

Center *for* Mississippi  
Health Policy

**BUILDING MISSISSIPPI'S  
HEALTH INSURANCE  
EXCHANGE**

*Winter 2012 Update*

*January 2012*

## ■ Timeline

- March 2010 Affordable Care Act (ACA) is signed into federal law.
- April 2010 Legislation establishing the Health Insurance Exchange Study Committee (SB 2554) is signed into Mississippi law.
- September 2010 Mississippi receives \$333,000 federal award for Consumer Assistance Program.<sup>1</sup>
- Mississippi Insurance Department (MID) receives \$1 million federal “State Planning Grant.”<sup>2</sup>
- March 2011 Legislation to create “Health Benefit Exchange” (HB 1220 and SB 2992) dies in conference at the end of Mississippi’s legislative session.
- April 2011 Legislation continuing the Health Insurance Exchange Study Committee (HB 377) is signed into Mississippi law.
- May 2011 Mississippi Comprehensive Health Insurance Risk Pool Association (“Association”) adopts resolution and amends its bylaws to establish and administer Mississippi’s Exchange.<sup>3</sup>
- July 2011 United States Department of Health and Human Services (HHS) releases proposed rules for the establishment and operation of Exchanges.
- August 2011 Mississippi receives \$20 million federal “Affordable Insurance Exchange Establishment Grant” to further its planning toward the establishment and operation of a Health Insurance Exchange.<sup>4</sup>
- September 2011 “Preparing Mississippi for the Mississippi Health Benefit Exchange: Final Report” issued by MID.
- January 2012 Inaugural Meeting of the Mississippi Health Insurance Exchange Advisory Board.
- January 1, 2013 Deadline for HHS approval or conditional approval of state-based Exchanges for individuals and small businesses.
- January 1, 2014 Deadline for states to have either state-based or federal Exchange programs for individuals and small businesses operational.

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## ■ “Exchange” Defined: Options for Mississippi’s Families and Businesses

The formation of Health Insurance Exchanges (“Exchanges”) is a fundamental component of the “Patient Protection and Affordable Care Act,” also known as the “Affordable Care Act” (ACA). Exchanges are intended to:

- Provide for greater choice and value for individuals and small businesses that need to purchase health insurance
- Present information about health plans in a standardized and simplified way to assist consumers in decision-making
- Facilitate enrollment in both public and private health insurance benefit programs

The proposed regulations released by the United States Department of Health and Human Services (HHS) in July 2011 outlined broad requirements for Exchange implementation and operation. There are two types of Exchanges: one for those seeking to purchase individual and family coverage, and one for small businesses known as the “Small Business Health Options Program” (SHOP). Mississippi can choose to operate these entities separately, or to combine the markets into one Exchange with shared administration, overhead, and risk pool.

## ■ Individual Exchange Will Be a Marketplace for Insurance Purchasers

\*In August 2011, the United States Court of Appeals for the 11th Circuit upheld a judicial ruling that stated the “individual mandate” was unconstitutional. The constitutionality of the provision will be decided by the United States Supreme Court in 2012.

Under the ACA, beginning in 2014 Americans will be required to carry health insurance or pay an annual assessment fee.\* Individuals can obtain insurance either through an employer, through public programs like Medicaid, or they may purchase insurance (with assistance if they qualify for premium tax credits) through the individual Exchange. Insurance will still be offered outside of the Exchange for people and businesses that wish to purchase coverage in that manner. The required minimum functions of the individual Exchange include the following:<sup>5</sup>

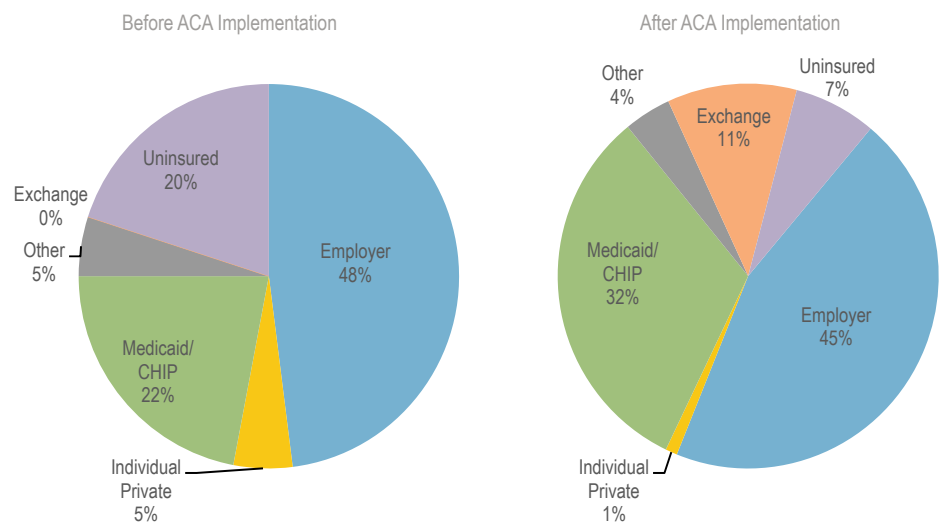
- Certify, recertify, and decertify health plans as “qualified health plans” (QHPs) to be offered through the Exchange
- Operate a toll-free telephone hotline for consumer assistance
- Maintain a website providing standardized comparative information on health plans
- Assign price and quality ratings to plans
- Present plan benefit options in a standardized format
- Provide information on Medicaid and CHIP, determine eligibility for applicants, and enroll eligible individuals in these programs
- Provide an electronic calculator to allow applicants to determine the actual cost of coverage, taking into account premium tax credits and cost sharing reductions for which they are eligible

- Certify individuals who may be exempt from the individual responsibility requirement
- Provide information to the Treasury Department and to employers on certain employees who are eligible for premium tax credits
- Establish a Navigator program that provides grants to entities to conduct outreach and education, as well as assists consumers in enrolling in qualified health plans through the Exchange

## 275,000 Mississippians Projected to Be Eligible to Enroll in the Exchange

Projections developed by economists at the Georgia Health Policy Center show that approximately 275,000 Mississippians (11% of non-elderly persons) are expected to enroll in coverage through an Exchange once the ACA is fully implemented.

### SHIFTS IN COVERAGE PROJECTED FOR MISSISSIPPI



Source: *An Overview of Health Reform*. (2010). Center for Mississippi Health Policy and Georgia Health Policy Center. Retrieved from: [http://www.mshealthpolicy.com/documents/MSOverviewFinal\\_PRINT.pdf](http://www.mshealthpolicy.com/documents/MSOverviewFinal_PRINT.pdf)

### INCOMES ASSOCIATED WITH 2011 FEDERAL POVERTY PERCENTAGES

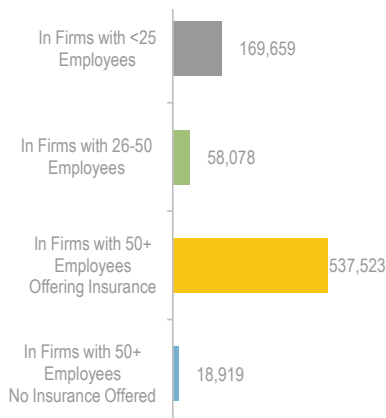
% FEDERAL POVERTY LEVEL	SINGLE	FAMILY OF FOUR
133%	\$14,484	\$29,726
250%	\$27,225	\$55,875
400%	\$43,560	\$89,400

Beginning in 2014, Mississippians with incomes between 133 percent and 400 percent of the Federal Poverty Level may be eligible for subsidies for the purchase of coverage within the Exchange through tax credits. Of the estimated 275,000 Mississippians projected to purchase coverage through the Exchange in 2014, about 229,000 should be eligible for subsidized coverage. Economists estimate the subsidies for these individuals will be worth approximately \$912 million in 2014, all to be funded by the federal government.<sup>6</sup> These estimates could change, however, once rules are established regarding enrollment, benefits, and coverage requirements.

Source: *The poverty guidelines updated periodically in the Federal Register by the U.S. Department of Health and Human Services under the authority of 42 USC 9002(2).*

## The SHOP Will Facilitate Small Business Insurance

### NUMBER OF EMPLOYEES BY SIZE OF PRIVATE FIRM IN MISSISSIPPI, 2010



Source: 2010 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

Another goal of Exchange formation is to create an environment where small businesses have the opportunity to offer health insurance plans similar to those offered by large businesses. The SHOP is designed to provide small businesses with the ability to pool risks with other small businesses, and share administrative and purchasing efficiencies. According to some estimates, small businesses currently pay up to three times as much in administrative costs compared to large group plans, and premiums are as much as 18 percent higher.<sup>7</sup> Participation in a SHOP is voluntary, with certain tax credits available to qualified employers to reduce the cost of insurance.

The ACA defines “small business” as one which employs fewer than 100 full-time equivalent employees (FTEs). Until 2016, state-based Exchanges can choose to limit the small group market to firms that employ fewer than 50 FTEs.<sup>8</sup> The Mississippi Insurance Department (MID) recommends that Mississippi limit small groups to fewer than 50 FTEs.<sup>9</sup> Both of Mississippi’s proposed House<sup>10</sup> and Senate<sup>11</sup> bills from 2011 would have adopted the 50 FTE definition. Beginning in 2017, Exchanges may allow organizations with more than 100 FTEs to participate in the SHOP.

Minimum required functions of a SHOP are similar to those of the individual Exchange, with the following exceptions:<sup>12</sup>

- The SHOP does not need to comply with the same requirements for the individual Exchange related to eligibility determination and enrollment into health plans. The SHOP is only responsible for verifying that businesses meet requirements to participate in the SHOP, and that the employee is qualified by virtue of his or her employment status. At minimum, the SHOP must verify that the employee is listed on the qualified employer’s roster of employees being offered coverage<sup>13</sup>
- The SHOP does not need to provide a calculator, given that individuals enrolled in employer-sponsored coverage are not eligible for premium tax credits
- The SHOP does not need to certify exemption from the individual coverage requirement
- The SHOP is exempt from requirements related to premium payments by individuals and special groups, because these groups will participate in the individual Exchange

### DEFINED CONTRIBUTION

In order to limit exposure to growing health care costs, employers may establish a set amount that the company is willing to contribute for health insurance.

In the small business market, the federal rule calls for the SHOP to provide a single monthly bill to each employer, combining premiums for all health plans in which employees are enrolled, and for the SHOP to collect the aggregated payment to distribute back to the health plans.<sup>14</sup> One potential feature of the small business market is the concept of “defined contribution.” It is possible for employers to limit exposure to growing health care costs by establishing a set amount that the company is willing to contribute for health insurance. Together with a contribution from the employee, this amount can be used to purchase health insurance from the SHOP.

## ■ Tax Credits and Penalties Apply to Certain Businesses

Under the ACA, there is no universal mandate requiring employers to offer health insurance. In order to encourage participation in the SHOP, the ACA includes a system of tax credits and penalties for businesses, dependent on the number of employees and type of health insurance coverage offered by the employer.

Businesses with fewer than 50 FTEs will not be penalized if they do not offer health insurance, and businesses with fewer than 25 FTEs may be eligible for certain tax credits.

### *Tax credits available to certain businesses*

Small business health care tax credits became available in 2010, and will increase in 2014 depending on firm size and filing status. Employers with fewer than 25 FTEs who pay at least 50 percent of the cost of health care for their employees and have average annual wages under \$50,000 are eligible for the following small business health care tax credit:<sup>15</sup>

Tax Status	2010-2013	2014
Non-profit groups	Up to 25% of premium costs	Up to 35% of premium costs
Small businesses	Up to 35% of premium costs	Up to 50% of premium costs

The Congressional Budget Office projected that health care tax credit claims would total around \$2 billion nationally in Tax Year 2010, and \$37 billion over ten years. The IRS found that \$278 million was claimed through May 2011 by approximately 228,000 businesses.<sup>16</sup>

### *Penalties assessed on other businesses*

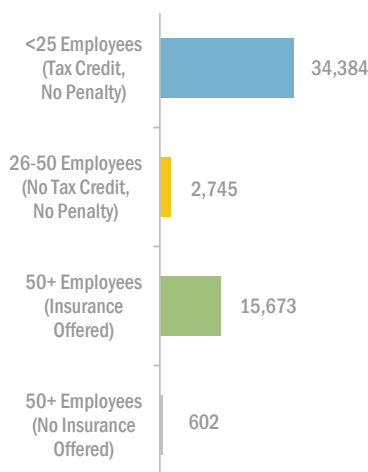
After 2014, there will be penalties, in the form of a “shared responsibility fee,” levied on large businesses who do not offer “minimum essential coverage.”<sup>17</sup>

- In Mississippi, approximately 70 percent of private employers have fewer than 50 employees,<sup>18</sup> and would therefore be exempt from penalties
- The remaining 30 percent of private employers with 50 or more employees may be subject to a penalty if they do not provide “minimal essential coverage”

In 2010, only one percent of Mississippi’s businesses had 50 or more employees and did not offer some form of coverage.<sup>19</sup> “Employer-sponsored minimum essential coverage” is defined as being both affordable, meaning that the required contribution for the employee does not exceed 9.5 percent of his or her annual household income, and providing a minimum value, in that it covers at least 60 percent of the cost of coverage.<sup>20</sup> Any business with more than 50 FTEs that does not provide “minimum essential coverage” will be assessed at a rate of \$3,000 per worker who obtains a subsidized plan in the Exchange, or \$2,000 per worker after the first 30 FTEs, whichever is lower.<sup>21</sup>

The Center for Mississippi Health Policy, in collaboration with the Georgia Health Policy Center, has developed a “Small Business Health Reform Calculator” to assist small employers in estimating current tax credits for which they might be eligible. The Calculator can be found on the Center’s website at [mshealthpolicy.com/smallbusinesscalculator.htm](http://mshealthpolicy.com/smallbusinesscalculator.htm).

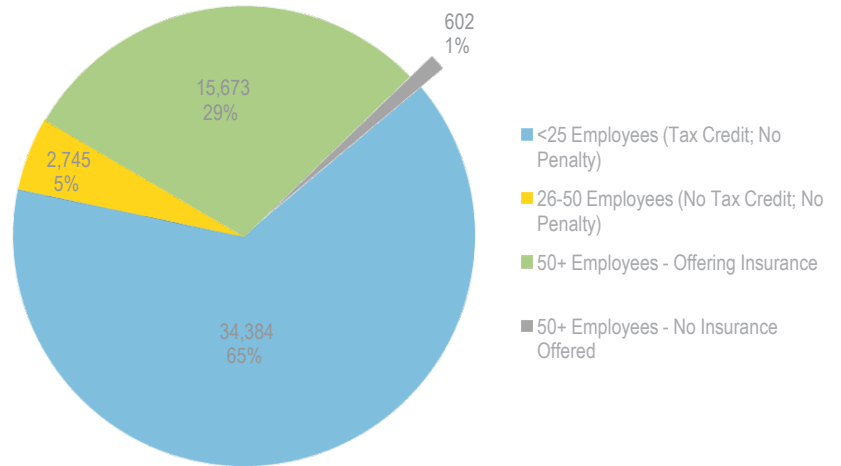
NUMBER OF PRIVATE ESTABLISHMENTS BY SIZE, MISSISSIPPI, 2010



Source: 2010 Medical Expenditure Panel Survey, Agency for Healthcare Research and Quality

While only 1 percent of Mississippi private businesses fall into the category of having more than 50 employees and not offering health insurance coverage, not enough information about the type of insurance coverage offered by the remaining large employers is available to determine how many may be subject to the penalty because they do not offer “minimum essential coverage.”

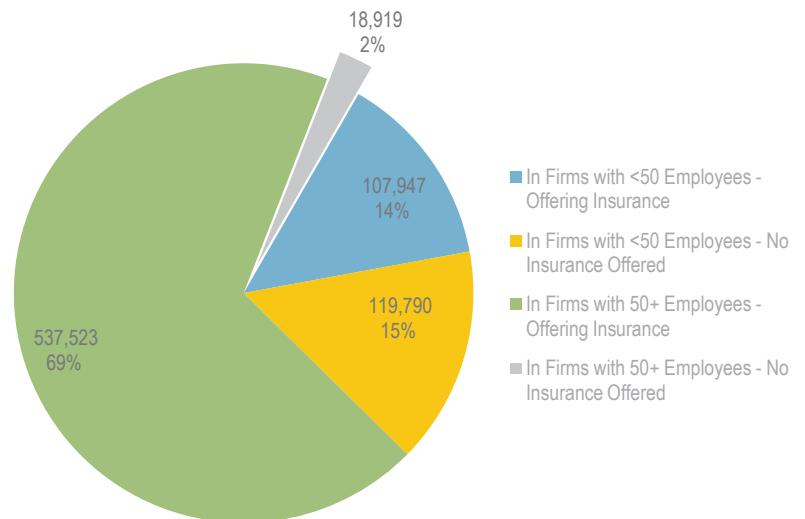
**DISTRIBUTION OF PRIVATE ESTABLISHMENTS BY SIZE, MISSISSIPPI, 2010**



Source: 2010 Medical Expenditure Panel Survey, Agency for Healthcare Research & Quality.

Approximately 19,000 private sector employees work for large employers in Mississippi who do not offer health insurance. In addition, there are 78,700 part-time employees working for large businesses that do offer insurance, but they may not be eligible for coverage due to their part-time status. Another 120,000 employees work for small businesses who do not offer health insurance coverage. Although these small employers are not subject to a penalty, they may choose to join the SHOP. If small employers do not enroll in the SHOP, their employees may to seek coverage through the individual Exchange.

**DISTRIBUTION OF EMPLOYEES BY SIZE OF PRIVATE FIRMS, MISSISSIPPI, 2010**



Source: 2010 Medical Expenditure Panel Survey, Agency for Healthcare Research & Quality.



## ■ Mississippi Moving to Establish a State-Based Health Insurance Exchange

A goal of forming Exchanges is to increase access to affordable health insurance coverage. The proposed federal regulations have left to the states many choices that will affect how this goal will be achieved. As Mississippi proceeds with developing an Exchange, important decisions must be made regarding the structure, functions, and operation of the Exchange.

### *Establishment of statutory authority*

Legislation proposed during the 2011 legislative session to establish an Exchange in Mississippi died at the end of the session. Subsequently, the Mississippi Insurance Department (MID) received legal advice that the Mississippi Comprehensive Health Insurance Risk Pool Association (“Association”) had the statutory authority to establish and administer the Exchange. Adopting this governance structure, MID applied for, and was awarded, over \$20 million from HHS to continue its work to establish an Exchange in Mississippi.<sup>22</sup>

### *Governance and Exchange oversight*

If a state decides to create a governing board for its Exchange, it may choose to combine the individual Exchange and SHOP governing boards or establish a separate board for each.<sup>23</sup> Regardless of which type of structure the state chooses, the regulations for either are explicit in a few areas. The federal requirements for Exchange governance state that individuals who are representatives of health insurance issuers, agents, brokers, or any other individual licensed to sell health insurance cannot make up the majority of voting members of the governing board. Additionally, the Exchange must publish and make available to the public a set of guiding governance principles (including ethical and conflict of interest standards) and financial interest disclosures. The governing board of the Exchange must also provide advance notice of and hold regular public meetings.<sup>24</sup>

The Association made its articles, bylaws and operating rules available in the Exchange Establishment Grant Application. If the Association’s governing board operates the Exchange, changes in the Board’s composition may be necessary in order to comply with federal rules. Currently, the Association’s board is made up of nine individuals, seven of which have voting privileges:<sup>25</sup>

- Four positions appointed by the Mississippi Commissioner of Insurance
  - Two members from the general public, not associated with the medical profession, a hospital, or an insurer
  - One representative of medical providers
  - One representative of health insurance agents
- Three positions appointed by members of the Association
  - These positions must be filled with members of the Association. Members of the Association must provide health insurance or healthcare benefits in the state
  - The bylaws state that at least one of these three positions be filled by a Mississippi domestic insurer
- Chair of the Senate Insurance Committee (nonvoting, ex-officio member)

**MEMBERS OF THE ASSOCIATION**  
According to the state law establishing the Mississippi Comprehensive Health Insurance Risk Pool Association, all insurers in Mississippi shall be members of the Association as a condition of doing business.  
Source: Miss. Code Ann. § 83-9-211

- Chair of the House Insurance Committee (nonvoting, ex-officio member)

The Association's bylaws include requirements for publicizing and holding regular meetings. The Association has made public an additional document that addresses conflicts of interest and business ethics policies, which includes a list of guiding governance principles and parameters for financial interest disclosure.

### *Composition of the Exchange Advisory Board*

In October 2011, MID released Bulletin 2011-9, outlining plans for the creation and operation of an Advisory Board and eleven Advisory Board Subcommittees.<sup>26</sup> The MID's plan for Exchange governance states the intention to establish eleven Advisory Board Subcommittees to inform one Exchange Advisory Board. MID's projected composition of the Advisory Board complies with the ACA requirement to consult with stakeholders from the public, plus additional groups. The following are the eleven Advisory Board Subcommittees described in the Bulletin (groups indicated with an asterisk are specifically mentioned in ACA §1311 (d) (6)):

\*Groups indicated with an asterisk are specifically mentioned in ACA §1311 (d) (6)

- Educated health care consumers\*
- Individuals and entities with experience in facilitating enrollment in health coverage\*
- Advocates for enrolling hard-to-reach populations (including individuals with mental health and substance disorders)\*
- Representatives of small businesses and self-employed individuals (MID specifies "small business" as having fewer than 100 employees for the purposes of this Subcommittee)\*
- Appropriate State government agencies or divisions (ACA specifies State Medicaid Offices)\*
- Federally-recognized tribes within the geographic area of the Exchange
- Public health experts
- Health care providers
- Large employers (those with more than 100 employees)
- Health insurance providers
- Health insurance agents and brokers

The Exchange Advisory Board will be made up of thirteen members: the chairperson of each of the eleven Subcommittees and two at-large members.<sup>27</sup>

### *Obtaining approval to launch*

*In order to receive HHS approval to operate a state-level Exchange by the ACA deadline of January 1, 2014, minimum requirements must be met by January 1, 2013.*

In order to receive HHS approval to operate a state-level Exchange by the ACA deadline of January 1, 2014, minimum requirements must be met by January 1, 2013. HHS requires that each state submit an Exchange Plan, and receive written approval based on a “readiness assessment” conducted by HHS to determine that the Exchange will be capable of carrying out minimum required functions, including enrollment, operation of a SHOP, and certification of Qualified Health Plans (QHPs). The Exchange must be capable of complying with information requirements related to payment of the premium tax credits and risk management programs. Finally, the entire geographic area of a state must be covered by one or more Exchanges.<sup>28</sup> Additional guidance on the approval process is expected at a future date.

## ■ The “Nuts and Bolts” of Mississippi’s Exchange

### *Operation will require implementing many systems*

Proposed federal rules provide states with an option of participating in a “flexible state partnership model,” with business functions such as eligibility and enrollment, financial management, and health plan management systems and services shared between the federal government and the Exchange.<sup>29</sup> The states can also create their own systems of operation, subject to HHS approval. Information Technology (IT) development will play an important role in the operation of Exchanges. In order to determine eligibility and ensure enrollment into either public or private health coverage programs, the Exchange will need to be able to process the single, streamlined application required by the ACA (§1413). In its Exchange establishment grant application, MID sets aside around \$12 million out of the \$20 million requested from the federal government to develop IT capacity for the Exchange.<sup>30</sup>

The application outlined plans to use those funds for the following activities:<sup>31</sup>

- Portal development (including website, eligibility and enrollment functions, premium calculator, standardized health plan comparison, quality ratings and disaster recovery and security capability)
- HHS Interface Requirements (including data services hub integration and risk mitigation)
- Small Business Functions (including functions to verify employer eligibility and assist employers in health plan administration)
- Financial Management
- Customer Support (including maintaining customer assistance call center and coordinating education and marketing outreach with the community)
- Governance (including built-in measures to ensure public accountability and transparency)
- Compliance
- Broker Management
- Stakeholder Consultation

#### **MEDICAID AND THE EXCHANGE**

Mississippi’s Exchange will evaluate and coordinate eligibility for applicants with the Mississippi Division of Medicaid, the Children’s Health Insurance Program (CHIP), and other state health programs.

*Source: Mississippi Insurance Department. (2011). Mississippi’s Application for Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges.*

In addition to these grant funds, state Medicaid agencies have the opportunity to take advantage of an enhanced federal match related to building IT capacity and coordinating with the Exchange. Beginning on April 19, 2011 and until December 31, 2015, states can receive a 90 percent match for expenditures related to “the design, development, installation, or enhancement of an eligibility determination system” that meets certain requirements defined in the regulation.<sup>32</sup> During that same time period, there is an additional enhanced match of 75 percent for state Medicaid expenditures for the operation of the eligibility determination system.<sup>33</sup>

### *Consumer education and outreach is necessary*

To address the difficulties consumers face in purchasing health insurance, individual Exchanges are required to have a number of consumer assistance components. One feature that will be vital to the success of Exchange operation is the Navigator program. The proposed rules give general standards for Navigators: Navigators must maintain expertise, facilitate enrollment in health plans, provide referrals for individuals with grievances, complaints, or questions, and use culturally and linguistically appropriate language. Exchanges must include entities from at least two of the following groups as Navigators:<sup>34</sup>

- Community and consumer-focused nonprofit groups
- Trade, industry, and professional organizations
- Commercial fishing industry, ranching, and farming organizations
- Chambers of commerce
- Unions
- Resource partners of the Small Business Administration
- Licensed agents or brokers
- Other public or private entities such as Indian tribes, tribal organizations, urban Indian organizations, and State or local human services agencies

*Only 12 percent of American adults have what is considered to be a “proficient” level of health literacy.*

Mississippi will decide which groups to authorize as Navigators, what kind of training or certification to require of Navigators, and how to implement the Navigator program.

Consumer outreach and education will be another key to Exchange success. If the Exchange presents coverage options clearly, more individuals will be able to access health insurance coverage. The 2006 National Assessment of Adult Literacy found that only 12 percent of American adults have what is considered to be a "proficient" level of health literacy. For example, one measure of "proficient" health literacy is an individual's ability to calculate an employee's share of health insurance costs for a year, based on information about family size and income. Another way to interpret these findings is that 88 percent, or nearly nine out of every ten American adults, would be unable to calculate the cost given the same test. Individuals considered to have an "intermediate" level of health literacy were able to successfully complete tasks such as using drug-label information to identify three substances that may interact with an over-the-counter drug. An example of a task a person with "basic" health literacy could complete would be to read a pamphlet, and then describe why a person with no symptoms of a specific disease should still consider being tested for the disease. An example of "below basic" health literacy would be demonstrated by one's inability to circle the date of a medical appointment on a hospital slip.<sup>35</sup>

More than half of the potential enrollees eligible to participate in the Exchanges have “below basic” or “basic” literacy skills.<sup>36</sup> Research specific to Mississippi has

documented low health literacy skills in certain low-income populations. In one study, almost three-quarters (74%) of participants scored in the two lowest health literacy categories.<sup>37</sup> MID reports 91 percent of Mississippi's uninsured have a high school diploma or less education.<sup>38</sup> Such limited literacy must be an important consideration in the design of Exchange programs in Mississippi.

*More than half of the potential enrollees eligible to participate in the Exchanges have “below basic” or “basic” literacy skills.*

As described in the Exchange establishment grant application, MID is working with a non-profit organization through a program called Health Help, and plans to contract with consumer assistance programs to establish presence in at least three other regional offices. Health Help currently assists individuals in accessing health care by providing information about public programs like Medicaid and CHIP, as well as newly required components of private insurance plans that were implemented by the ACA, such as required coverage for children with pre-existing conditions. Health Help currently operates a toll-free consumer assistance telephone number, and maintains a website.<sup>39</sup>

Marketing of health plans is another aspect of Exchange operation addressed by the federal rule. While states are permitted to develop more specific marketing rules to ensure they do not inadvertently allow for insurance companies to sidestep the intent of the law, the regulations state that marketing practices of health plans must comply with state laws, and cannot discourage participation of “individuals with significant health needs.”<sup>40</sup> In addition to encouraging prohibitions against “cherry-picking,” the comments from HHS also suggest that Exchanges work to protect vulnerable members of the population from predatory marketing. One example of such practices would be targeting at-risk individuals to enroll them in unnecessary or redundant plans.

### ***Plans must include development of funding mechanisms***

The HHS regulations prohibit federal funds from being used to operate state-based Exchanges after January 1, 2015. Therefore, states must develop a self-sustaining funding mechanism. The following options for funding are offered by HHS:<sup>41</sup>

- General state revenues
- Insurance provider taxes
- “Other funding that spreads costs beyond imposing assessments or user fees on participating issuers”

In its preliminary evaluation for Exchange establishment, the MID conducted key informant interviews and town hall meetings. The results are compiled in "Preparing for the Mississippi Health Benefit Exchange: Final Report." The report indicates that while most of the individuals surveyed (including health care professionals, experts, and government officials) "could not identify an effective solution for funding the Exchange," many suggested funding it in the same manner as the Mississippi Comprehensive Health Insurance Risk Pool Association, specifically suggesting that carriers be charged an assessment fee to participate in the Exchange.

States that have implemented or taken significant steps toward implementation of Exchanges have avoided reliance on general state revenues, choosing for the most part to either study the issue or implement assessment of fees.<sup>42</sup> The planned structure of fees differs from state-to-state, hinging on whether to charge fees for all plan providers, or only those offering health plans through the Exchange. States with legislative or executive orders in place to fund Exchange activities by levying fees include California and Maryland.<sup>43</sup> West Virginia's establishment legislation allows for the Exchange to begin collecting fees from insurers on health plans offered inside and outside of the Exchange beginning on July 1, 2011.<sup>44</sup>

### *The Exchange must determine eligibility and facilitate enrollment*

In order to prevent individuals from having to enter personal information multiple times, HHS requires that state Exchanges use a single application process to collect information to determine eligibility for enrollment in a qualified health plan, Medicaid or CHIP and to determine advanced payments of the premium tax credit and cost-sharing reductions.<sup>45</sup> While it remains to be seen how this eligibility function will be conducted, the goal is seamless enrollment in all programs through the Exchange, regardless of individual qualifications. On August 17, 2011, HHS released a number of proposed rules and commentary associated with the integration of Medicaid, CHIP, and the Exchange. In order to enroll individuals into any of these three programs, the Secretary of HHS will devise an electronic system through which state Exchanges will be able to obtain information from federal agencies to verify eligibility for Medicaid, CHIP, or subsidized premiums for coverage through the Exchange.<sup>46</sup> The proposed regulation allows for a state-operated Exchange to make Medicaid eligibility determinations, but asked for comment with regards to how to address non-profit Exchanges or other entities that might have an interest in determining eligibility.<sup>47</sup>

### *Multiple options for processing premium payments*

In the individual Exchange, states have three options for setting up premium payments:<sup>48</sup>

- Take no part in the collection and distribution of premiums and have individuals pay the insurance company directly
- Use a "pass-through" system, facilitating payment from the individual to the insurance company
- Collect premium payments from individuals and pay the aggregated sum to the insurance company

#### MAXIMUM SUBSIDY "CLAWBACKS"

ANNUAL HOUSEHOLD INCOME (AS % FPL)	MAXIMUM AMOUNT OF REPAYMENT
<200% FPL	\$600
<200% - <300% FPL	\$1,500
<300% - < 400%	\$2,500

The individual Exchange will have to implement mechanisms to apply premium tax credit subsidies. One particular area of concern is around "clawbacks," or the over-payment of premium tax credits to individuals who later have a change in income within the same year. There is some concern that individuals who qualify for tax credits toward premium payments will not understand the potential liability associated with any change in income that may disqualify them from the credit, and may even create a debt at the end of the tax year. It is important to note that at the lower end of the socioeconomic spectrum, there may be an increase in variability of income that can change day-to-day or week-to-week.

Source: Comprehensive 1099 Taxpayer Protection and Repayment of Exchange Subsidy Overpayments Act of 2011.

**PREMIUMS AS PERCENTAGE OF INCOME**

FEDERAL POVERTY LEVEL	PREMIUM AS % OF INCOME
UP TO 133%	2%
133%	3%
150%	4%
200%	6.3%
250%	8.05%
300%	9.5%
350%	9.5%

Source: Health Insurance Exchanges: Key Issues For State Implementation (September 2010). Robert Wood Johnson Foundation State Coverage Initiative.

**Premium subsidies to be distributed on sliding scale**

Beginning in 2014, individuals whose household income falls between the range of 133 percent to 400 percent of the Federal Poverty Level (FPL) might be eligible to receive a premium tax credit to apply toward the cost of coverage. One qualification is lack of affordable “minimum essential coverage” through their employer. “Affordable coverage” is that which has a required contribution of less than 9.5 percent of the taxpayer’s annual income. “Minimum value” is defined as covering at least 60 percent of the cost of coverage.

As shown below, the amount of premiums individuals and family members will be expected to pay will be based on a sliding scale, linked to the Modified Adjusted Gross Income (MAGI). The ACA dictates that the premium percentage for individuals purchasing insurance with tax credits be linear. Therefore, between 133 percent and 300 percent FPL, there may be as many as 167 different premium percentages used to calculate contributions. Above 300 percent FPL, the figure is set at 9.5 percent.

**FAMILY SHARE OF PREMIUMS AS PERCENT OF INCOME**



For individuals at or below 400 % FPL, the premium subsidy for the individual consumer is based on the cost of the second lowest priced Silver plan.

Source: Health Insurance Exchanges: Key Issues For State Implementation (September 2010). Robert Wood Johnson Foundation State Coverage Initiative.

1		4	
NUMBER OF FAMILY MEMBERS	1	NUMBER OF FAMILY MEMBERS	4
MAGI	\$27,775	MAGI	\$55,875
MAGI AS % OF FPL	250%	MAGI AS % OF FPL	250%
FAMILY SHARE OF PREMIUM AS % OF INCOME	8.05%	FAMILY SHARE OF PREMIUM AS % OF INCOME	8.05%
FAMILY SHARE OF MONTHLY PREMIUM	\$193	FAMILY SHARE OF MONTHLY PREMIUM	\$396

Source: Adapted by the Center for Mississippi Health Policy from Health Insurance Exchanges: Key Issues For State Implementation (September 2010). Robert Wood Johnson Foundation State Coverage Initiative.



## EXCHANGE BENEFIT LEVELS

PLAN LEVEL	% BENEFITS PROVIDED BY PLAN
BRONZE	60%
SILVER	70%
GOLD	80%
PLATINUM	90%

Source: ACA § 1302 (d) (1)

## Selecting and certifying qualified health plans

In addition to some basic requisites outlined by HHS, states are given some flexibility in how to choose and allow plans to participate in the Exchange, with the caveat that the Exchange must find health plans to be “in the interest of individuals and businesses in the state.”<sup>49</sup> The procedures for certifying health plans are nearly identical for the individual market and the SHOP, except where administration of premium of tax credits and cost-sharing reduction measures are specific to the individual market, and where the SHOP has rate setting and premium payment standards, enrollment periods and enrollment processes specific to small businesses.

Commentary associated with the HHS guidance recommends that states use suggested additional criteria to determine a health plan’s appropriateness:<sup>50</sup>

1. Reasonableness of estimated costs for the plan’s premium and cost-sharing levels
2. Issuer’s reputation and past performance
3. Quality improvement activities
4. Enhancement of provider network
5. Service area of the health plan (size of area and amount of choice for area consumers)
6. Premium rate increases from years preceding the Exchange operation and proposed rate increases

An Exchange is prohibited from excluding a plan in the following circumstances:

1. On the basis that it is a fee-for-service plan
2. By imposing premium price controls
3. On the basis that the plan provides expensive but necessary treatments to prevent patients’ deaths in circumstances deemed too costly by the Exchange

The regulations released in July 2011 explicitly require that health plan issuers must guarantee that participating plans meet network adequacy standards, and make available to potential Exchange participants a provider directory (both in print and online) that includes denotation for providers who are not accepting new patients.<sup>51</sup> The general requirement is that a qualified network must have “a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals.”<sup>52</sup> These “essential community providers” include Federally Qualified Health Centers, among other facilities generally considered to be part of the “safety net” for medically underserved populations.<sup>53</sup> In Mississippi, about 300,000 adults are served by Federally Qualified Health Centers.<sup>54</sup>

*A qualified network must have “a sufficient number of essential community providers, where available, that serve predominantly low-income, medically underserved individuals.”*

The Exchange's decision to act as an open market facilitator or as an active purchaser is an important one. At one end of the spectrum, the Exchange may allow any plan that meets minimum federal certification requirements to be offered in the Exchange.<sup>55</sup> At the other end, the Exchange may use collective bargaining power to negotiate for better rates and benefit offerings for plans sold through the Exchange. The latter scenario is impacted by the ACA requirement that rates for plans offered inside the Exchange must be identical to the rates for the same plans offered by the same health plan issuer outside the Exchange. If the number of participants inside the Exchange is low, there will be little incentive for issuers to offer lower rates, or participate in the Exchange at all. As a result, achieving a high rate of participation among individuals eligible to purchase insurance through the Exchange is a key factor in determining whether the Exchange will be able to negotiate with plan issuers. The ability of the Exchange to be selective will also be limited by the availability of plans in the market.

## ■ Summary

As part of the Affordable Care Act (ACA), states will be required to either form a state-based or regional Health Insurance Exchange or participate in a federal program. Exchanges are intended to increase the variety and value of health insurance coverage offered to individuals and businesses. Another goal of Exchange formation is to provide standardized and simplified information to help consumers make informed decisions. Exchange implementation is expected to increase enrollment in both public and private health insurance benefit programs and reduce the number of uninsured citizens. The ACA requires that the Exchange determine eligibility and ensure enrollment of individuals deemed eligible into Medicaid and CHIP, as well as advise individuals regarding eligibility for premium subsidies.

Mississippi is moving forward to establish a state-based Health Insurance Exchange by the ACA deadline of January 1, 2014. The Mississippi Insurance Department has applied for and received federal grants to fund the development of a state Exchange. The Mississippi Comprehensive Health Insurance Risk Pool Association has taken steps to adapt its bylaws and rules of operation to meet federal guidelines to serve as the governing entity for Mississippi's Exchange, although changes in the composition of its board of directors may be necessary to comply with federal rules.

Approximately 275,000 Mississippians are anticipated to enroll in coverage through an Exchange once the ACA is fully implemented in 2014. Out of those expected to utilize Mississippi's Exchange, approximately 229,000 should be eligible for premium subsidies, which will be administered by the federal government in the form of tax credits. While there is not a universal mandate for businesses to provide coverage, a "shared responsibility fee" will be assessed on certain larger employers not offering "minimum essential coverage" by 2014. In 2010, approximately 70 percent of Mississippi private employers had fewer than 50 employees, exempting them from penalties. That same year, less than 1 percent of businesses in Mississippi had more than 50 employees and did not offer some form of health coverage. While the state has made significant progress in laying the foundation for the Exchange, 2012 will be an important year for erecting the infrastructure. Key decisions made this year will determine the value of the Exchange for Mississippi's families and businesses for years to come.

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