Dooley, California Health and Human Services Secretary; and Paul Fearer, of Union Bank. A fifth member has yet to be named by state Senate President Pro Tem Darrell Steinberg.
http://www.baycitizen.org/blogs/pulse-of-the-bay/state-health-benefit-exchange-has-first/

Connecticut:

Health Insurance Exchange Forums 04/20/2011

The State of Connecticut announced five upcoming public forums on Health Insurance Exchange development to be conducted throughout the state during the months of April and May. These forums will provide Connecticut residents an opportunity to give feedback on exchange design as well as learn about the purpose and functions of an exchange. For more information, visit http://www.ct.gov/opm/cwp/view.asp?a=3072&Q=471284.
http://tolland.patch.com/articles/health-insurance-exchange-forums-an-easter-egg-hunt-and-a-fenway-park-anniversary

Colorado:

Colorado health exchange bill alive, for now 04/19/2011

A Colorado proposal to set up a health insurance marketplace is moving ahead in the Colorado Legislature. But it's still unclear whether the insurance exchange will overcome Republican opposition this year. A procedural committee cleared Senate Bill 200 for debate by the full Senate, with four Republican senators voting against it.

http://www.businessweek.com/ap/financialnews/D9MMT4QG0.htm

Georgia:

Georgia Gov. Deal signs health care compact bill into law 04/20/2011

Gov. Nathan Deal has signed legislation that would have Georgia join a proposed interstate health care compact, seen as a snub of the federal health law. The law would allow Georgia to create alliances with other states on health care. Compact bills have been popping up in several states, pushed by tea party groups as part of a national states' rights push.

http://www.therepublic.com/view/story/e0899aaf1372480094f63ea193333cb7/GA--Health-Care-Compact/

Idaho:

Idaho governor blocks federal health care reform law 04/21/2011

Gov. C.L. "Butch" Otter, a Republican, issued an executive order Wednesday prohibiting state agencies from implementing the controversial law. Otter's order states that "no executive branch department, agency, institution or employee of the state shall establish or amend any program or promulgate any rule to implement any provisions" of the law. Otter vetoed a bill passed by the GOP-dominated state legislature that, similar to his order, would block implementation of the law. The governor said he was concerned the bill would prevent Idaho from setting up a state-run health insurance exchange and inadvertently allow Washington to do so instead.

http://www.cnn.com/2011/POLITICS/04/21/idaho.health.care.reform/index.html?hpt=T2

Otter vetoes revised nullification bill 04/20/2011

Idaho Gov. Butch Otter has vetoed HB 298, the final version of a much-debated legislative effort to "nullify" the federal health care reform law. The bill declared that Idaho wouldn't comply with discretionary provisions of the law for one year, made various declarations, and prohibited the state from accepting federal money to implement the federal law or from moving to set up a health care exchange. However, Otter said Idaho can set up its own health care exchange regardless of the national law - and if it doesn't, under the law, the federal government could step in and set up Idaho's exchange.

http://www.spokesman.com/stories/2011/apr/20/otter-vetoes-revised-nullification-bill/

Iowa:

Let Washington fashion health options 04/18/2011

Sen. Jack Hatch has been involved in crafting legislation to create Iowa's exchange. His bill was on the right track by helping ensure transparency and prevent insurance industry insiders from running the show. But his fellow Democrat, Sen. Tom Rielly, an insurance agent, insisted on adding a provision that would force Iowans to go through a licensed insurance agent to get to get coverage in an exchange. His provision would guarantee those agents a commission of at least 5 percent of the cost. That would likely lead to health insurance costing more. Now Democrats can't come to an agreement to drop this provision. Republicans, including Gov. Terry Branstad, aren't stepping up with good ideas for Iowa's exchange.

http://www.desmoinesregister.com/article/20110419/OPINION03/104190335/1091/SPORTS02/?odyssey=nav%7Chead

Maryland:

Maryland must consider creating multi-state health exchange 04/22/2011

Maryland must study setting up a regional health insurance exchange with neighboring states as part of a bill signed into law April 12 by Gov. ***Martin O'Malley****. The legislation — formally House Bill 166 and Senate Bill 182 — requires the state's soon-to-be-appointed nine-member board overseeing the exchange to submit a report to the Maryland General Assembly by next year's session.*
http://www.bizjournals.com/baltimore/print-edition/2011/04/22/maryland-must-consider-creating.html

Massachusetts:

Massachusetts, pioneer of universal health care, now may try new approach to costs 04/15/2011

Five years ago this week, Massachusetts became the first state to move toward universal health insurance, foreshadowing the 2010 federal health-care overhaul. Now, the commonwealth is debating whether to become a role model again — by replacing the fee-for-service system that has long defined U.S. medicine. The governor's plan — stirring an impassioned debate inside the gold-domed State House on Beacon Hill and among players in the state's vaunted health-care industry — would make Massachusetts the only state to promote wholesale new arrangements of "integrated care."
http://www.washingtonpost.com/national/massachusetts-pioneer-of-universal-health-care-now-may-try-new-approach-to-costs/2011/04/07/AFDrunkD_story.html

Centene Corporation's Celtic Unit Renews Commonwealth Care Contract with Massachusetts 04/15/2011

Centene Corporation (NYSE: CNC) today announced that Celtic Group's subsidiary, CeltiCare Health Plan of Massachusetts, Inc. (CeltiCare), has renewed its contract with the Commonwealth of Massachusetts to serve Commonwealth Care members, effective July 1, 2011. CeltiCare will continue to be a lowest-cost health plan option for low-income, working adults (up to 300% of the federal poverty level) enrolled in the Commonwealth Care program.
http://www.sunherald.com/2011/04/15/3030221/centene-corporations-celtic-unit.html

Minnesota:

St. Paul City Council supports single-payer health care in state 04/21/2011

The St. Paul City Council passed a resolution Wednesday supporting the Minnesota Health Plan, a proposal that's floating around the Legislature (but not yet close to passing) for single-payer, universal health care in the state. The Minneapolis and Duluth city councils previously have voted to support the plan, too.
http://www.minnpost.com/politicalagenda/2011/04/21/27685/st_paul_city_council_supports_single-payer_health_care_in_state

DFL, GOP both open to deal on health vouchers 04/20/2011

Amid the politics of doom and confrontation in St. Paul, some key legislators are considering compromise over a potentially explosive Republican proposal to partly privatize Minnesota's public health care programs and require some low-income residents to buy their own insurance. Republicans hope the experiment will lead to greater privatization of government health programs; DFLers see it as a path to faster implementation of health care ''exchanges.''
http://www.startribune.com/politics/statelocal/120327504.html

Chamber wants to shape health care exchange 04/16/2011

While the Chamber of Commerce has been far from supportive of the health reform act, the business group is pushing to get a law passed this session to create a taxpayer-funded exchange. It's doing so even as many businesses remain hostile to the idea and newly elected business-friendly Republicans have vowed to stymie implementation of the federal law.
http://www.startribune.com/business/119938344.html

Mississippi:

Chaney had a health exchange backup all along 04/17/2011

As commissioner, he said he has the authority to choose an entity to operate the federally mandated health exchange, which is part of the administration's health care law and will serve as a one-stop shop for insurance consumers. He selected the Comprehensive Health Insurance Risk Pool Association, a nonprofit that provides coverage to those who are not eligible for private insurance because of health conditions.
http://www.hattiesburgamerican.com/article/20110418/OPINION/104180301/Chaney-had-health-exchange-backup-all-along

New Hampshire:

We need ObamaCare Plan B 04/20/2011
While I and others across the county and in Washington continue to work toward the repeal of this federal legislation, as an elected official here in New Hampshire, it is my responsibility to ensure our state is on the right track should those repeal efforts fail. To create a viable second path, I believe we should take advantage of available federal planning grants - provided no strings attached - to meet the requirements of ObamaCare in the event repeal attempts prove unsuccessful. This is why I've advocated accepting a $666,000 federal grant to study the establishment of a health insurance exchange here in the Granite State. – Senator Ray White
http://www.concordmonitor.com/article/252319/we-need-obamacare-plan-b

New York:

Cuomo administration meets with stakeholders on insurance exchanges 04/21/2011
*New York Gov. **Andrew Cuomo**'s administration met for the first time Thursday with about 150 stakeholders to start creating a health insurance exchange for small businesses and consumers. If the Business Council of New York State gets its wish, the exchange will be market-based rather than grounded on a Medicaid foundation. The group also wants businesses to be able to comparison shop for health insurance in and outside of the exchange, said Maggie Moree, the group's director of federal affairs. The group also doesn't want the state to be the exchange's regulator as well as its operator. The Department of Insurance should continue as regulator, it says, adding that private models could be adapted to meet the state's objectives for the exchange.*
http://www.bizjournals.com/albany/news/2011/04/21/stakeholders-met-for-first-time-on.html

Oklahoma:

Health Insurance Exchange Do-Over 04/14/2011
There will be another bill in the Legislature this year setting up a health insurance exchange in Oklahoma, but it will NOT be paid for with federal money. Governor Mary Fallin told reporters today that, "we will not receive any of the $54-million Early Innovator grant" from the federal government. She says the bill will instead create the Health Insurance Private Enterprise Network, a public entity trust governed by a seven member board that will include the State Insurance Commissioner, members of the insurance industry and consumers.
http://oklahoma.watchdog.org/1796/health-insurance-exchange-do-over/

Oregon:

Senate Committee Passes Exchange Bill without Consumer Amendments 04/15/2011
Members of the Senate Committee on Health Care, Human Services and Rural Health unanimously passed Senate Bill 99 with amendments. Sen. Chip Shields (D-N/NE Portland) said he voted for the bill out of courtesy even though he disagreed with several provisions. Details that allow insurance brokers into the exchange, loosens the restrictions on conflicts of interest for board members and limits the board's ability to negotiate for lower insurance prices led a coalition of healthcare consumer advocates to oppose the bill. The coalition includes more than a dozen organizations from Oregon State Public Interest Research Group, AARP of Oregon, SEIU and the Oregon Nurses Association.
http://www.thelundreport.org/resource/senate_committee_passes_exchange_bill_without_consumer_amendments

Texas:

House Gives Early OK to Health Care Compact 04/20/2011

On Wednesday, House lawmakers put their initial stamp of approval on a health care compact — a partnership with other states to ask the federal government for control over Medicaid and Medicare in Texas. But opponents say the proposal won't get much traction in Washington, where the Obama administration is unlikely to cede authority over the programs that provide health care for children, the disabled, the elderly and the very poor.
http://www.texastribune.org/texas-health-resources/health-reform-and-texas/house-gives-early-ok-to-health-care-compact/

Ogden Revives Key Piece of Federal Health Reform 04/19/2011

Implementing a key piece of federal health care reform in Texas — something Gov. Rick Perry has expressed his firm opposition to — may be back on the table. A bill authored by the influential chair of the Senate Finance Committee, Sen. Steve Ogden, R-Bryan, would create a state health insurance exchange, a marketplace for the public to seek out insurance options. But that's not the only surprise element in SB 1586, which will get a hearing today. The bill also appears to lift, at least in part, Texas' long-standing ban on hospitals hiring doctors — as long as it is part of a state pilot program to seek cost savings and efficiencies in health care. ***BUT PERRY WON'T BITE—*** *His office tells PULSE that its stance on the health reform law has not changed: Texas will not implement the law until the federal court challenges are settled.*
http://www.texastribune.org/texas-health-resources/health-reform-and-texas/ogden-revives-key-piece-of-federal-health-reform/

Vermont:

N.E. Editorial Roundup 04/16/2011

Sen. Kevin Mullin, the only Republican member of the Senate Health and Welfare Committee, has made a positive contribution to the progress of health care reform through an amendment creating safeguards to ensure the new system will work. Mullin has questions about whether a single-payer system will work, and so he authored an amendment putting conditions on the approval of any single-payer system. A study would have to show that the financing of a new system would be sustainable and that overall costs would decline.
http://www.boston.com/news/local/new_hampshire/articles/2011/04/16/ne_editorial_roundup/

Tug-of-war over health care bill intensifies 04/18/2011

The Senate Finance Committee got it from all sides on Friday. The subject? H.202, the universal health care bill. Lobbyists and advocates across the spectrum (right to left) pitched amendments in a last-ditch attempt to shape the bill before it goes to the floor of the Senate this coming week.
http://vtdigger.org/2011/04/18/tug-of-war-over-health-care-bill-intensifies/

Virginia:

Cuccinelli Makes Long-Shot Supreme Court Bid to Overturn Health-Care Law 04/17/2011

Ken Cuccinelli, the Virginia attorney general challenging President Barack Obama's health- care overhaul, is quick to agree that his request for fast-track review by the U.S. Supreme Court is a long shot. "It is," Cuccinelli said. "But there's so much money at stake for the states and for the private sector and there's so much uncertainty produced in the economy because of this legislation that it was worth the ask." Cuccinelli says his state alone is spending between $20 million and $30 million preparing to implement the law. The measure calls on states to set up exchanges where residents can buy insurance.
http://www.bloomberg.com/news/2011-04-18/cuccinelli-makes-long-shot-court-bid-to-overturn-obama-s-health-care-law.html

Wisconsin:

Dept. of Health Services: State launches health coverage purchasing exchange survey 04/21/2011

As part of its effort to develop a consumer driven, free market health care coverage purchasing exchange, the Office of Free Market Health Care today launched an online survey to gather input from various stakeholders impacted by the creation of an

exchange. Specific parts of the survey are tailored to individuals, small employers, small employees, insurers, agents, brokers, and health care providers. The survey can be found online at http://www.freemarkethealthcare.wi.gov/section.asp?linkid=1702&locid=173.
http://www.wisbusiness.com/index.iml?Article=234250

- The Federal budget agreement eliminates a provision of the health-care law enabling low-income workers to opt out of employer-offered health insurance and shop for more affordable coverage on insurance exchanges.
- Free risk adjustment software and website building tools are now offered by Milliman, Inc. and the Robert Wood Johnson Foundation.
- Maryland's implementation bill is signed by Governor O'Malley, Colorado legislators take a second look at their implementation bill, and legislation moves forward in Iowa, Oregon, and Washington.
- New Mexico's exchange legislation is vetoed by Governor Martinez, Governor Fallin rejects Oklahoma's Innovator Grant, and Missouri's attorney general, Democrat Chris Koster, broke with his party by filing an amicus brief challenging the individual mandate.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 04/08/2011 – 04/15/2011

Federal News

Multi-state Health Insurance Exchanges 04/14/2011

This brief describes the potential gains and drawbacks for states if they join together to offer regional or multi-state exchanges. For instance, such exchanges might "promote pooling across state lines" and "create the necessary critical mass of insured persons to establish stable risk pools." However, "the fact that cross-state risk-sharing would lead to one state's population effectively subsidizing another state's population and create a complex environment for decision-making, multistate exchanges are likely to focus on shared administrative structures and efficiencies as opposed to risk-sharing."
http://www.urban.org/publications/412325.html

Obama lifts 1099 tax reporting burden 04/14/2011

President Obama on Thursday signed into law a bill repealing the healthcare reform law's 1099 tax reporting requirement, the first provision of the Democrats' law to get the ax. The Senate passed the law, 87-12, on April 5. The Republican controlled House cleared it in March.
http://thehill.com/blogs/healthwatch/taxes-and-fees/156171-obama-lifts-1099-business-reporting-burden

Analysis Estimates Deductibles for Plans in Health Insurance Exchanges 04/14/2011

A new Kaiser Family Foundation analysis projects the deductibles that consumers could see under health reform when purchasing health insurance in 2014 through new health insurance exchanges. Because projections of deductibles are subject to variation in estimating techniques and databases used, to present the most likely range of out-of-pocket costs, the Foundation commissioned separate analyses from three different actuarial consulting firms to present a range of potential estimates.
http://www.kff.org/healthreform/8177.cfm

Milliman Offers Sophisticated Risk Adjustment Software to State Insurance Exchanges Free of Charge 04/12/2011

Milliman, Inc., a premier global consulting and actuarial firm, today announced that it will provide its risk adjustment software, Milliman Advanced Risk Adjusters (MARA), to states implementing a health insurance exchange. MARA provides a library of risk adjustment tools. The software can work with varying data sources and has both concurrent and prospective models that will provide states with the kinds of insights necessary to effectively operate an exchange and make strategic and operational decisions using advanced predictive modeling.
http://www.prnewswire.com/news-releases/milliman-offers-sophisticated-risk-adjustment-software-to-state-insurance-exchanges-free-of-charge-119709874.html

Building an Effective Health Insurance Exchange Website 04/05/2011

A new toolkit provides state officials with valuable information and resources to design an effective website for their state's health insurance exchange. This toolkit series, released by the Robert Wood Johnson Foundation and the Blue Cross Blue Shield of Massachusetts Foundation, provides examples, templates and lessons from Massachusetts. Each toolkit will include a written narrative and a variety of source documents, including examples of organizational structures, job descriptions, requests for proposals, etc.
http://www.rwjf.org/healthpolicy/product.jsp?id=72129

Budget Deal Targets Pieces of Health Care Law 04/10/2011

The budget deal reached Friday would affect two initiatives contained in last year's health-care law that were bitterly opposed by businesses, killing one outright and slashing funding for the other. The agreement would eliminate a provision of the health-care law enabling low-income workers to opt out of employer-offered health insurance and shop for more affordable coverage on insurance exchanges, according to congressional aides and business groups. The budget bill will also cut $2.2 billion in funding from a program that would encourage the development of health-care cooperatives-not-for-profit entities that would compete with private, for-profit health-insurance companies.
http://www.foxnews.com/politics/2011/04/10/budget-deal-targets-pieces-health-care-law/?cmpid=cmty_twitter_Gigya_Budget_Deal_Targets_Pieces_of_Health_Care_Law

We're having the wrong argument on health-care costs 04/08/2011

The basic theory of Ryan's plan is that you can control costs by focusing on the insurance system. Seniors become consumers and their decision-making holds down costs. The Affordable Care Act has a lot of the same insurance-system reforms that Ryan does, but the basic theory of that plan is you control costs through the care delivery system. It's about knowing what treatments work and what treatments don't, paying for value rather than quantity, cutting down on unnecessary readmissions and errors, doing more to manage chronic diseases, etc. It's only once you can do all that that exchanges really become useful, because then and only then will insurers — be they private or public — really be able to control costs.
http://www.washingtonpost.com/blogs/ezra-klein/post/were-having-the-wrong-argument-on-health-care-costs/2011/04/08/AF11I92C_blog.html

Health Insurance Exchange Challenges on Display at AARP Forum 04/05/2011

In Washington yesterday, the AARP hosted a solutions forum titled Launching Health Insurance Exchanges. In a robust panel discussion, leaders from Virginia, Maryland, Colorado, and Utah outlined challenges they are experiencing with their efforts to establish the health insurance exchanges mandated under the Affordable Care Act (ACA).
http://www.input.com/blogs/public/index.cfm/2011/4/5/Health-Insurance-Exchange-Challenges-on-Display-at-AARP-Forum

State News

Colorado:

Marketplace act gives choice to individuals, small businesses 04/14/2011

A number of small-business men and women have attended workshops in Fort Collins to learn more about the state health insurance exchange, which takes effect in 2014. There was notable enthusiasm for this concept, since many small business people want to contribute to their employees' health insurance, but it's difficult to do so financially. The exchange in Colorado will be called the Colorado Health Benefits Insurance Marketplace.
http://www.coloradoan.com/article/20110415/OPINION04/104150306/Marketplace-act-gives-choice-individuals-small-businesses?odyssey=mod%7Cnewswell%7Ctext%7CFRONTPAGE%7Cs

A second life for health exchange bill? 04/12/2011

House Majority Leader Amy Stephens says everybody needs to take a deep breath and realize that a bill she is sponsoring to set up health insurance exchanges is not dead. "The bill is still alive," Stephens, R-Monument, said. "I think everyone has to calm down." The bill was to be heard in Legislative Council on Wednesday, but has been bumped to next Tuesday as the House begins work on the state budget.
http://blogs.denverpost.com/thespot/2011/04/12/a-second-life-for-health-exchange-bill/27640/

Idaho:

AARP's Winners & Losers of the 2011 Idaho Legislative Session 04/08/2011

Idahoans struggling with health insurance costs are hit twice making it even harder to have access to affordable health insurance: 1) Saying "NO" to fed. dollars even in rough state budget times. Legislators turned down federal dollars to set up a health insurance exchange, making it easier for Idaho families and small businesses to find health insurance they can afford - opting instead to set up an exchange using money from the state coffers. 2) Nullification take two. After the first attempts to stop implementation of the PPACA were declared unconstitutional and failed to advance, a second approach, taking aim at key components passed both Houses.

http://www.prnewswire.com/news-releases/aarps-winners--losers-of-the-2011-idaho-legislative-session-119482959.html

Iowa:

Health care law: Getting the basics 04/11/2011

Sen. Daryl Beall D-Fort Dodge said the state Senate is currently working out how the state insurance exchange will work in Iowa. In Iowa, there will be a Web portal for people to compare costs, similar to Priceline or Expedia services people use when planning vacations, said Davis. Beall said there will be three tiers intended to be pro-consumer so individuals can pick and choose the coverage they need at a price that's affordable. He added that the only debate right now is how to reimburse insurance agents who help people choose plans on the exchange. One idea is to set up a health insurance exchange board and let them set the commission for agents. Another would allow a 5 percent commission, which would come out of the insurance industry's administrative costs.

http://www.messengernews.net/page/content.detail/id/538242/Health-care-law--Getting-the-basics.html?nav=5010

Maryland:

Maryland seeks board members, advisers for health exchange 04/14/2011

Maryland's health department is looking for individuals interested in becoming board members or advisers for the state's new health insurance exchange. The state's Department of Health and Mental Hygiene started soliciting applications Wednesday. Maryland Health Insurance Exchange Board will include three state officials and six nongovernmental members appointed by O'Malley.

http://www.bizjournals.com/baltimore/news/2011/04/14/maryland-seeks-advisers-for-health.html

Md. lawmakers tax IWIF's premiums, approve health exchange details 04/13/2011

Two bills, passed by the Maryland General Assembly and signed into law by Gov. Martin O'Malley, change the insurance landscape in Maryland. Maryland became one of the first states to implement a health insurance exchange under the Maryland Health Benefit Exchange Act of 2011 (HB 166/SB 182). The new law calls for a study of how to market the exchange, giving the insurance industry additional opportunities to promote the role of insurance agents and brokers under federal health reform.

http://ifawebnews.com/2011/04/13/md-lawmakers-tax-iwifs-premiums-approve-health-exchange-details/

General Assembly approves public health care exchange 04/11/2011

The General Assembly approved legislation Monday morning that would create the framework of a public health care exchange where individuals and small businesses would one day be able to compare and purchase insurance policies. Gov. Martin O'Malley's proposal would task an independent state agency with overseeing the exchange, which states are required to create as part of President Barack Obama's Affordable Care Act.

http://thedailyrecord.com/2011/04/11/general-assembly-approves-public-health-care-exchange/

Massachusetts:

Limits to save $80m on health plan 04/14/2011

Regulators in charge of the Massachusetts health insurance law are expected to approve new contracts today that will save the state $80 million, in part by offering a narrower choice of hospitals, physicians, and specialists to thousands of patients insured

through the state-subsidized Commonwealth Care program. The new contracts will allow state funding to remain level, even as enrollment in the program is expected to grow from 158,000 low- and moderate-income residents to 175,000 over the next year.
http://www.boston.com/news/local/massachusetts/articles/2011/04/14/limits_to_save_80m_on_health_plan/

Missouri:

Keep an eye on essential benefits 04/13/2011
In Missouri, committees designated to craft our state's implementation of the reform law have been meeting, but there have been few public traces of planning beyond House Bill 609, which creates the Show-Me Health Insurance Exchange. Missouri has 47 health mandates already in statute. Like other states, we will need to analyze the costs and benefits for each existing mandate, deciding whether to eliminate it or incorporate it into our EHBs. Every mandate is a potential victim on the chopping block.
http://www.columbiatribune.com/news/2011/apr/13/keep-an-eye-on-essential-benefits/

Examiner Editorial: States rebel against Obamacare's insurance exchanges 04/13/2011
Missouri's attorney general, Democrat Chris Koster, broke with his party Monday by filing an amicus brief with the 11th Circuit Court of Appeals in support of the 26-state suit challenging Obamacare's individual mandate. With Virginia and Oklahoma pursuing their own separate legal actions, Koster's brief makes Missouri the 29th state to go on record against President Obama's signature domestic policy accomplishment.
http://washingtonexaminer.com/opinion/editorials/2011/04/states-rebel-against-obamacares-insurance-exchanges

Mo. lawmakers to debate unemployment, insurance 04/11/2011
House leaders say they plan to debate legislation that develops a state health insurance exchange. The exchange would allow individuals and small businesses to compare and buy health insurance plans.
http://www.koamtv.com/Global/story.asp?S=14419899

New Hampshire:

House tells AG - we won't blink on health care suit 04/15/2011
House Speaker William O'Brien said Thursday he wants lawmakers to require the attorney general to join a Florida suit challenging the constitutionality of federal health care reform -- and he wants the federal money for New Hampshire to implement the reform sent back to Washington to reduce the deficit.
http://www.unionleader.com/article.aspx?headline=House+tells+AG+-+we+won't+blink+on+health+care+suit&articleId=b9bb12f0-f05e-404c-b09d-cba7d57bbc61

New Mexico:

Senators criticize Martinez vetoes 04/08/2011
New Mexico Senators criticized vetoes made today by Gov. Susana Martinez. Today is the last day for Martinez to act on bills passed by the legislature otherwise they are pocket vetoed. Sens. Dede Feldman, D-Albuquerque, and George Munoz, D-Gallup, said a veto of a bill to create a health insurance exchange may mean more federal control of the insurance marketplace in New Mexico.
http://newmexicoindependent.com/69561/senators-criticize-martinez-vetoes

North Carolina:

NC fight brews over who benefits from health pool 04/12/2011
The North Carolina health insurance marketplace for individuals and small businesses taking shape is drawing howls from consumer advocates. The latest version reserves adds a permanent seat on the 12-member oversight board for insurance agents in addition to the six seats reserved to big business, small business, insurance companies, hospitals and doctors. Two people would represent consumers.
http://www.wral.com/news/state/nccapitol/story/9424469/

Oklahoma:

OK gov turns down insurance exchange federal grant 04/14/2011

Gov. Mary Fallin reversed course Thursday by rejecting a $54.6 million federal grant to help create a health insurance exchange for uninsured Oklahoma residents that is required by the new federal health care law. The Republican, who previously said she would accept the money, said legislative leaders have agreed to consider using state and private funds to create the Health Insurance Private Enterprise Network.

http://www.businessweek.com/ap/financialnews/D9MJMQO80.htm

Federal ties to insurance exchange split GOP 04/10/2011

Plans to create a sanitized version of a state health-care exchange - free of links to the Obama administration and a $54 million federal grant - broke down somewhat last week. While the Thursday defeat of House Bill 1996 in a Senate committee doesn't end the chances for a Republican version of an exchange this year, it does illustrate how toxic the topic is, especially among the party's most conservative legislators. Sen. Bill Brown, R-Broken Arrow, chairman of the Senate Retirement and Insurance Committee, had planned to insert a simplified, market-based exchange into the bill after details were worked out among legislative leaders and Gov. Mary Fallin

http://www.tulsaworld.com/news/article.aspx?subjectid=11&articleid=20110410_11_A10_Pastra847408

Oregon:

Health insurance exchange bill clears committee 04/14/2011

The Oregon Senate will soon vote on legislation creating a state exchange for health insurance. Senate Bill 99 was approved Thursday by the Senate Health Care Committee, which proposes a seven-member board for a public corporation that will set standards for insurance plans and let individuals and small businesses shop for them on a website.

http://www.statesmanjournal.com/article/20110415/NEWS/104150357/Health-insurance-exchange-bill-clears-committee?odyssey=mod%7Cnewswell%7Ctext%7CNews%7Cs

Zoomcare: Putting a Price Tag On Health Care 04/08/2011

When you go to the grocery store, everything has a price clearly marked. But not a doctor's office. Complex insurance and billing systems mean patients usually don't know how much they're going to have to pay until after a visit. A new Oregon company is trying to change that -- by giving patients a price up front.

http://news.opb.org/article/zoomcare-putting-price-tag-health-care/

Rhode Island:

OSPRI urges go-slow approach to health insurance benefits exchange 04/12/2011

In an effort to slow down the legislative effort to create a health insurance benefits exchange in Rhode Island, the Ocean State Policy Research Institute issued a position paper on April 8 urging a go-slow approach. "There should absolutely be no rush in building an exchange in Rhode Island when federal law does not require it until 2014," said Mike Stenhouse, OSPRI's executive director. "Let's have a full debate and analysis before the Rhode Island House rubber stamps it."

http://www.pbn.com/OSPRI-urges-go-slow-approach-to-health-insurance-benefits-exchange,57166

South Carolina:

Health care panel studies insurance options for state 04/15/2011

The future of health care reform in South Carolina might include insurance marketplaces as required by federal law, but this state can't afford to limit itself to planning for that one scenario, Health and Human Services Director Tony Keck said Thursday. Keck is one of 12 members on the South Carolina Health Exchange Planning Committee created this past month by Gov. Nikki

Haley. The committee, which has removed the word "exchange" from its name, is funded by a $1 million grant from the federal government.
http://www.goupstate.com/article/20110415/ARTICLES/104151007/1083/ARTICLES?p=1&tc=pg

Mitchell fights Haley, tea party over health insurance exchange 04/10/2011

State Rep. Harold Mitchell feels like he is fighting a war of words. On one hand, he's up against the Governor's Office, which he has accused of operating behind closed doors and, more recently, playing both sides against the middle and risking the future of health care access in this state. On the other, there's the tea party, which has driven away Republican support for his own health care exchange legislation by threatening to send them home in the 2012 election.
http://www.goupstate.com/article/20110410/ARTICLES/110419997/1027/OPINION?Title=Mitchell-fights-Haley-tea-party-over-health-insurance-exchange

Vermont:

Vermont Senate expected to take up health reform legislation this week 04/11/2011

A committee of the Vermont Senate is expected to work an extra day Monday — and a long one at that — as lawmakers push to finish work on a bill that would move the state toward Gov. Peter Shumlin's goal of universal, single-payer health care. Lawmakers usually work Tuesday through Friday, but Senate Health and Welfare Committee members say they're expecting to work from 8 a.m. to 8 p.m. Monday finishing their version of the bill, a version of which already has passed the House.
http://www.therepublic.com/view/story/e41bfb2ed0f54622a4d883ffc96ee0ee/VT--Health-Care/

Businesses worry and engage on Vermont's health reform bill 04/09/2011

The legislation, a priority for Gov. Peter Shumlin, would set the state on a course toward a more unified, government-financed health care system offering coverage to all Vermonters. The transformation -- which would take place over three to five years -- would involve dramatic changes in the health insurance market. That makes many business owners like Poulin nervous, and has prompted them to email, call and come to the Statehouse to lobby senators as they draft their version of the health reform bill for a vote in two weeks. The House already passed the bill.
http://www.burlingtonfreepress.com/article/20110409/NEWS03/104090302/1009/Vermont-Electric-Cooperative-surprised-Entergy-announced-deal/Businesses-worry-engage-Vermont-s-health-reform-bill?odyssey=nav%7Chead

Washington:

House OKs bill to create health benefit exchange 04/11/2011

Washington House lawmakers have approved a bill to establish a health benefit exchange by 2014 in compliance with federal health care reform. If the bill passes, Washington will be eligible to apply for federal grants to aid in the exchange's implementation. Lawmakers would determine the scope of the exchange next session. Monday's House vote was 75-22. The measure now returns to the Senate for approval of amendments.
http://www.theolympian.com/2011/04/11/1613219/house-oks-bill-to-create-health.html#ixzz1JJNkKfVx

- The House Energy and Commerce Committee approved steps to eliminate federal funds for state-based exchange development grants.
- Exchange legislation advances in Missouri and Rhode Island, while exchange planning progresses in Wyoming and California.
- New Hampshire decides to accept federal money, but won't award it to the Insurance Department's chosen contractor – Wakely Consulting Group.
- Oklahoma Senate Republicans suggest creating the exchange using only state and private funds, rejecting the $54 million federal innovator grant funds. However, until a definitive plan is decided on, the state will continue moving forward with its current plan.

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 04/01/2011 – 04/08/2011

Federal News

Health Insurance from Both Sides: KHN Interview of Aetna CEO Bertolini 04/07/2011

To a greater degree than most insurance company CEOs, Mark Bertolini has had his own first-hand experiences with the health system. Bertolini, the head of the powerful insurer Aetna, faced a tough time in 2001 when his teenage son Eric was diagnosed with a rare form of cancer that was considered incurable.
http://www.kaiserhealthnews.org/Stories/2011/April/08/bertolini-aetna-q-and-a.aspx

State Health Care Flexibility: The Good, the Bad and the Broke 04/06/2011

Real state flexibility could be a solution to many of our health care problems—at least for those who live in the right (i.e., red) states. But the results would surely be a mixed bag: some good, some useless and some terrible. We would likely see the kind of red state-blue state segmentation in state health care reform that we currently see in taxes and regulations. High tax and pro-regulation blue states seem to want even more government control over health care, including a single-payer health care system.
http://blogs.forbes.com/merrillmatthews/2011/04/06/state-health-care-flexibility-the-good-the-bad-and-the-broke/

Committee Approves Legislation to Eliminate Health Care Slush Fund, Limit HHS' Unprecedented Power and Restore Congress' Oversight Role 04/05/2011

The House Energy and Commerce Committee, chaired by Rep. Fred Upton (R-MI), today approved five pieces of legislation that take initial steps to defund the health care law. Specifically, section 1311(a) of PPACA provides the Secretary of Health and Human Services an unlimited amount of funds for state-based exchange grants. H.R. 1213, authored by Rep. Fred Upton (R-MI), strikes the unlimited direct appropriation and rescinds any unobligated funds. The bill passed through the committee by a vote of 31 to 20.
http://energycommerce.house.gov/News/PRArticle.aspx?NewsID=8444

Red tape cut in health care law 04/05/2011

Congress on Tuesday passed the first major changes to last year's health care law, undoing both a burdensome paperwork requirement for small businesses and rewriting part of the way the health exchange subsidies are paid for. The changes are complex and don't affect the fundamental operations of the health law, but Republicans said they are symbolic nonetheless

because they mark the first repeals of significant provisions from Democrats' signature legislative achievement under President Obama.
http://www.washingtontimes.com/news/2011/apr/5/congress-makes-first-major-dent-health-care-law/

GOP lawmakers weigh privatizing Medicare with exchanges 04/04/2011

For Medicare, the proposed Rivlin-Domenici reforms would raise Part B premiums from 25% to 35% of program costs over five years, leverage the program's buying power to increase rebates from drug companies, reform the beneficiary co-payment structure, and bundle payments for post-acute care to encourage efficiency and cost reduction. Starting in 2018, current Medicare patients also would have the choice to remain in traditional fee-for-service or access a private health plan through a Medicare exchange. However, it would not retain a fee-for-service option for new enrollees.
http://www.ama-assn.org/amednews/2011/04/04/gvsb0404.htm

State News

California:

First Exchange Board Meeting within 'Couple of Weeks' 04/07/2011

Just because California doesn't have a full board for the Health Benefits Exchange doesn't mean it can't get to work. "As long as we have a quorum, we can meet," exchange board member Kim Belshé said yesterday. "And we expect to meet in the next couple of weeks, whether we have that fifth person or not."
http://www.californiahealthline.org/capitol-desk/2011/4/exchange-board-to-meet-sans-member.aspx

RAND study: Health care reform will cause 7% jump in state spending 04/05/2011

National health care reform will help 6 million Californians obtain health insurance when it is fully implemented in 2016 — but it will also increase state spending by 7 percent, a new RAND Corp. study concludes. The increase in coverage will be caused by a jump in people buying policies through a newly created state insurance exchange and enrolling in Medi-Cal, the government health care program for the poor. The rise in state spending is the result of higher Medi-Cal costs, according to researchers.
http://www.bizjournals.com/sacramento/news/2011/04/05/rand-study-health-care-reform-will.html

Official: Budget Gridlock May Delay Health Reform 04/04/2011

A prominent California health official warned that health care reform could be delayed because of the ongoing state budget impasse, despite strong support among California's voters. "This partisan divide is real and intractable, and it has been very frustrating in these first three months of this administration," said Diana Dooley, secretary of the California Health and Human Services Agency.
http://www.baycitizen.org/health/story/partisan-gridlock-slows-health-reform/

Lawmakers, Advocates Call for New Consumer Health Office 04/04/2011

The Assembly Committee on Health this week gets its first look at a bill to create a one-stop shop for consumers looking for health care help in California. AB 922, by Assembly member Bill Monning (D-Carmel), would create the Office of Health Consumer Assistance to steer people in the right direction, answer questions and help resolve problems related to health care. Designed with an eye toward millions of newly insured Californians, the new state agency is aimed primarily at consumers, but it also will help health care providers navigate new waters.
http://www.californiahealthline.org/features/2011/lawmakers-advocates-call-for-new-consumer-health-office.aspx

Massachusetts:

Poll: Mass. voters say health law not working 04/06/2011

Nearly half of Massachusetts voters are saying the state's landmark health care law isn't working. That's according to a new poll by Suffolk University and WHDH-TV which found 49 percent of respondents said they didn't feel the 2006 law was helping. Thirty-eight percent said it was working. Thirteen percent were undecided.
http://www.kaiserhealthnews.org/Daily-Reports/2011/April/07/state-health-round-up.aspx

Mississippi:

MS Insurance Commish Mike Chaney talks about the death of MS Health Care Exchange Law 04/07/2011

In the end, our goal to improve healthcare for all 2.9 million Mississippians and our argument that a market-based exchange … 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. Despite the best efforts of myself and the Mississippi Insurance Department, exchange legislation that has been hailed as model legislation, died.
http://yallpolitics.com/index.php/yp/post/28766/

Missouri:

Missouri House begins work on health insurance exchanges 04/01/2011

A Missouri House panel laid the groundwork Thursday to carry out one of the most far-reaching provisions of the Affordable Care Act by voting to set up an exchange program that could make health insurance more affordable for small businesses and some individuals. Although some groups are unhappy with parts of the Show-Me Health Insurance Act (HB 609), the legislation got a unanimous vote in the Health Insurance Committee.
http://www.stlbeacon.org/health-science/health/109285-missouri-house-begins-work-on-health-insurance-exchanges

New Hampshire:

NH Council accepts federal grant for ObamaCare exchange 04/06/2011

A divided Executive Council voted yesterday to accept $660,000 from the federal government to study how to set up a Health Insurance Exchange. The all-Republican council approved spending the money by a 3-2 vote despite statements of opposition to the health care law. The councilors stopped short of awarding a $610,675 contract to the consulting firm chosen by the state Insurance Department, after councilors suggested the company's role in developing an exchange in Massachusetts indicated it was predisposed to a costly and expansive solution.
http://newhampshire.watchdog.org/8385/nh-council-accepts-federal-grant-for-obamacare-exchange/

Oklahoma:

Insurance Exchange a Worthy Idea if Done Correctly 04/07/2011

State Rep. Lisa J. Billy supports HB2130, stating "If done correctly, an insurance exchange could promote the free market in health care by providing a patient-centered shopping venue consistent with conservative values."
http://paulsvalleydailydemocrat.com/statenews/x1281104750/Insurance-Exchange-a-Worthy-Idea-if-Done-Correctly

Fallin, leaders discuss health insurance grant 04/06/2011

Gov. Mary Fallin met with legislative leaders Tuesday to discuss whether and how the state should pursue a health insurance exchange - a debate that has divided the state's Republican Party and put a $54 million federal grant in doubt. A key lawmaker in the process says if he gets his way any state exchange will be very simple and won't spend a penny of federal money.
http://www.tulsaworld.com/news/article.aspx?subjectid=16&articleid=20110406_16_A1_CUTLIN852250

Health exchange plan paid by federal grant still alive 04/03/2011

Although House Bill 2130 - legislation to give a legal foundation for a future state health insurance exchange - is dead, state officials are still working on a plan to build an exchange using $54 million in federal money. The Legislature and Gov. Mary Fallin could come up with another plan, which might not use the federal grant. Until it gets definitive instructions, the Oklahoma Health Care Authority will keep working on the grant program, said Nico Gomez, deputy CEO of the authority.
http://www.tulsaworld.com/news/article.aspx?subjectid=16&articleid=20110403_16_A1_Althou538988

Oregon:

Public Option Could Mean Buy-In to OHP 04/07/2011

A public health plan option might still be alive in Oregon after its chances appeared to have died during this year's legislative session. Sen. Alan Bates (D-Ashland) said he plans to introduce an amendment to the health insurance exchange legislation (SB 99) that would allow people to buy into the Oregon Health Plan as early as 2014. He said an amendment by Sen. Ron Wyden (D-Oregon) to the federal health reform law could make a state-based public option possible.
http://www.thelundreport.org/resource/public_option_could_mean_buy_in_to_ohp

Bill Bars Health Exchange from Negotiating Lower Costs 03/31/2011

Consumers and small businesses are alarmed that the bill under consideration in the Senate health subcommittee today (SB 99-3) would not allow the exchange to negotiate for lower premiums for enrollees like large businesses currently do.
http://www.ospirg.org/newsroom/health-care/health-care-news/bill-bars-health-exchange-from-negotiating-lower-costs2

Morse backs new plan for Oregon health care 04/05/2011

The massive federal health care reform bill that became law last year includes a provision that allows states to design alternative plans of their own. Now a bipartisan group of Oregon lawmakers has set out to do just that. Senate Bill 972, dubbed the Oregon Health Care Ingenuity Plan, is a "study bill" that creates a framework for a new statewide health care system. It directs the Oregon Health Authority to hammer out the details and present a formal proposal to the 2012 Legislature for further action. Unlike House Bill 3510, a single-payer proposal that would eliminate most private health insurance, SB 972 would let private insurers sell the basic plan through a state insurance exchange.
http://www.gazettetimes.com/news/local/article_42a06d1e-5f50-11e0-938f-001cc4c002e0.html

Rhode Island:

State Senate Approves Health Care 'Exchanges' 04/06/2011

Rhode Island took a significant step towards health care reform yesterday when the state Senate approved legislation to establish a health insurance exchange. "The exchange is the first step towards increasing access to health care for all Rhode Islanders," said President Paiva Weed. "This is the centerpiece of our health care reform implementation. The exchange will create a health benefit marketplace that is fair, competitive, transparent and understandable to individuals and small businesses."
http://www.golocalprov.com/health/state-senate-approves-health-care-exchanges/

Texas:

Study: Health Reform's Effects on Texas 04/05/2011

If federal health care reform stays on the books, it will help 5 million Texans get health insurance and increase state health care spending by roughly 10 percent in the next five years, according to a new study by the RAND Corporation, a policy think tank. Among the Texas findings: By 2016, roughly 18 percent of non-elderly Texans would get health coverage through a state health insurance exchange.
http://www.texastribune.org/texas-health-resources/health-reform-and-texas/study-health-reforms-effects-on-texas/

Lone Star reform hinges on Gov. Rick Perry 04/05/2011

POLITICO interviews with Texas legislators and lobbyists indicate that Gov. Rick Perry is unlikely to take the steps necessary to implement the insurance exchange required under the federal health reform law, which means the task will probably be left to the Obama administration. "[Perry] is adamant about no exchange until the court case is decided," said Arlene Wohlgemuth, director of health policy for the pro-free-market Texas Public Policy Foundation, which had supported a state-run exchange until the Florida ruling. "We've backed away from that proposal. Some say implementation wouldn't hurt our case, but the judge is the judge, so we're listening to him."
http://www.politico.com/news/stories/0411/52507.html

Session '11: Reps. Zerwas and Coleman 04/03/2011

On this edition of Session '11, Reps. John Zerwas, R-Simonton, and Garnet Coleman, D-Houston, discuss Texas' need for a health care insurance exchange.

http://www.kxan.com/dpp/news/politics/session-11-reps-zerwas-and-coleman

West Virginia:

W.Va. to lose $16.2B under GOP plan, group warns 04/07/2011

Among the states most dependent on Medicare and Medicaid, West Virginia stands to lose $16 billion over the next decade under a Republican plan for the federal budget, a health care advocacy group said Thursday. As reflected in Thursday's estimate, the Republican plan would also eliminate $3.1 billion in tax credits for people who buy private coverage through the federal law's health insurance exchange provision. West Virginia's Legislature approved creating a state-run exchange during the recently completed regular session.

http://www.businessweek.com/ap/financialnews/D9MF0L9O0.htm

Wyoming:

Group weighs options for Wyo health insurance exchange 04/01/2011

The state committee that will recommend whether Wyoming should create a health insurance exchange showed little interest Thursday in leaving the federal government to design the program. Instead, the Wyoming Health Benefit Exchange Steering Committee seemed inclined to either develop a statewide exchange or partner with others on a regional system.

http://trib.com/news/local/state-and-regional/article_02fc7431-5de1-5174-828b-92ffc777740d.html

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 03/25/2011 – 04/01/2011

Federal News

The Economics of Privately Sponsored Social Insurance 04/01/2011

A government-run health insurance exchange is not such a novel idea, nor should it be controversial. The federal government's Office of Personnel Management has for decades run such an exchange for every member of Congress and for federal employees, and very successfully, by all accounts. To see why the Affordable Care Act is actually trying to mimic employment-based private health insurance, let me propose this definition: Employment-based group health insurance, American style, is publicly subsidized, privately sponsored, community-rated social insurance sold to American employees on formally organized health insurance exchanges.

http://economix.blogs.nytimes.com/2011/04/01/the-economics-of-privately-sponsored-social-insurance/?src=busln

New ACO Rules Outline Gains and Risks for Doctors, Hospitals 03/31/2011

Doctors and hospitals that join together under a new model of care could pocket as much as 60 percent of the money they save Medicare but could also face hefty penalties if they fall short under rules proposed Thursday by the Obama administration. The Medicare Shared Savings Program, which would allow providers to band together as "accountable care organizations," has been one of the most eagerly awaited creations of last year's health care law.

http://www.kaiserhealthnews.org/Stories/2011/March/31/ACO-rules.aspx

Senate to Vote on Repealing Portion of Health Care Law 03/31/2011

The Senate set up a vote for Tuesday on a bill that would make the first significant change to President Barack Obama's signature health care overhaul law. Under an agreement reached Thursday, the Senate will vote on a House-passed bill that would repeal a tax-reporting requirement included in the health care law.

http://www.rollcall.com/news/senate_to_vote_on_repealing_portion_of_health_care_law-204519-1.html

House Panel Marks Up Health Funding Bills 03/31/2011

Members of the House Energy and Commerce Committee health subcommittee today marked up a collection of 5 health care funding bills, including one that would repeal health insurance exchange program funding. The health insurance exchange funding cut-off bill, H.R. 1213, would repeal a provision in the Patient Protection and Affordable Care Act (PPACA) that provides federal support for starting an American Health Benefit Exchanges program.

http://www.lifeandhealthinsurancenews.com/News/2011/3/Pages/House-Panel-Marks-Up-Health-Funding-Bills.aspx

CBO's Health Law Estimate Indicates 10-Year Net Deficit Decrease of $210 Billion 03/31/2011

Previously, the Congressional Budget Office had estimated a 10-year deficit reduction figure of $124 billion. The update reflects a change in the time period on which the projection is based. Also while testifying before a House subcommittee, CBO Director Douglas Elmendorf said the budget office was aware of the so-called "hidden" $105 billion in the health bill. However, at the same hearing, Centers for Medicare and Medicaid Services chief actuary Richard Foster offered a more skeptical view of the whether the measure will ultimately reduce the deficit.

http://www.kaiserhealthnews.org/Daily-Reports/2011/March/31/elmendorf-and-foster.aspx

HealthPlan Services to Highlight Offerings to Help Carriers Thrive Under Healthcare Reform at World Health Care Congress 03/29/2011

HealthPlan Services (HPS) will feature its proven processes for managing medical loss ratios (MLR) and expanding sales channels that enable carriers to survive – and thrive – in today's post-healthcare reform environment at the World Health Care Congress. HPS, the nation's leading technology and administrative services provider for the insurance and managed care markets, will be featured in Booth #318 at the conference, which takes place April 4-6, 2011 in Washington, D.C.
http://www.prnewswire.com/news-releases/healthplan-services-to-highlight-offerings-to-help-carriers-thrive-under-healthcare-reform-at-world-health-care-congress-118839419.html

Report Estimates Impacts of Rising Medicare Eligibility Age in Light of Health Reform 03/29/2011

Raising Medicare's age of eligibility to 67 would achieve significant savings, but shift costs to 65- and 66-year-olds, other individuals, employers and Medicaid, a new analysis shows. The study estimates three in four people ages 65 and 66 would pay $2,400 more on average for health care in 2014 than they would if they remained in Medicare.
http://www.kff.org/medicare/8169.cfm

Lawmakers Return To Wrangle Over Health Law, 1099 Repeal Funding - Health on the Hill Transcript 03/28/2011

As Congress returns to Washington, funding for implementation of the health law is expected to pay a major role in the debate over funding the federal government beyond April 8 when the current continuing resolution expires. Separately, House and Senate lawmakers remain at odds over how to finance the repeal of a paperwork provision in the health law known as the "1099" provision that has drawn criticism from small business groups.
http://www.kaiserhealthnews.org/Stories/2011/March/28/health-on-the-hill-transcript.aspx

Accepting Federal Exchange Funding for Obamacare: A Dangerous Proposition for the States 03/25/2011

Right now, states across the country are trying to figure out what to do in response to Obamacare and its health insurance exchange architecture In Oklahoma, the question has gone even further as the state government debates whether or not to accept federal funding, appropriated in the Obamacare statute, to create a state information technology system for a health care exchange. In Ed Haislmaier's recent paper, he describes this dilemma.
http://blog.heritage.org/2011/03/25/accepting-federal-exchange-funding-for-obamacare-a-dangerous-proposition-for-the-states/

State News

Alaska:

Alaska Senate delves into health care reform 03/29/2011

A Senate panel Monday probed state government's preparations for health care reform, with members suggesting they may seek a greater hand in the process. But a state health officer said Alaska can prepare for an insurance exchange without adding new laws to the books. The comment echoes comments from Gov. Sean Parnell.
http://newsminer.com/bookmark/12537109-Alaska-Senate-delves-into-health-care-reform

Arkansas:

Insurance Dept. budget passes; exchange to develop 03/31/2011

House members broke a deadlock Thursday to approve funding for the Arkansas Department of Insurance, and both legislative chambers passed the state's $4.6 billion budget just a day before the General Assembly is scheduled to complete its session. Republicans had blocked the department's proposed budget three times this week because part of the bill would help implement the new federal health care law. The bill was finally approved on an 83-7 vote, and it still allows Arkansas to start planning for a state health insurance exchange.
http://www.beaumontenterprise.com/news/article/Insurance-Dept-budget-passes-exchange-to-develop-1316001.php

Beebe: Session may end without Insurance budget 03/30/2011

Republicans have blocked the agency's proposed budget three times — the latest two failed votes on Wednesday — because the bill would, with the help of $1 million in federal grant money, create a state health insurance exchange. But another attempt would likely come Thursday, and Rep. Kathy Webb, who co-chairs the Joint Budget Committee, was hopeful the bill would pass. She said the only reason Wednesday's second vote was taken was because the House's GOP leader, John Burris, had ensured Democratic House Speaker Robert Moore that they had the needed 75 votes.
http://www.ctpost.com/news/article/Beebe-Session-may-end-without-Insurance-budget-1314868.php

Health exchange bill advances 03/28/2011

A House committee today endorsed a bill that would allow the state to begin creating the rules necessary to implement a health insurance benefits exchange as part of the federal health care law. The House Insurance and Commerce Committee also endorsed legislation intended to repay a more than $330 million unemployment debt to the federal government. House Bill 2138 by Rep. Fred Allen, D-Little Rock, which fell one vote short Friday, advanced today after testimony from state Insurance Commissioner Jay Bradford and former state Medicaid chief Ray Hanley, who is now director the Foundation for Medical Care.
http://arkansasnews.com/2011/03/28/health-exchange-bill-advances/

Panel rejects bill to allow planning for federal health care law 03/25/2011

A House committee today rejected a bill that would allow the state to begin creating the rules necessary to implement a health benefits exchange as part of the federal health care law. House Bill 2138 by Rep. Fred Allen, D-Little Rock, which needed 11 votes for approval by the House Insurance and Commerce Committee, fell one vote short. Seven members voted "no." State Insurance Commissioner Jay Bradford later described the vote as "weird," while Gov. Mike Beebe used the word "ironic." Allen said later that he plans to bring the measure back to the committee for another vote Monday.
http://arkansasnews.com/2011/03/25/panel-rejects-bill-to-allow-planning-for-federal-health-care-law/

Moore: We should implement health care exchange 03/25/2011

House Speaker Robert Moore took questions from the press after today's House session. He reiterated his desire to conclude business by April 1. Notable quotes: Moore said the legislature should go ahead and pass legislation to set up the health care exchange that will be required by the Patient Protection and Affordable Care Act. A bill designed to do just that failed in the House Insurance and Commerce Committee this morning. Moore said he expects the bill to come up again.
http://www.arktimes.com/ArkansasBlog/archives/2011/03/25/moore-we-should-implement-health-care-exchange

Colorado:

Co-sponsors amendment called "poison pill" for state insurance exchanges 04/01/2011

A bill setting up health care insurance exchanges cleared a Senate committee Thursday, but its future is in doubt after a Republican co-sponsor — facing Tea Party pressure — backed an amendment that Democrats said would gut the bill. The news that House Majority Leader Amy Stephens, R-Monument, was offering the new language brought a sharp response from Gov. John Hickenlooper, whose office has been closely involved in months of negotiations over Senate Bill 200. Stephens' proposed amendment would say the exchanges could take effect only after the state receives a federal waiver to opt out of the health care law. The governor would have to request the federal waiver within 60 days of the exchange legislation taking effect.
http://www.denverpost.com/legislature/ci_17747868

Colorado health exchange up for 1st hearing 03/31/2011

A new health insurance market for Colorado is up for its first big test in the state Legislature. A Senate committee planned to start work Thursday on a divisive proposal to create a health insurance exchange. It would be an insurance pool allowing individuals and small businesses more choice when shopping for health insurance.
http://www.denverpost.com/search/ci_17741033

GOP leader: Health bill isn't Obamacare 03/29/2011

A Republican leader pushed back Tuesday at tea party critics who accused her of selling out the opposition to President Barack Obama's health-care bill. Stephens, a former Focus on the Family executive, has a reputation as one of the Legislature's most conservative members, and she said Tuesday that her critics from the "extreme part of the tea party movement" do not

understand the issue and the need to compromise with Democrats. "Many people didn't read the bill. They saw the word 'exchange' and jumped to the idea that it's Obamacare," Stephens said.
http://durangoherald.com/article/20110330/NEWS01/703309916/-1/s

Left, Right Both Skeptical of Health Exchange Bill 03/25/2011

The most important health care bill before the state legislature this year is being delayed again. The bi-partisan "health insurance exchange" bill was supposed to see its first debate yesterday, but now it's being held for another week.
http://www.cpr.org/article/Left_Right_Both_Skeptical_of_Health_Exchange_Bill

Georgia:

Seagraves: GOP works against Georgians 03/25/2011

As noted in a March 21 Associated Press story in the Banner-Herald, the health exchange idea - part of the federal health care law passed by Democrats in Congress in March of last year - was actually promoted by Georgia Republicans in the state legislature in 2007. But now, the GOP in Georgia - pressured by the tea party - is disowning the concept.
http://onlineathens.com/stories/032511/let_804906446.shtml

Idaho:

Idaho Becomes Latest State to Reject Health Exchange 03/25/2011

Idaho's legislature voted 50-15 to reallocate federal funds which had been intended for use in creating the health insurance exchange mandated by President Obama's law. As Dustin Hurst of IdahoReporter.com reports, the debate in Idaho resembles the conflict among state legislators on this issue across the nation. If Idaho doesn't take the money and set up its own exchange, the minority leader argued, the federal government will step in and impose its will on the state. "We will have no say," said Rusche. However, the floor sponsor of the appropriation, Rep. Fred Wood, R-Burley, told IdahoReporter.com that it's likely the measure would have failed on the floor if given a vote.
http://www.heartland.org/healthpolicy-news.org/article/29635/Idaho_Becomes_Latest_State_to_Reject_Health_Exchange.html

Eye on Boise: Insurance Dept. budget bill pulled from House amid health reform protests 03/25/2011

House Appropriations Chairwoman Maxine Bell, R-Jerome, pulled the budget bill for the Idaho Department of Insurance from the House floor today, after House members indicated they wouldn't pass it with $2.5 million in federal grants in it to allow the state to begin planning for its own health insurance exchange, because. "It's been hanging for some days, and I could not find any buy-in on that federal money," Bell said. "Frankly, it's one of those cutting off your nose to spite your face affairs, because somebody's going to get that money. They're passing it out, and we couldn't see that there were any strings attached. Frankly, I kinda thought it was a rebate on money I just paid in taxes."
http://www.spokesman.com/blogs/boise/2011/mar/25/insurance-dept-budget-bill-pulled-house-amid-health-reform-protests/

Iowa:

Center for Rural Affairs says rural residents will benefit from insurance exchange 03/28/2011

A report from the Center for Rural Affairs finds so-called health insurance marketplaces, part of the federal health care law, will benefit rural residents and rural families. Jon Bailey, the center's director for research and analysis, says the study shows some of the critical considerations going into setting up state health insurance exchanges.
http://www.radioiowa.com/2011/03/28/center-for-rural-affairs-says-rural-residents-will-benefit-from-insurance-exchange/

Maryland:

Maryland Senate approves softened health exchange plan 03/31/2011

A plan for creating a Maryland health insurance exchange, calling for more study of how the exchanges will be marketed, has been sent to Gov. Martin O'Malley for approval.
http://ifawebnews.com/2011/03/31/maryland-senate-approves-softened-health-exchange-plan/

House passes Maryland health reform package 03/29/2011

*Gov. **Martin O'Malley**'s health care reform package — House Bills 166 and 170 — passed in the House of Delegates late Monday, marking a major step forward for efforts to implement federal health care reform. The House and Senate Finance committee adopted several amendments to the bills that had been developed by O'Malley administration to address concerns of businesses, insurance brokers, hospitals and others in the health care industry. Under new amendments from Lt. Gov. Anthony Brown, the state's health insurance exchange would be established as a hybrid public-private entity.*
http://www.bizjournals.com/baltimore/news/2011/03/29/maryland-health-exchange-bills-pass.html

Lt. Gov. Brown Praises Movement of Health Care Reform Package 03/27/2011

Today, Lt. Governor Anthony G. Brown, co-chair of Maryland's Health Care Reform Coordinating Council, released the following statement applauding advancement of the O'Malley-Brown Administration's Health Care Reform Package by the General Assembly: "As we mark the one-year anniversary of the Affordable Care Act this week, it is exciting to see the General Assembly move forward on our health care reform package, which will help reduce costs, expand access, and improve the quality of care for all Marylanders. We have …worked closely with all stakeholders to create a framework for Maryland's health benefit exchange. I applaud House and Senate committee members for their work on these measures, and I will continue working with the General Assembly to enact this important health care legislation."
http://www.thebaynet.com/news/index.cfm/fa/viewstory/story_ID/21863

Md. health exchange bill changed to require lawmakers' approval of board recommendations 03/25/2011

Maryland lawmakers have made a significant change to a bill to implement federal health care reform in the state. The House adopted an amendment on Friday to a measure that sets up the Maryland's health exchange. Under the amendment, recommendations made by the exchange's board of trustees would have to be approved by the General Assembly. Under the original bill, the board could have implemented exchange policies.
http://www.therepublic.com/view/story/284cf800ab2a48748efe71b558ec1078/MD-XGR--Health-Exchange-Maryland/

Massachusetts:

Benefit Caps Could Pose Problems for Young Adults 03/28/2011

The Massachusetts Health Connector is the among the first of 50 such exchanges nationwide prescribed by last year's federal health care reform. Here, the exchange has been hailed an easier way for consumers and businesses to compare various plans and pick one that suits them. But when it comes to a number of plans for individual young adults available through the Health Connector, one feature could leave 18- to 26-year-olds in a lurch: benefit caps on some of the plans as low as $50,000 per year. That is 15 times lower than the $750,000 minimum annual cap required under the federal law, which mandates a $1.25-million minimum cap by September and the elimination of benefit caps altogether by 2014.
http://www.wbjournal.com/news48702.html

Nevada:

Input sought on health insurance exchange plan 03/27/2011

Residents and business owners who want a say in how Nevada will enact provisions of the Patient Protection and Affordable Care Act will have a chance to speak up several times in the coming weeks. The Nevada Division of Health Care Financing and Policy will host several public forums from Tuesday through May 25 around the state.
http://www.lvrj.com/news/input-sought-on-health-insurance-exchange-plan-118731519.html?ref=519

New Hampshire:

New Hampshire Department Recommends Taking Exchange Grant 04/01/2011

New Hampshire Insurance Department officials say taking a $1 million federal health insurance exchange planning grant might be a good idea. The department can take the $1 million even if the state decides not to set up an exchange, and, if the state decides not to set up an exchange, the U.S. Department of Health and Human Services (HHS) may simply set up an exchange for New Hampshire, officials say in an exchange planning grant memo.
http://www.lifeandhealthinsurancenews.com/News/2011/3/Pages/New-Hampshire-Department-Recommends-Taking-Exchange-Grant.aspx

Council tables grant to start ObamaCare Exchange 03/30/2011

New Hampshire's Executive Council voted unanimously tabled a request from the state Insurance Commissioner to accept $666,000 to study how to set up a health insurance exchange called for under the PPACA.
http://newhampshire.watchdog.org/8283/council-tables-grant-to-start-obamacare-exchange/

N.H. may get health exchange grant 03/26/2011

A one-stop shop for health benefits that lets individuals and small business owners easily compare health insurance costs could become a reality in the Granite State. Jeanne Ryer and Karen Ager with the Endowment for Health, along with AARP state President Fred Kocher, met with the Foster's editorial board Friday to discuss a federal grant that would allow for the planning of a health insurance exchange in New Hampshire.
http://www.fosters.com/apps/pbcs.dll/article?AID=/20110326/GJNEWS_01/703269926&template=DoverRegion

Executive Council: Take the money 03/25/2011

Last month, New Hampshire House Speaker William O'Brien and Majority Leader DJ Bettencourt asked the Executive Council to reject a $610,000 federal grant that would help fund the creation of a state health insurance exchange, a marketplace that would allow consumers to choose from a selection of easily understood health insurance plans that meet minimum coverage standards. The council would be mad to agree.
http://www.concordmonitor.com/article/247578/executive-council-take-the-money

North Carolina:

Business outnumbers consumers on NC health panel 03/29/2011

Whether North Carolina makes health insurance as easy for individuals and small businesses to shop for as a plane ticket on a travel web site could be left up to an oversight board on which business interests outnumber consumer advocates.
http://www.businessweek.com/ap/financialnews/D9M93ROG1.htm

Consumer Groups Eye Blue Cross Health Market Role 03/29/2011

A North Carolina legislative panel considers a proposal that could give the state's largest health insurer a permanent seat on the body that will run the marketplace designed to offer affordable coverage to individuals and small businesses. The House Health and Human Services Committee on Tuesday considers whether compromise is possible on legislation that creates a health benefit exchange.
http://www.wral.com/news/state/story/9346200/

Oklahoma:

Senate leader rejects health-care exchange bill 04/01/2011

The state Senate won't pursue controversial legislation backed by Gov. Mary Fallin to establish a health-care exchange for the state because of concerns that the measure would tie Oklahoma to Obamacare, Senate President Pro Tem Brian Bingman said Thursday. Senate Republicans are increasingly concerned that House Bill 2130, which would establish the legal basis for moving ahead with a $54 million federal grant to build an exchange, would commit the state to the same federal health-care law the state is challenging in court, Bingman said.
http://www.tulsaworld.com/news/article.aspx?=504&articleid=20110401_16_A1_OKLAHO884806

Protesters opposed to health care exchange demonstrate outside Okla. governor's appearance 03/24/2011

About a dozen people opposed to Gov. Mary Fallin's decision to accept a $54 million federal grant to implement a state health insurance exchange protested during her appearance in Tulsa. Demonstrators held signs and American flags as Fallin addressed the Tulsa Health Underwriters Association at the Tulsa Country Club Thursday.
http://www.therepublic.com/view/story/4bceaf1db2fd4eb3947609f41b07e41f/OK--Fallin-Health-Care-Protest/

Oregon:

Community Health and Consumer Advocates Oppose Exchange Bill 03/29/2011

The latest amendments to Oregon's health exchange legislation have incensed many of the bill's former supporters by altering key provisions around consumer protection, conflicts of interest among exchange board members and the exchange's negotiating power. "We cannot support [Senate Bill] 99-3," stated a letter to legislators from a large coalition of human services and consumer advocacy organization leaders.
http://www.thelundreport.org/resource/community_health_and_consumer_advocates_oppose_exchange_bill

South Carolina:

Health plan advocates: SC may get fed exchange 03/31/2011

Supporters of a bill that would create a state health insurance exchange said Wednesday that conservative activist groups attempting to kill the bill could open the door for the federal government to take over the process. Meanwhile, state Health and Human Services Director Tony Keck said South Carolina will move forward with a health insurance exchange study committee financed by a $1 million federal grant despite calls from the groups to return the federal money.
http://www.goupstate.com/article/20110331/ARTICLES/103311019/1083/ARTICLES?Title=Health-plan-advocates-SC-may-get-fed-exchange

Tea Party Blocks SC "Obamacare" Exchange 03/29/2011

Ten days after our website broke the news of a Tea Party-led assault on the Palmetto state's "Obamacare" health insurance exchange, S.C. House Ways and Means Chairman Danny Cooper (RINO-Anderson) has yanked legislation that would have created this controversial government-run "marketplace." "Due to its controversial nature I chose not to add it to the agenda and there is no plan to ask the committee to add it by a majority vote, which is our only means of adding legislation after an agenda is published," Cooper wrote to Talbert Black, leader of the S.C. Campaign for Liberty.
http://www.fitsnews.com/2011/03/29/tea-party-blocks-obamacare-exchanges-in-sc/

Texas:

Zerwas: Texas Health Insurance Exchange May Be Dead 03/29/2011

State Rep. John Zerwas, the Simonton Republican who has filed legislation to implement one of the key elements of federal health care reform, said his bill may be permanently stuck. Zerwas, who proposed establishing a Texas health insurance exchange not because he approves of federal health reform, but because he fears the feds will do it for Texas, said he's been told Gov. Rick Perry's office doesn't support the measure.
http://www.texastribune.org/texas-health-resources/health-reform-and-texas/zerwas-texas-health-insurance-exchange-may-be-dead/

Vermont:

Vermont moves closer to single-payer health care system 03/25/2011

H.B. 202, which cleared the House Wednesday on a 92-49 vote, would establish a five-member board to develop a health care benefits package that would be available to all state residents through a new state insurance exchange. Under the measure, "all Vermont residents shall be eligible for Green Mountain Care, a universal health care program that will provide health benefits through a single-payment system," the legislation says.
http://www.businessinsurance.com/article/20110325/BENEFITS03/110329934

West Virginia:

State seeks guidance on health reform 03/28/2011

The state Offices of the Insurance Commissioner last week released a bid document asking consultants for advice on how to set up the state's new Health Insurance Exchange. Jeremiah Samples, an official tasked with helping oversee the creation of the exchange, said the state is looking for a consultant to produce data so officials can see how the choices they make will affect the cost and quality of insurance.

http://www.dailymail.com/News/statenews/201103270673

Wisconsin:

Wisconsin leads in health insurance exchange system 03/30/2011

The exchange effort is being led by the Wisconsin Office of Health Care Reform, which Doyle created to administer the Patient Protection and Affordable Care Act. In December, the office released a report outlining its vision for the state's insurance marketplace. A prototype can be found at https://exchange.wisconsin.gov/.

http://www.wisconsinrapidstribune.com/article/20110331/WRT0101/103310629/1861/WRT06/Wisconsin-leads-health-insurance-exchange-system?odyssey=nav%7Chead

Wyoming:

Group studying Wyoming insurance option meets today in Casper 03/31/2011

The state committee examining options for a Wyoming health insurance exchange meets today in Casper. The Wyoming Health Benefit Exchange Steering Committee is studying whether the state should create an insurance exchange. If it recommends pursuing an exchange, the committee will also offer a plan for developing the program.

http://trib.com/news/opinion/blogs/wolfjammies/article_6c322f65-b06e-5f08-af53-60ecee24a28c.html

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 03/18/2011 – 03/25/2011

Federal News

Some states advance IT for health insurance exchanges 03/23/2011

Kansas, Maryland and other states are beginning to assemble the information technology building blocks needed to create their health insurance exchanges called for under the year-old health reform law. For example, Kansas has extended its new eligibility system for its Medicaid and Children's Health Insurance Program (CHIP) and is integrating it with the state health insurance exchange, said Sandy Praeger, Kansas state insurance commissioner.

http://govhealthit.com/newsitem.aspx?nid=76795

Overlooked but Not Forgotten: Three Lesser-Known Reforms 03/23/2011

Most recent coverage of PPACA continues to focus on the same core issues: the law's sweeping changes to health coverage and the delivery system, how states are responding to new rules and the overhaul's constitutionality. However, PPACA's sheer scope has ensured that -- even a year later -- there are some reforms that have been overlooked. Here are three changes that you may have missed.

http://www.californiahealthline.org/road-to-reform/2011/overlooked-but-not-forgotten-three-lesser-known-reforms.aspx

Health exchange head start reaps dollars 03/22/2011

The purpose of the "early innovators" program is to guide other states in developing the backbone information systems that will drive state-level health insurance exchanges. The improved technology is supposed to assist them in getting an exchange ready for federal approval in 2013. Some of those that are only beginning to get their IT operations ready are going to have a tough time meeting the deadline.

http://www.stateline.org/live/details/story?contentId=560722

On Health Law's Anniversary: Predictions for Next Year 03/20/2011

Kaiser Health News asked players and experts from across the nation what they thought the landscape would be like – and, in their view, should be like. They discussed issues ranging from the new insurance marketplaces called exchanges to the future of ACOs: combinations of hospitals, doctors and sometimes insurers. Here are their edited responses:

http://www.kaiserhealthnews.org/Stories/2011/March/21/health-reform-law-anniversary-looking-forward.aspx

Health Law Waivers Draw Kudos, and Criticism 03/19/2011

Obama administration officials say they were expecting praise from critics of the new health care law when they offered to exempt selected employers and labor unions from a requirement to provide at least $750,000 in coverage to each person in their health insurance plans this year. Instead, Republicans have seized on the waivers as just more evidence that the law is fundamentally flawed because, they say, it requires so many exceptions.

http://www.nytimes.com/2011/03/20/health/policy/20health.html?pagewanted=1&_r=1&src=twrhp

Health Insurers Respond To Reform by Snapping Up Less-Regulated Businesses 03/19/2011

Here's one change few were talking about when the health overhaul law passed: It's sent insurers - worried the law could stunt profits and growth - looking for new types of business. Where are they investing? In less-regulated companies that could yield strong profits and make the main business - insurance - more lucrative. The purchases also could increase insurers' control over more parts of the health system.

http://www.kaiserhealthnews.org/Stories/2011/March/20/health-insurers-reform-business.aspx

Shaping GOP entitlement reform plans 03/19/2011

In the coming recess week, House Budget Committee Chairman Paul Ryan (R-Wis.) and staff will be preparing options to present to colleagues for the 2012 House budget resolution. The committee is expected to look especially hard at four documents when forming the recommendations: the April 2009 Republican alternative budget resolution produced under Ryan when the Democrats were in charge, Ryan's own Roadmap for America proposal, the recommendations of the Bipartisan Policy Center and the recommendations of the president's fiscal commission.
http://thehill.com/blogs/on-the-money/budget/150831-four-previous-plans-give-clues-to-gop-entitlement-reforms

Gingrich: Healthcare reform will be repealed in 2013 03/18/2011

Former House Speaker Newt Gingrich predicted the Democrats' healthcare reform law will be repealed, but not before the 2012 election. "I think it will be repealed," said Gingrich, who is exploring a presidential run. "I think it will be repealed probably by March or April 2013." He noted it was possible that the courts will strike down the law. "As a strategy, I wouldn't count on that," he said at a Friday press conference to mark the one-year anniversary of healthcare reform.
http://thehill.com/blogs/ballot-box/presidential-races/150691-gingrich-healthcare-reform-will-be-repealed-in-2013

A Profile of Health Insurance Exchange Enrollees 03/2011

This March 2011 Kaiser Family Foundation report describes those 24 million Americans expected to purchase private health insurance through the new Health Insurance Exchanges. Among the key findings from the report is that those purchasing coverage are likely to be relatively older, less educated, and more racially diverse and report to have poorer health, but have fewer diagnosed conditions than those who currently have private insurance.
http://www.kff.org/healthreform/8147.cfm

State News

Alaska:

Committee Moves Legislation Forward To Enact Health Exchange 03/22/2011

Alaska Senate's Labor and Commerce Committee forwarded legislation that would enact a health exchange out of committee on Tuesday, though questions remained over how necessary the legislation would be. Sen. Hollis French, says establishing the board by legislative action is required by provisions of the federal health care overhaul. However, Gov. Sean Parnell says his administration will take steps to create an exchange and does not need legislation to do so.
http://www.ktuu.com/news/ktuu-committee-moves-legislation-forward-to-enact-health-exchange-20110322,0,4829533.story

No magic method for controlling rising state Medicaid budget 03/18/2011

Alaska Department of Health and Social Services Commissioner Bill Streur didn't comment on the governor's decision to turn down the federal grant but he said the state's establishment of its own system would result in one that is simpler and more suited to the Alaska health insurance market. Utah has developed a health insurance exchange for its residents that provides a model for Alaska, Streur said. Utah has petitioned the federal government to have its exchange accepted in place of one created by the federal government in 2014 and Alaska could do the same, the commissioner said.
http://www.alaskajournal.com/stories/031811/loc_nmmcrs.shtml

Arkansas:

Ark. House panel hears arguments; delays vote on bill that would start federal health overhaul 03/24/2011

A House committee postponed a vote Wednesday on a bill that would give the state insurance commissioner authority to develop a health benefits exchange, a first step toward implementing the federal health care overhaul. Insurance Commissioner Jay Bradford told members of the Insurance Committee that the state must have its framework complete by January 2013, a year before the exchange goes into operation.
http://www.canadianbusiness.com/markets/market_news/article.jsp?content=D9M5JPG80

California:

How Can California Exchange Minimize 'Churning'? 03/21/2011

Veterans of the Medi-Cal system in California -- providers, counselors, state officials and beneficiaries -- have said for years that one of the keys to making the Medicaid program work is continuity of care. But in most lives --and perhaps especially in low-income lives -- things change. People move, they change or lose jobs, their family situations evolve. When change happens, eligibility for subsidized coverage shifts and health care is often interrupted. We asked stakeholders and experts: What strategies should state officials employ in the building and operation of the exchange to minimize churning?
http://www.californiahealthline.org/think-tank/2011/how-can-california-exchange-minimize-churning.aspx

Viewpoints: Reviled health care law already helping people 03/20/2011

There are concrete ways the health care law has made things better. This spring, when California college seniors graduate and begin new jobs or the next stage in their education, they'll be able to stay on their parents' insurance plans, instead of being thrown off. California patients can now get preventive care without co-payments and deductibles, which will keep them healthier and will lower costs for everyone. The California Legislature became the first state in the country to pass legislation establishing a new competitive health insurance marketplace, or exchange.
http://www.sacbee.com/2011/03/20/3487157/reviled-health-care-law-already.html

Insurer wants focus on what drives up health costs 03/19/2011

On Wednesday, Blue Shield of California called off rate increases for the rest of the year for its 340,000 individual and family policyholders. "We hoped if we could take the rate increases off the table, we could focus on the rising cost of medical care," said Tom Epstein, a vice president and spokesman for Blue Shield of California, based in San Francisco. But the problem of passing along costs to consumers isn't going away.
http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2011/03/19/MNCE1I3D1T.DTL&type=health

Colorado:

Bill introduced to create health care exchange 03/22/2011

In another attempt to drive down insurance premiums and spread health care coverage, House Majority Leader Amy Stephens, R-Monument, has joined with Democrats to sponsor what she says is "very badly needed" — a bill to create health care exchanges. Her prime Democrat allies are Gov. John Hickenlooper and Senate President Pro-tem Betty Boyd, D-Lakewood, who chairs the Health and Human Service Committee.
http://www.gazette.com/articles/care-114961-health-create.html

Bipartisan lawmakers roll out health care exchange proposal 03/21/2011

While some national health care reform laws don't take effect for years and others will likely spend years held up in federal courts, Colorado is pushing ahead on its own to create a health care exchange. Joined by bipartisan sponsors, Gov. John Hickenlooper Monday introduced a proposal to create a statewide exchange, a voluntary and competitive insurance marketplace aimed at making it easier and more affordable for small businesses and individuals to find health care plans that meet their needs.
http://www.kdvr.com/news/politics/kdvr-bipartisan-lawmakers-roll-out-health-care-exchange-proposal-20110321,0,3759860.story

Connecticut:

Governor Malloy Highlights Benefits of Obamacare for Connecticut 03/24/2011

On the one year anniversary of President Obama signing national health reform legislation into law, Governor Dannel P. Malloy highlighted what Connecticut has already been able to accomplish.
http://www.thegovmonitor.com/world_news/united_states/governor-malloy-highlights-benefits-of-obamacare-for-connecticut-47926.html

Georgia:

Health Exchange on Hold in Georgia 03/23/2011

State lawmakers recently tabled legislation that would have created a federally-mandated state health care exchange. That leaves Georgia with some unused cash. Georgia received a $1 million grant from the federal government to create a state healthcare exchange. Gov. Nathan Deal said the money's in the bank. "We still have a year or so in which to put the exchange in place and that money will be used for that purpose," he said.
http://www.gpb.org/news/2011/03/23/health-exchange-on-hold-in-georgia?utm_source=feedburner&utm_medium=twitter&utm_campaign=Feed%3A+GPBNewsFeed+(GPB+News)

Nothing short of repeal will save the states 03/21/2011

Now that I'm governor of Georgia and facing mandates with crippling price tags for my state's taxpayers, I'm seeing firsthand the job-destroying effects of the federal government's overreach. No one would confuse me for an advocate of the law. So it's no surprise that I fully support congressional Republicans' efforts to repeal Obamacare. But with that effort stalled in the Democratic Senate, some of my House GOP friends have discussed simply cutting off the money for its implementation.
http://dailycaller.com/2011/03/21/nothing-short-of-repeal-will-save-the-states/

Health exchange faces political opposition in Ga. 03/19/2011

Facing pressure from tea party groups, Gov. Nathan Deal and the House on Wednesday scuttled a bill that would have taken the first step toward creating a health exchange in Georgia under the federal law. Instead, they adopted a bill that would enter Georgia into a proposed interstate health care compact, essentially in defiance of the federal law.
http://www.macon.com/2011/03/19/1493679/health-exchange-faces-political.html

In Georgia, health exchange gets mired in politics of Obama and the federal health overhaul 03/19/2011

In 2007, Georgia Republicans began promoting a novel idea in the state: exchanges they said would introduce market forces into the health arena. Now that those insurance exchanges are part of President Barack Obama's federal health care overhaul, however, they can't seem to run away fast enough.
http://www.therepublic.com/view/story/18cf08a9dd2e416e9f27a956c8262003/GA-XGR--Health-Exchange/

Idaho:

Idaho seeks public comments on planned health-insurance exchange 03/22/2011

The Idaho Department of Insurance has begun holding public stakeholder meetings to solicit comments for a health insurance exchange proposal being developed by the state. The first meeting, geared toward small business owners and employers, was Tuesday morning in Caldwell. Future meetings will be geared toward specific stakeholder perspectives.
http://www.idahostatesman.com/2011/03/22/1576144/idaho-seeks-public-comments-on.html

Illinois:

Gov. Pat Quinn Gives Illinois Health Care Reform a Big, Fat Push Forward 03/24/2011

In Illinois, Governor Pat Quinn has been blazing forward to implement its provisions. In fact, since taking office, Quinn has been on tear to reform Illinois health care more broadly. Since March 23, 2010, the federal government has awarded $89.4 million in health reform funding to Illinois, and the law has delivered to 151,922 Illinois Medicare beneficiaries a one-time, tax-free $250 rebate to help pay for prescriptions in the "donut hole" coverage gap. In 2011, they will receive a 50% discount for covered brand-name prescriptions in the hole.
http://www.huffingtonpost.com/david-ormsby/gov-pat-quinn-illinois-health-care_b_840134.html

Iowa:

Consumers need help navigating insurance 03/21/2011

Health insurance is an important tool in protecting individuals and families from financial disaster. Because health insurance policies are confusing, complicated and have many options, most people choose to sit down, face to face, with a licensed professional when making decisions that provide these protections. Health plans offered through the "exchange" will not be identical - they will be "actuarially equivalent."
http://www.desmoinesregister.com/article/20110322/OPINION04/103220333/Consumers-need-help-navigating-insurance

Kansas:

Bill protesting federal health reform law likely headed to 'stalemate' 03/24/2011

Senate Minority Leader Anthony Hensley predicted today that coming negotiations between the House and Senate over a bill protesting the federal health reform law would likely result in a, "stalemate." The Topeka Democrat said he expected disagreements over various provisions added to the bill in the Senate, notwithstanding an additional Senate amendment to House Bill 2182, saying that no Kansan could be compelled to buy health insurance.
http://www.khi.org/news/2011/mar/24/bills-protesting-federal-health-reform-law-likely-/

One year later health reform still uncertain 03/24/2011

Health care reform in America, one year later: More people can get insurance but some premiums are higher. Seniors can get checks for drug costs, but taxes for that "fake bake" tan are higher. Health care reform politics, one year later: A fierce push to repeal or de-fund the law. An intense legal assault challenging the law's constitutionality. Republicans angrily insisting the federal government has overreached. Meanwhile, states are quietly working on establishing exchanges where millions of Americans will eventually find coverage. Kansas appears to be ahead of the game. Thanks to a federal grant, the state may be able to hire contractors to design its exchange system a year ahead of schedule.
http://www.kansascity.com/2011/03/24/2751192/one-year-later-health-reform-still.html

Louisiana:

Louisiana to opt out of health insurance exchanges in federal law 03/23/2011

Louisiana will opt out of creating state-level insurance exchanges as part of the new federal health-care law, Health and Hospitals Secretary Bruce Greenstein said Wednesday. Greenstein said Louisiana will return a $1 million federal grant it received to help set up the exchanges, which are designed to create a regulated marketplace where individuals and small businesses can buy subsidized private coverage.
http://www.nola.com/politics/index.ssf/2011/03/louisiana_to_opt_out_of_health.html

Maryland:

Public-private Maryland health exchange moves forward 03/24/2011

The state's new health insurance exchange is one step closer to being set up as a public-private hybrid entity. The Senate Finance Committee on Wednesday approved Senate Bill 182, Gov. Martin O'Malley's health insurance exchange bill, on a party line vote of 8 to 3. The House Health and Government Operations Committee is expected to soon vote on the counterpart version of the bill, House Bill 166. The House committee said it is still working on amendments to the bill.
http://www.bizjournals.com/baltimore/news/2011/03/24/public-private-maryland-health.html

Massachusetts:

Commonwealth Connector needs repairs, study says 03/25/2011

The Commonwealth Connector, Massachusetts' version of a health insurance exchange, has failed to attract many small business purchasers and individuals who are not eligible for subsidies. That's the assessment of a new report from a nonpartisan, privately funded research group in the state, the Pioneer Institute. Small businesses and individuals who do not qualify for subsidies make up only 1.5 percent of the Connector's membership. And less than 1 percent of small group insurance purchases in the state are made through the exchange, the report found.
http://www.stateline.org/live/details/story?contentId=561879

Minnesota:

Republican plan upends Minnesota health care programs 03/23/2011

It's our money. I don't know why the people in Washington think they know how we need to spend our taxpayers' money," said Sen. David Hann, R-Eden Prairie, who on Wednesday introduced his plan that serves as the basis for the Senate's omnibus health and human services spending bill. It includes a provision for the state to cease spending on implementing the federal health care law until and unless it is declared constitutional by the U.S. Supreme Court. Meanwhile, DFL Gov. Mark Dayton's health and finance commissioners criticized the House plan as "untenable," and Dayton signed an executive order targeting HMOs — a move that Republicans have made rumblings about but so far have avoided.
http://www.twincities.com/minneapolis/ci_17687181?nclick_check=1

Bloom Health's Sen bets on end of employer-sponsored health plans 03/21/2011

So is an employer-sponsored health plan someday going to be a benefit as quaint and luxurious as, say, a pension plan is today? At least one entrepreneur, Abir Sen of Minneapolis-based Bloom Health, says he knew the answer in 2009, and he's using his one-year-old startup to offer a middle ground that he thinks will replace employer-sponsored plans in much the same way that the 401(k) plan has mostly replaced the pension.
http://www.minnpost.com/medcitynews/2011/03/21/26776/bloom_healths_sen_bets_on_end_of_employer-sponsored_health_plans

Missouri:

Mo. conservatives back state health insurance exchanges despite efforts to limit federal law 03/19/2011

Nearly one year after a federal law overhauling the nation's health care system was enacted; Missouri lawmakers have taken a small step toward implementing some of its provisions by creating a health insurance exchange. Rep. Chris Molendorp, a Belton Republican, is sponsoring a bill to create the insurance exchange. That bill was passed by a House committee last week. Molendorp says the state must set up the exchange soon in order to meet federal deadlines.
http://www.fox4kc.com/news/sns-ap-mo-xgr--healthinsuranceexchanges,0,6166675.story

Montana:

House panel kills off health insurance exchange bills 03/23/2011

Republicans on a House committee today killed two bills that would begin setting up a federally required health-insurance Internet marketplace in Montana. The House Business and Labor Committee voted 14-7 along party lines to kill a Democratic proposal to begin setting up a state-based health insurance exchange. The panel later failed by a single vote to endorse House Bill 620, a compromise measure sponsored by Republican Rep. Tom Berry of Roundup, and then voted 12-9 to kill that bill, too - just one day after a hearing at which insurers, insurance agents, business representatives and consumer groups turned out to support it. Republican members said they may approve a separate bill to have a legislative panel study the issue over the next two years, and make recommendations to the 2013 Legislature.
http://helenair.com/news/article_bfbad5c2-5579-11e0-8fc4-001cc4c03286.html

Lindeen supports compromise on health exchange 03/23/2011

The office of Montana Insurance Commissioner Monica Lindeen testified Tuesday in favor of HB 620, a bill to create the Treasure State Health Gateway. "I have worked tirelessly with both sides of the aisle and all stakeholders across the state to craft a bi-partisan plan for the benefit of Montana's families and small businesses," said Lindeen. "The Treasure State Health Gateway will allow us to create a Montana solution for an online marketplace where individuals and small businesses can easily compare rates, benefits and quality among health plans."
http://www.clarkforkchronicle.com/article.php/2011032300575166

Some MT Republicans now back health care exchange 03/22/2011

A plan to set up a state-regulated health insurance marketplace is getting a second chance in the Montana Legislature. Republican legislative leaders have often spoken out against the Obama administration's federal health care law, part of which

calls for state-run health care exchanges. Now HB 620, sponsored by Rep. Tom Berry (R), is giving the proposal a second life. Berry's bill would set up the state health insurance exchange that Democrats have asked for, but it would also give insurance companies more power in the regulation of the exchange to appeal to critics of the federal health care law.
http://www.businessweek.com/ap/financialnews/D9M4HGUG0.htm

Nevada:

State Lawmaker Seeks Bill to Increase Transparency of Health Insurance Plans for Consumers 03/18/2011

Assembly Speaker John Oceguera testified today in support of a bill that would expand health insurance transparency for consumers so they can shop for the best coverage. Assembly Bill 309, reviewed by the Assembly Commerce and Labor Committee, is opposed by many companies offering health insurance in Nevada. Only one insurance representative testified against the bill at the hearing, however. The measure was supported by Nevada Insurance Commissioner Brett Barratt, who said it will dovetail nicely with the state's effort to set up a health insurance exchange under the federal health care law so individuals can shop for and purchase health insurance.
http://www.nevadanewsbureau.com/2011/03/18/state-lawmaker-seeks-bill-to-increase-transparency-of-health-insurance-plans-for-consumers/

New Mexico:

Changes coming for schools, health care, law enforcement 03/20/2011

On Saturday, Martinez was unsure whether she'd sign or veto two health care proposals that state lawmakers sent her. One proposal would force health insurers seeking to hike premiums to open their financial books to the state of New Mexico. It also would change how appeals of premium rate decisions are handled. The other would establish a state health care exchange, a clearinghouse where individuals and small businesses can shop for insurance as well as subsidies that could help them pay for it.
http://www.santafenewmexican.com/Local%20News/2011-Legislature-changes-coming-for-schools--health-care--law-e

Summary of 2011 NM legislative session 03/19/2011

Passed: Establish a health insurance exchange for individuals and small businesses to buy health insurance; allow people to donate unused prescription drugs to doctors, licensed clinics and health care facilities; strengthen regulatory review of health insurance premium increases; cover doctor corporations in state's medical malpractice system and raise liability cap from $600,000 to $1 million.
http://www.necn.com/03/19/11/Summary-of-2011-NM-legislative-session/landing_politics.html?&blockID=3&apID=e51187dbb6a440d592533c5b49cdd912

North Carolina:

Lawmakers debate health care exchange 03/21/2011

The N.C. General Assembly will consider pieces of legislation that propose different ways to set up the state's health benefits exchange, a part of the health care system that each state must establish under the Affordable Care Act passed in March 2009. The assembly is in the early stages of passing a bill to create the exchange, which will include an online marketplace where individuals and small businesses can shop among different health insurance policies.
http://reesenews.org/2011/03/21/lawmakers-debate-health-care-exchange-program/12786/

Brief reprieve on Blue Cross health reform bill? 03/21/2011

The bill to create a health benefits exchange in North Carolina was supposed to get a committee hearing tomorrow. But notification went out a few minutes ago pulling the legislation from the committee calendar. If you recall, the exchange is a new insurance marketplace in North Carolina that will open in 2014. It will provide for meaningful competition between health insurance companies and help serve as a consumer watchdog. At least that's how it should operate. Instead Blue Cross and Blue Shield of North Carolina is pushing a bill that would provide for a stripped down exchange where insurance companies and other interest groups would have a role in regulating themselves.
http://pulse.ncpolicywatch.org/2011/03/21/brief-reprieve-on-blue-cross-health-reform-bill/

Oklahoma:

Fallin, insurance commissioner defend decision to accept money 03/24/2011

Gov. Mary Fallin and Insurance Commissioner John Doak on Thursday defended Fallin's decision to accept a $54 million federal grant to implement a state health insurance exchange. Speaking separately to the Tulsa Health Underwriters Association at Tulsa Country Club, Fallin and Doak said refusing to act could lead to the federal government imposing such a program. Asked if the state could afford to implement an exchange without the federal money, Fallin said, "No, We have a $500 million hole in our budget."

http://www.tulsaworld.com/news/article.aspx?subjectid=17&articleid=20110324_12_0_GovMar663833

GOP rips Fallin over health-care bill 03/24/2011

Gov. Mary Fallin is being criticized by fellow Republicans because of her support for a proposal that some say is the first step to implementing "Obama-care" in Oklahoma. Fallin campaigned against federal health-care reform, voted against it while she was in Congress and maintains that it is unconstitutional. But she is being ripped by some of the most conservative members of her own party for backing House Bill 2130, which would set up a framework for health-care insurance exchanges in the state.

http://www.tulsaworld.com/news/article.aspx?subjectid=16&articleid=20110324_16_A1_CUTLIN993267

Oklahoma Governor Proposes Alternative to Federal Health Care Law 03/22/2011

Oklahoma Governor Mary Fallin has announced a proposed alternative to President Obama's health care law, also known as the Patient Protection and Affordable Care Act (PPACA). Governor Fallin sent a letter to state lawmakers Tuesday asking them to pass House Bill 2130. The measure would create an Oklahoma Health Insurance Exchange, which Fallin says would help avoid the forced implementation of the federal health care law in Oklahoma.

http://www.newson6.com/Global/story.asp?S=14302325

Oregon:

Amendment Challenged for Insurance Exchange with Brokers 03/21/2011

Testimony at last Thursday's work session on Oregon's health insurance exchange bill illustrates the rough road ahead for the legislation. Rep. Mitch Greenlick (D-Portland), who was invited to the work session along with Reps. Jim Weidner (R-Yamhill) and Val Hoyle (D-West Eugene), quickly steered the conversation toward the role of independent insurance agents in the exchange. "If we have them in this, it could easily take me and my caucus off the bill," said Greenlick, protesting an amendment to the original Senate Bill 99 that would allow the exchange to employ insurance brokers.

http://www.thelundreport.org/resource/amendment_challenged_for_insurance_exchange_with_brokers

Oregon NFIB Poll on ObamaCare 03/21/2011

Oregon NFIB member Poll Puts Finger on the Pulse of the Problem with ObamaCare: The narrowest margin of difference came on the question: Should Oregon establish its own health insurance exchange instead of deferring to the federal government? Only 36 percent of NFIB-member, small-business owners voted 'Yes,' 35 percent said 'No,' and 29 percent were undecided.

http://oregonbusinessreport.com/2011/03/oregon-nfib-poll-on-obamacare/

Pennsylvania:

Corbett says health-care challenges should go straight to Supreme Court 03/24/2011

Gov. Corbett on Wednesday waded into the debate on the federal health-care law, urging the Obama administration to petition to have challenges of that law sent straight to the U.S. Supreme Court, bypassing lower appellate courts because of the urgency of the issue. "Pennsylvania and all states need clarity," Corbett said, appearing as star witness at a congressional hearing held in an unusual setting - the state Capitol, on the law's first anniversary.

http://www.philly.com/philly/news/local/20110324_Corbett_says_health-care_challenges_should_go_straight_to_Supreme_Court.html

Rhode Island:

Mandatory Health Insurance: How Will It Affect You? 03/19/2011

Dozens of Rhode Islanders spent their Friday morning getting a crash course on how they will be affected by the creation of a mandatory health insurance exchange that will be fully operational by 2014, as required by President Obama's Affordable Care Act.

http://www.golocalprov.com/news/mandatory-health-insurance-how-will-it-affect-you/

South Carolina:

Sen. DeMint chooses ideology over doctor's promising device 03/23/2011

Dr. David Cull, a prominent vascular surgeon in Greenville, had invented a small valve system that, if it works, could spare 300,000 dialysis patients across the country enormous suffering and save U.S. taxpayers billions of dollars. But Cull's hometown senator, Jim DeMint, would not write a letter supporting the surgeon's application for a federal grant under the landmark health care bill that President Barack Obama signed into law a year ago today.

http://www.miamiherald.com/2011/03/23/2129578/sen-demint-chooses-ideology-over.html

South Carolina insurance study panel gets project leader 03/19/2011

The state Department of Insurance hired someone to head a health insurance exchange study committee this week, and members of competing efforts to create such an exchange agreed to sit down and talk. The Insurance Department hired Gary Thibault, who most recently served as executive director of the S.C. Worker's Compensation Commission. Thibault was hired as the project manager of a $1 million federal grant to plan for health insurance exchanges. Gov. Haley last week issued an executive order to create a 12-member study panel.

http://www.goupstate.com/article/20110319/ARTICLES/103191007/1083/ARTICLES?Title=South-Carolina-insurance-study-panel-gets-project-leader

Texas:

Texas needs to establish its own health exchange 03/22/2011

It has been one year since President Obama signed the Patient Protection and Affordable Care Act into law, and Texas is at a policy crossroads: We can choose to lead with responsible public policy or become supporting actors in a national political sideshow. The reality is that the success of health reform now depends on the states.

http://www.chron.com/disp/story.mpl/editorial/outlook/7486700.html

JOE STALLINGS: Don't exchange your insurance agent 03/20/2011

Proponents of the new health care law claim to have seen the future of Texans' health care — and they say it's a lot like air travel. According to some, come January 2014 choosing a health insurance plan in the new exchanges will be as easy as shopping on Orbitz. By cutting insurance agents from the transaction and forcing consumers and employers to buy policies direct, advocates claim that the exchanges will trim costs.

http://www.gosanangelo.com/news/2011/mar/20/joe-stallings-dont-exchange-your-insurance-agent/

Vermont:

House OKs health care 03/25/2011

The Vermont House of Representatives passed a bill calling for a single-payer system Thursday afternoon, putting the state on a path to become the first in the nation to adopt universal access to health care. Lawmakers voted 92 to 49 after nearly two days of debate, including discussion on the floor until the early morning hours on Thursday. Advocates hail the measure as the solution to control costs by reducing administrative overhead. However, critics said it leaves too much financial uncertainty and could hurt the economic growth in Vermont.

http://www.reformer.com/localnews/ci_17695660

Vermont House to begin health reform debate Tuesday 03/21/2011

Tuesday the Vermont House of Representatives begins debate on health-care reform — one of the most important bills of the session for Democratic Gov. Peter Shumlin and the Democratic majorities in the Legislature. Originally touted as an initiative that would head the state to a single-payer system, the 96-page bill now carries a new, less controversial name: "Road map to a universal and unified health system."
http://www.burlingtonfreepress.com/article/20110321/NEWS03/110320013/1053/COLUMNISTS03/Vermont-House-begin-health-reform-debate-Tuesday?odyssey=nav%7Chead

Wisconsin:

Wisconsin Republicans' Bill Would Block Health Care Law 03/23/2011

A bill being circulated by Sen. Joe Liebham of Sheboygan and Rep. Robin Vos of Racine would amend the state Constitution to prohibit passing any law requiring residents to participate in a health care plan. Attorney General J.B. Van Hollen claims the law is unconstitutional and joined a multistate lawsuit against the law in January. Wisconsin is also looking into private alternatives to the health care exchanges. The bill would have to be approved in two consecutive legislative sessions and voted on in a statewide referendum before the change could take effect.
http://www.nbc15.com/state/headlines/Wisconsin_Republicans_Bill_Would_Block_Health_Care_Law_118536489.html

Business-related columns and commentary: Good intentions, unrealistic expectations 03/21/2011

Over time, the state of Wisconsin has found itself wading deeper and deeper into the business of providing health insurance for our citizens. The downturn in the state's economy has resulted in a record number of enrollees in BadgerCare – products that are meant to provide a safety net for low income families around the state to ensure they receive quality affordable health care as they work to improve their personal financial situation and obtain private insurance.
http://bizopinion.wisbusiness.com/2011/03/good-intentions-unrealistic.html

Wisconsin's health-care fight illustrates challenges as states change leadership 03/18/2011

Two weeks after President Obama signed the nation's health-care overhaul into law, then-Wisconsin Gov. Jim Doyle (D) issued an executive order creating an Office of Health Care Reform. Then, in late January, Doyle's Republican successor, Scott Walker, issued his own executive order, dissolving the health reform office and replacing it with the Office of Free Market Health Care. In a primary example of obeying the law selectively, Walker said he will create one or more marketplaces called exchanges to help individuals and small businesses buy insurance. But the exchanges will not do everything the law says. "We believe it's got to be free-market driven, not government driven," Walker said.
http://www.washingtonpost.com/national/wisconsins-health-care-fight-illustrates-challenges-as-states-change-leadership/2011/03/09/ABHdjhq_singlePage.html

Guam:

Guam Gets $1M Health Exchange Grant from U.S. Department of Health 03/23/2011

Congresswoman Madeleine Bordallo has announced that the Government of Guam will receive $1 million in an Exchange Planning and Establishment Grant. This grant will allow the Guam Department of Revenue and Taxation to survey small businesses and collect data on insured and uninsured employees—including those who might be eligible to participate in the Exchange, and those whom are eligible but not currently enrolled in Medicaid or an employer's coverage.
http://www.pacificnewscenter.com/index.php?option=com_content&view=article&id=12662:guam-gets-1m-health-exchange-grant&catid=45:guam-news&Itemid=156

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 03/11/2011 – 03/18/2011

Federal News

States put own spin on Obama health care law 03/18/2011

Rancor over President Obama's health care overhaul has largely overshadowed some states' efforts to use the law to help them move as fast as possible to insure more people and increase control over insurance companies. Minnesota, Connecticut and Washington, D.C., have leveraged more federal dollars to expand coverage of childless adults. Vermont is exploring a single-payer health care system that would phase out most private insurance, a strategy rejected by Congress as too radical for the rest of the nation. Oregon is focusing on preventive care and providing proven treatments.
http://www.burlingtonfreepress.com/article/20110318/NEWS03/103180306/States-put-own-spin-Obama-health-care-law?odyssey=nav%7Chead

Flexibility Key Word at Senate Hearing on State Exchanges 03/18/2011

State officials from different political perspectives expressed interest in establishing health insurance exchanges, and an administration official promised "a wide berth" in how states choose to construct parts of the reform law.
http://www.kaiserhealthnews.org/Daily-Reports/2011/March/18/health-exchanges.aspx

At One-Year Mark, Implications of Health Law Emerge 03/17/2011

Media outlets report on a range of issues related to implementation of the health law and its one-year anniversary — among them, the unexpected importance taken on by waivers, the marketplace impact on health insurance brokers, the geography of the health care workforce issues likely to result from coverage expansions and the continuing problems faced by lawmakers who are trying to repeal the measure's 1099 reporting provision.
http://www.kaiserhealthnews.org/Daily-Reports/2011/March/17/health-reform-policy-implications.aspx

CMS Seeking Health IT Advisory Panel Feedback on Eligibility Web Hub 03/16/2011

CMS has requested feedback from the Health IT Policy Committee's enrollment work group about a Web-based hub that would support the exchange of information from applicants for state health and human services programs, Government Health IT reports. The exchange of eligibility data will become increasingly important as more states take steps to build electronic health insurance exchanges under the federal health reform law.
http://www.ihealthbeat.org/articles/2011/3/16/cms-seeking-health-it-advisory-panel-feedback-on-eligibility-web-hub.aspx#ixzz1GsKevap5

Insurance brokers seek protection as health-care law squeezes payments to them 03/16/2011

Insurance brokers, worried that their livelihoods are in jeopardy from the health law, are pressing Congress and state legislatures to safeguard agent commissions and guarantee them a role in new online marketplaces where people will shop for coverage. The efforts are spawning political clashes between consumer advocates and brokers as well as a debate about whether the proposed broker protections would help people save money or increase premiums.
http://www.washingtonpost.com/business/economy/political-clash-develops-on-insurance-broker-protections/2011/03/16/ABZrHHf_story.html

Kevin Counihan Named President of CHOICE Administrators Exchange Services 03/16/2011

Kevin J. Counihan, a 25-year veteran of the health insurance industry, has been appointed president of CHOICE Administrators Exchange Services, effective March 15. CHOICE Administrators Exchange Services is a division of CHOICE Administrators, the nation's leading developer and administrator of health insurance exchanges.
http://insurancenewsnet.com/article.aspx?id=252198

Ron Goldstein Named Chief Executive Officer of CHOICE Administrators 03/15/2011

Concurrent with the company's continued growth across the United States, Ron Goldstein, CLU, has been named president and chief executive officer of CHOICE Administrators. CHOICE Administrators has been the nation's leading developer and administrator of health insurance exchanges for nearly two decades and serves as the umbrella company for several consumer- and employer-focused health insurance exchange programs, covering hundreds of thousands of Americans.
http://insurancenewsnet.com/article.aspx?id=251961&type=newswires

Health broker bill could be the next 1099 03/15/2011

Legislators and lobbyists are eyeing a bill supporting health insurance brokers as the next health reform tweak that, after the 1099 repeal, has a fighting shot at passing. The legislation, expected to hit the House floor this month, would pull health insurance broker commissions out of the new medical loss ratio regulation, a reform provision that requires insurers to spend 80 percent of every premium dollar on medical costs. In the regulation, agent commissions are categorized as a nonmedical cost, which has encouraged insurers to slash broker rates as a way to shrink administrative spending to 20 percent of subscriber premiums.
http://www.politico.com/news/stories/0311/51295.html

New Report Estimates the Effect of the ACA on States 03/11/2011

A new report from the Robert Wood Johnson Foundation, "Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid," provides estimates on the effects of the ACA for the 50 states and the District of Columbia. The authors used modeling to predict their results based on full implementation of the ACA.
http://www.rwjf.org/files/research/71952.pdf

State News

Alaska:

Alaska businesses surveyed on health care exchange, other issues 03/12/2011

NFIB-Alaska asked five questions of the group's 2,000 Alaska members, which is about 10 percent of the state's "nonfarm businesses" according to relatively recent Census data. When asked whether a health insurance exchange should be created by the state or by the federal government, small businesses were not so sure. The NFIB claims that 53 percent of their members preferred the state alternative. But the other 47 percent were either undecided or thought it best left to the Department of Health and Human Services to set the standards.
http://www.alaskadispatch.com/article/alaska-businesses-surveyed-health-care-exchange-other-issues

California:

Blue Shield of California Withdraws Planned Rate Hike 03/17/2011

Part of the reason for the decision may have been the result of political and public pressure, but an unexpected development may have made the retreat easier for the company to accept — it's paying out less than expected for claims.
http://www.kaiserhealthnews.org/Daily-Reports/2011/March/17/calif-blue-shield-rates.aspx

Colorado:

Colorado House leader wants Colorado out of federal health reform but into exchanges 03/16/2011

House Majority Leader Amy Stephens is no fan of "Obamacare." So Stephens seemed an unlikely co-sponsor of legislation that would enact one of the key tenets of health reform: health insurance "exchanges." "I think you have to explore the exchange issue on its own," Stephens said. "I've always been intrigued by the exchange idea and how it might help small business." Stephens has agreed to be the House sponsor for a Senate bill with Sen. Betty Boyd, D-Lakewood, that would set up the insurance exchanges in Colorado. The two have not finalized the bill, which is expected to be introduced soon.
http://www.denverpost.com/search/ci_17622803

Bill coming soon to establish Colorado health exchange 03/15/2011

A bipartisan bill that would develop the specifics of a Colorado health exchange will be introduced late this week or early next week according to bill sponsor Sen. Betty Boyd, D-Lakewood. Speaking in a meeting put together by the American Diabetes Association, Boyd said that she and House Majority Leader Amy Stephens had worked together to develop a bill she thought may be one of the only bipartisan health exchange bills in the country.
http://coloradoindependent.com/79051/bill-coming-soon-to-establish-colorado-health-exchange

Florida:

Florida Passes Bill to Opt Out of Obamacare Abortion Funding 03/15/2011

A Florida committee passed two pieces of legislation that would allow the state to opt out of the abortion funding allowed under the Obamacare health care reform law. On Monday, the Senate Health Regulation Committee passed SB 1414 that would make it so health insurance plans under the state exchange would not be able to fund abortions with taxpayer dollars in nearly all cases. The second measure is a proposed amendment to the state Constitution that bans any state taxpayer funding of abortion unless necessary to save the life of the mother and it is a bill sponsored by Rep. Anitere Flores, a Miami Republican.
http://www.lifenews.com/2011/03/15/florida-passes-bill-to-opt-out-of-obamacare-abortion-funding/

Georgia:

Governor pulls health exchange bill after tea party objects 03/16/2011

A last-minute tea party protest prompted Gov. Nathan Deal on Wednesday to shelve legislation that would have planned for a Georgia health insurance exchange. The legislation enjoyed wide support until phone calls started rolling in this week from tea partyers. Deal said Wednesday that he would put the legislation on hold and instead create an advisory committee to study the state's options for an exchange.
http://www.ajc.com/news/georgia-politics-elections/governor-pulls-health-exchange-874973.html

GOP Holds Off On Healthcare Bill 03/16/2011

GOP leaders pulled a bill from the House floor that would have fulfilled one of law's requirements. Governor Nathan Deal's legislation would have begun the process of setting up the exchange this year. But after his office and other Republican leaders, including House Majority Whip Ed Lindsey, met with groups including tea party activists, they decided to put it off.
http://www.gpb.org/news/2011/03/16/gop-holds-off-on-healthcare-bill

Idaho:

Senate OKs using federal health reform money for insurance exchange 03/16/2011

The Idaho Senate voted 20-15 Tuesday to let the Department of Insurance use a $2.5 million grant from the 2010 federal health reform plan to research a health insurance exchange. Many senators spoke against the plan, due to their opposition to the overall health insurance plan.
http://www.idahoreporter.com/2011/senate-oks-using-federal-health-reform-money-for-insurance-exchange/

Maryland:

Md. unveils tax credit campaign for small businesses 03/15/2011

State health officials and advocates joined CareFirst BlueCross BlueShield Tuesday in unveiling a more than $150,000 campaign to spread the word about tax credits available to small businesses under federal health care reform.

http://www.baltimoresun.com/business/bs-bz-small-business-campaign-20110315,0,6224878.story

Massachusetts:

Speaker DeLeo Says Towns Must Match Or Join State Health Plan 03/15/2011

Massachusetts House Speaker DeLeo says towns must match or join State Health Plan. DeLeo spoke to the Greater Boston Chamber of Commerce today. ... "By the time the House completes its work on the state budget, we will have passed legislation that establishes the state's Group Insurance Commission as the benchmark against which all municipal plans will be measured. If cities and towns can't meet or beat the GIC, they will be forced to join it. I've seen my hometown of Winthrop save $800,000 annually by joining the GIC."

http://commonhealth.wbur.org/2011/03/deleo-gic/

Missouri:

Small businesses missing out on health reform benefits 03/16/2011

Over 85,000 of Missouri's small businesses are eligible for tax credits under the Affordable Care Act to help offset the cost of health insurance for their employees. However, thousands of those businesses still have not claimed the subsidies available through the health care reform law. The law provides for a tax credit for small businesses (25 or fewer full-time employees) that covers up to 35 percent of the premiums a small business pays took effect in March 2010. In 2014, the tax credit will increase to 50 percent.

http://www.stlamerican.com/business/business_briefs/article_8c771326-5013-11e0-8f1b-001cc4c002e0.html

Montana:

New Montana health-insurance exchange bills coming forward 03/16/2011

A new bill that seeks a compromise on a federally mandated Internet health-insurance marketplace in Montana was introduced at the Legislature Wednesday, with support from Democrats and some Republicans. Yet its chief sponsor, Rep. Tom Berry, R-Roundup, said he still expects the measure to be controversial, and that it may be difficult to push it through the Legislature.

http://missoulian.com/news/state-and-regional/article_1efc8180-502e-11e0-8e3f-001cc4c03286.html

New Mexico:

NM House Committee Kills Health Insurance Exchange Bill 03/15/2011

Yesterday in the New Mexico House Appropriations and Finance Committee (HAFC), a bill that would initiate the early stages of creating a health insurance exchange was killed by an 8-5 vote. The combined Senate Bill 38/370, sponsored by Senators Dede Feldman (D-Bernalillo-13) and George Munoz (D-Cibola, McKinley-4), previously gained passage in the Senate by a vote of 36-3 and a Do Pass in the House Consumer and Public Affairs Committee (HCPAC) by a 3-2 margin.

http://www.democracyfornewmexico.com/democracy_for_new_mexico/2011/03/nm-house-committee-kills-health-insurance-exchange-bill.html

North Carolina:

NC health exchange/marketplace coalition launches new website 03/16/2011

A large number of groups representing the interests of thousands of consumers in NC – Citizens for Responsible Health Care – launched a new website today with the intention of bringing the debate over NC's attempt to create a new health marketplace under national health reform to a wider audience.

http://pulse.ncpolicywatch.org/2011/03/16/nc-health-exchangemarketplace-coalition-launches-new-website/

Oklahoma:

Oklahoma House approves bill for insurance exchange board that would help the uninsured 03/18/2011

The Oklahoma House of Representatives has approved a bill that would set up the membership of a board that will create a state health care exchange for uninsured residents. The bill sponsored by House Speaker Kris Steele passed 51-34 Thursday and now heads to the Senate.

http://www.canadianbusiness.com/markets/market_news/article.jsp?content=D9M1MFO00

Ohio:

Healthcare reform legislation: How Ohio can fight back 03/15/2011

Health care reform has been unpopular with Buckeye State voters for some time; more than 60 percent favored repeal in a Rasmussen poll taken just before the midterm elections. Fortunately, Ohio can help defeat this top-heavy federal takeover of its residents' access to health care. By refusing to establish the "health insurance exchanges" prescribed by the new law, Ohio's leaders can avoid wasting state tax dollars doing the reform law's dirty work — and protect the health insurance choices of their constituents in the process.

http://www.medcitynews.com/2011/03/healthcare-reform-legislation-how-ohio-can-fight-back/

Pennsylvania:

Insurance Commissioner: Gov Worked Hard for Alternative to AdultBasic 03/18/2011

At a Senate Appropriations Committee hearing, Acting Insurance Commissioner Michael Consedine said he would like to see a Supreme Court ruling on the measure's constitutionality, before Pennsylvania decides whether or not to create a state-level health care exchange.

http://wduqnews.blogspot.com/2011/03/insurance-commissioner-gov-worked-hard.html

Pennsylvania sued for axing low-income health plan 03/16/2011

Pennsylvania's governor and other state politicians have been sued in a class action suit after 41,000 residents lost health coverage following the state's axing of an insurance program for low-income workers.

http://in.reuters.com/article/2011/03/15/us-pennsylvania-health-idINTRE72E8UM20110315

South Carolina:

Bill would set up health exchange for small firms 03/18/2011

Legislation facilitating insurance coverage in South Carolina under the federal health care law has received unanimous approval from a House subcommittee. The bill, which now moves to the full Ways and Means Committee, was sponsored by Rep. Harold Mitchell Jr., D-Spartanburg, and co-sponsored by 23 legislators. On Wednesday, three GOP legislators, Rep. Rita Allison, Rep. Jenny Horne, and Rep. Bill Herbkersman, requested their names be removed as co-sponsors.

http://www.thetandd.com/news/local/article_7ff173bc-5112-11e0-8b41-001cc4c03286.html

Vermont:

State-Based, Single-Payer Health Care — A Solution for the United States? 03/16/2011

One analysis of Vermont's health care system found that the system capable of producing the greatest potential savings and achieving universal coverage was a single-payer system — one insurance fund that covers everyone with a standard benefit package, paying uniform rates to all providers through a single payment mechanism and claims-processing system. The analysis

showed that Vermont could quickly save almost 8% in health care expenditures through administrative simplification and consolidation, plus another 5% by reducing fraud and abuse.
http://healthpolicyandreform.nejm.org/?p=13939

Washington:

State lawmakers get started on health reform 03/14/2011

Washington lawmakers already are moving to put pieces of federal health reform into place well before the January 2014 drop-dead date for it to be implemented. Rival bills that set up a state health insurance exchange sailed through the House and the Senate this month. Some Republicans backed those and other related bills too. Democratic Rep. Eileen Cody of Seattle said Gov. Chris Gregoire could move ahead administratively to set up the exchange, which the Legislature approved but did not fund a few years ago
http://www.theolympian.com/2011/03/14/1578258/state-lawmakers-get-started-on.html

West Virginia:

Approval of the Exchange 03/17/2011

West Virginia is the fourth state to pass legislation setting up a health insurance exchange. The state legislature completed action on the health care reform bill last week. State Insurance Commissioner Jane Cline says the approved bill will enable her office to set up the framework that will one day be a marketplace for health insurance for those who don't have it.
http://www.wvmetronews.com/news.cfm?func=displayfullstory&storyid=43999

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 03/04/2011 – 03/11/2011

Federal News

Obama Administration Takes New Steps to Support Innovation, Empower States 03/10/2011

The Affordable Care Act gives states the flexibility to receive a State Innovation Waiver so they may pursue their own innovative strategies to ensure their residents have access to high quality, affordable health insurance. Under the law, State Innovation Waivers are available in 2017. President Obama supports bipartisan legislation that would make waivers available to states beginning in 2014. The proposed regulation announced today describes the content of the waiver application and how such proposals may be disclosed to the public, monitored, and evaluated.
http://www.hhs.gov/news/press/2011pres/03/20110310a.html

As Health Costs Soar, G.O.P. and Insurers Differ on Cause 03/04/2011

As Congress continues to debate the new health care law, health insurance costs are still rising, particularly for small businesses. Republicans are seizing on the trend as evidence that the new law includes expensive features that are driving up premiums. But the insurance industry says premiums are rising primarily because of the underlying cost of care and a growing demand for it.
http://www.nytimes.com/2011/03/05/health/policy/05cost.html?_r=3&hp

State News

Alabama:

Alabama Works toward Health Insurance Exchange 03/05/2011

Gov. Robert Bentley said he hopes to have legislation passed this session establishing a framework for the exchange. Bentley is a strong critic of the federal health care law, calling it "the worst bill that Congress has passed in many, many years." But Bentley said he also favored establishment of a state insurance exchange before it was mandated by the federal government. Rep. Greg Wren, R-Montgomery, said he hopes to have legislation introduced next week establishing a raw framework for the exchange. Wren said the bill would establish a board that would have the authority to create the exchange.
http://blog.al.com/spotnews/2011/03/alabama_works_toward_health_in.html

Alaska:

Alaska State Legislative Committee to Take Up Proposal to Create Health Care Exchange 03/08/2011

An Alaska senator says a legislative effort to establish a health insurance exchange is more important than ever following a judge's decision last week. Democratic Sen. Hollis French has proposed legislation to establish an exchange. Alaska was the only state that didn't apply for federal funds to implement a program.
http://www.canadianbusiness.com/markets/market_news/article.jsp?content=D9LR5J280

Georgia:

Georgia Takes First Step toward Healthcare Reform 03/07/2011

A House subcommittee unanimously approved a bill (HB 476) that would create the Georgia Health Exchange Authority. Georgia is moving forward with plans for a state-run exchange while it is also vigorously contesting the constitutionality of the Patient Protection and Affordable Care Act. State legislators know that if the law stands and Georgia doesn't set up its own health insurance exchange, then the federal government would design and run Georgia's marketplace.
http://www.ajc.com/news/georgia-politics-elections/georgia-takes-first-step-864218.html

Georgia HB476 03/07/2011

The purpose of this Act is to provide for a Georgia Health Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this state in accordance with federal law. This Act also provides for the establishment of a Small Business Health Options Program (SHOP) Exchange to assist qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans offered in the small group market.
http://www1.legis.ga.gov/legis/2011_12/fulltext/hb476.htm

Indiana:

Indiana Seeks Input on Health Exchange 03/09/2011

The state is launching an online questionnaire for Hoosiers to give their input on a potential health care exchange. The Family & Social Services Administration says the responses will help shape the Indiana Insurance Market Inc. The plan is in line with Governor Mitch Daniels' executive order earlier this year calling for the conditional establishment of a health exchange.
http://www.insideindianabusiness.com/newsitem.asp?ID=46563

Kansas:

Kansas Insurance Department Seeks Vendor Input on Statewide Exchange 03/08/2011

Forming a statewide insurance network is a new concept for the Kansas Insurance Department. That's why its leaders are asking vendors to demonstrate how their products would work with a health insurance exchange. The Kansas Insurance Department has invited three vendors, GetInsured.com, Choice Administrators, and eHealthInsurance to demonstrate their products on March 15 and 31 in Topeka, respectively. The insurance department says it still has one available vendor slot for the 31st.
http://www.bizjournals.com/wichita/blog/2011/03/kansas-insurance-department-seeks.html#ixzz1G2l1SXjw

Massachusetts:

Health Care Reform Study: Massachusetts Health Insurance Exchange Fails to Cut Costs 03/10/2011

The conservative Pioneer Institute releases a report stating that the Massachusetts health insurance exchange has failed to attract small businesses, isn't controlling rising health insurance costs and faces imminent budgetary threats from national health care reform.
http://massdevice.com/news/health-care-reform-study-massachusetts-health-insurance-exchange-fails-cut-costs

Minnesota:

Minnesota in Depth: Gottwalt's Bill Anticipates New Health Law 03/05/2011

Debate is brewing over how or if Minnesota will adopt a health insurance exchange. Rep. Steve Gottwalt, R-St. Cloud, authored a bill to create an exchange. Gottwalt says he opposes the federal health law, but would rather see Minnesota design its own exchange than cede the task to the federal government. Yet Gottwalt's bill has divided some fellow critics of the federal law. Some conservatives are rallying against the Gottwalt measure, opposing any step to align Minnesota with the federal health care act. But key business groups — some of them no fans of the federal health law — support Gottwalt's proposal, saying they want the insurance exchange built here in Minnesota.
http://www.sctimes.com/article/20110305/NEWS01/103050011/1001/NEWS/In-depth--Gottwalt-s-bill-anticipates-new-health-law

Missouri:

Missouri Ponders Creating a Health Insurance Exchange 03/08/2011

Missouri residents and small businesses would be able to compare prices and purchase health care in a state-sponsored marketplace under legislation heard Tuesday in a House committee. The federal health care law passed last year requires the establishment of such exchanges, but the idea has been around Missouri for longer than that, said the bill's sponsor, Chris Molendorp, a Belton Republican.
http://www.kansascity.com/2011/03/08/2709535/missouri-ponders-creating-a-health.html

Montana:

Lindeen Testifies on Health Insurance Exchange, which Remains in Political Limbo 03/10/2011

State Auditor Monica Lindeen appeared Thursday before a House committee to support creation of a Montana health insurance "exchange" under the federal health reform law, saying the Internet marketplace eventually will help the uninsured get affordable policies.
http://billingsgazette.com/news/state-and-regional/montana/article_92aa3736-6322-5222-9700-2fcdba015660.html

North Carolina:

The Business Report covers Blue Cross Health Exchange Bill 03/11/2011

Justin Catanoso, executive editor of The Business Journal, discussed the controversy over establishing a health benefits exchange in North Carolina with a reporter from WFDD. Here's what Catanoso said about the Blue Cross bid to sit on the board of the exchange: "But having a vote on how these decisions are made really raises questions of board of governance, of conflicts-of-interest, and of ethics…" The entire interview can be accessed through the link below.
http://pulse.ncpolicywatch.org/2011/03/11/the-business-report-covers-blue-cross-health-exchange-bill/

North Carolina Health Exchange Deal Proposed 03/09/2011

The state's largest health insurer would not have a vote in how North Carolina's anticipated health insurance exchange is run, under a proposal state Insurance Commissioner Wayne Goodwin took to lawmakers Tuesday. Goodwin told a House committee that his plan is a compromise between two competing bills that would either put Blue Cross and Blue Shield of North Carolina on the board that would oversee the exchange or keep the company off. Consumer advocates have accused the company of orchestrating the legislation that would have given it a seat, but the company denies that.
http://www.newsobserver.com/2011/03/09/1039427/health-exchange-deal-proposed.html

Oregon:

Oregon Senate health committee hears strong support for Oregon Health Insurance Exchange 03/10/2011

Health care providers and small business owners testified before a Senate committee today in favor of creating a health insurance exchange in Oregon, but many of them said they don't want any insurance company employees on the governing board.
http://www.oregonlive.com/politics/index.ssf/2011/03/oregon_senate_health_committee.html

South Carolina:

South Carolina Panel will Study Health Exchanges 03/11/2011

Gov. Nikki Haley, a vocal opponent of the new federal health-care law, has taken the first step toward allowing the state to opt out of the plan. Haley told GreenvilleOnline.com on Thursday she has signed an executive order setting up a 12-member commission to study the idea of the state creating its own health exchange, a marketplace required under the new law where small businesses and individuals not covered by work insurance can shop for insurance at competitive rates.
http://www.greenvilleonline.com/article/20110311/NEWS/303110008/S-C-panel-will-study-health-exchanges

Tennessee:

Tennessee State Planning and Establishment Grant First Quarter Project Report 03/07/2011
Tennessee Planning Initiative for the PPACA Health Insurance Exchange First Quarter Project Report submitted for the State Planning and Establishment Grants for the Affordable Care Act's Exchanges.
http://www.tn.gov/nationalhealthreform/forms/planninggrant1stqtr.pdf

Utah:

Bill Could Artificially Help Utah's Health Exchange 03/08/2011
HB404 would direct lawmakers to scour the Public Employee Health Plan for places to cut costs and consider dumping its 25,000 beneficiaries, mostly state workers, into the exchange. The bill passed the House late Monday night 45-28.
http://www.sltrib.com/sltrib/home/51380556-76/health-exchange-utah-bill.html.csp

Virginia:

Virginia health exchange seeks private donations 03/11/2011
In what's believed to be an unprecedented step, the group trying to electronically connect Northern Virginia's hospitals, clinics, pharmacists and doctors will seek funding directly from private businesses outside of the health care industry.
http://www.bizjournals.com/washington/print-edition/2011/03/11/virginia-health-exchange-seeks-private.html

West Virginia:

West Virginia Agents Balk at Health Insurance Exchange 03/08/2011
With the Legislature's minority Republicans already opposing the pending bill, West Virginia's independent insurance agents are wary of this session's bid to create a state-run health insurance exchange. Supporters of the pending measure include Highmark Blue Cross Blue Shield West Virginia, the state's largest private insurer, industry giant United Healthcare, and the state's HMO associations. Their representatives were among two dozen who spoke in favor of the bill at a House Judiciary hearing last week.
http://www.insurancejournal.com/news/southeast/2011/03/08/189441.htm

Wisconsin:

Medicaid/Healthcare Numbers in Wisconsin - How do they look? 03/05/2011
As of the end of January 2011, there were about 1.16 million Wisconsinites on Medicaid-related programs, including 775,000 on BadgerCare, 193,000 Seniors and people with disabilities, more than 90,000 on SeniorCare, and about 57,000 receiving family planning services. During the same month, 36,947 Wisconsin residents were eligible under a Community Medicaid Waiver program and 20,581 Medicaid recipients were institutionalized in facilities of some kind.
http://www.livinglakecountry.com/blogs/communityblogs/117456083.html

Wisconsin Governor Issues Layoff Notices 03/04/2011
Wisconsin Governor Scott Walker, whose proposal to curb collective-bargaining rights has sparked protests across the U.S., issued notices to unions notifying them of possible job cuts that may come as soon as April. Members of bargaining units could receive the notices, according to letters sent from Wisconsin's Office of State Employment Relations today and made available by the governor's office.
http://www.detnews.com/article/20110304/NATION/103040452/1020/nation/Wisconsin-governor-issues-layoff-notices

A Health Insurance Exchange

Client Information Update

News and Information Highlights for 02/28/2011 – 03/04/2011

Designing an Exchange: A Toolkit for State Policymakers 03/03/2011

The National Academy of Social Insurance has released a toolkit for state policymakers on issues related to designing and implementing a state health insurance exchange. The new toolkit offers information about the health insurance exchange provisions of health reform and outlines key issues in the creation of an exchange.
http://mentalhealthcarereform.org/designing-an-exchange-a-toolkit-for-state-policymakers/

New Mexico Health Exchange Passes Senate 03/03/2011

A bill to create the New Mexico Health Insurance Exchange has passed the Senate by a vote of 36 to 3. The barebones bill will draw on the New Mexico Health Insurance Alliance and the New Mexico Medical Insurance Pool to provide board members and staff for the Exchange.
http://www.publicbroadcasting.net/krwg/news/news.newsmain/article/1/0/1770424/Regional/NM.Health.Exchange.Passes.Senate

Washington Senate OKs Bill To Set Up Health Care Law 03/03/2011

Senators in Washington have approved a bill that lays the ground work for the federal health care overhaul in the state by establishing a state health insurance exchange. The exchange will promote competition and drive down costs when the federal health care law is fully implemented.
http://www.kptv.com/yourvote/27064545/detail.html

Idaho Launches Health Exchange Website 03/03/2011

Idaho has launched a website to provide updates on the state health insurance exchange: http://healthexchange.idaho.gov. The site will have information on stakeholder meetings that begin this month.
http://www.idahostatesman.com/2011/03/03/1550402/state-launches-health-exchange.html

Illinois Health Care Reform Implementation Panel Releases Initial Recommendations 03/02/2011

A state panel convened by Governor Pat Quinn to guide Illinois' implementation of national health care reform released its initial recommendations today. The Health Care Reform Implementation Council urged the creation of a health benefit exchange through which individuals and small businesses would be able to purchase health coverage at competitive prices.
http://www.illinois.gov/PressReleases/ShowPressRelease.cfm?SubjectID=1&RecNum=9252

Texas Lawmakers Want State, Not Federal, Insurance Connector 03/01/2011

Rep. John Zerwas, R-Simonton, is no fan of "Obamacare." But he told his House colleagues this afternoon that if they don't set up a health insurance exchange — one of the tenets of the reform — by 2014, the federal government will do it for them.
http://www.texastribune.org/texas-health-resources/health-reform-and-texas/lawmakers-state-not-federal-insurance-connector-/

LEAVITT PARTNERS and CICERO GROUP COMPANY PROFILES

About Leavitt Partners

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 Mississippi'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.

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About the Cicero Group

Cicero Group companies include:
- Cicero Research
- Dan Jones & Associates
- Education Direction

Cicero Group belongs to the following professional organizations:
- 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 e-mail 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 produce higher completions rates on survey projects.

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