Affordable Care Act

Providing Opportunities for Mississippi's Children and Families

Mississippi Center for Justice

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Contents

ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

This Issue Brief is intended to summarize the important opportunities federal health care reform provides in improving insurance coverage for Mississippi children and families. It is designed to highlight key elements of the federal law, its impact in Mississippi, and recommendations for the state's implementation of health care reform.

In March 2010, the Affordable Care Act (ACA) made sweeping changes to the way Americans will access and use health care. As a result of federal health care reform, it is estimated that over 500,000 of Mississippi's uninsured children and adults will be able to obtain affordable coverage.[1]
Key provisions include:

- Medicaid income eligibility for all individuals under the age of 65, with incomes up to 133% of the Federal Poverty Level (FPL);
- Extension of the Children's Health Insurance Program (CHIP) through 2019, with funding through 2015;
- Tax credits to help moderate-income Mississippi residents purchase private insurance;
- The establishment of state-based Health Benefit Exchanges where people can go to purchase and enroll in healthcare coverage;
- The requirement for states to develop streamlined and consumer-friendly eligibility determination and enrollment processes for consumers across public programs;
- Elimination of discriminatory practices in private insurance, such as denying coverage for pre-existing conditions, and imposing annual and lifetime caps on coverage; and
- Children's eligibility to remain on their parents' insurance up to age 26.

Mississippi is moving forward in implementing health care reform and Health Benefits Exchange planning, with the Mississippi Insurance Department responsible for planning and implementation efforts. On August 12, 2011, the Insurance Department received a $20,143,618 Level 1 Exchange Establishment grant, which is to be used for outreach, education, and development of a streamlined eligibility and enrollment system. Mississippi will also receive federal funding for 100% of the expansion in Medicaid coverage through 2016, and at least 90% thereafter.

In order to ensure health care reform is implemented successfully and Mississippi families are able to access coverage, the Mississippi Center for Justice makes the following recommendations:

1. Simplify the enrollment pathway and prioritize the development of consumer-friendly systems. Mississippi must design the state's Exchange and make policy decisions in a way that will support simplified and consumer-friendly pathways to coverage by offering options for enrollment online, in person, by telephone, and by mail. Each enrollment pathway must have guided application assistance, use plain language, and be available in multiple languages for those with limited English proficiency. Information technology (IT) systems should support real-time eligibility determinations; paper documentation for verification of eligibility may be used only as a last resort. Planning and implementation work must be guided by a stakeholder engagement process that includes consumer advocates.

2. Robust Navigator Program. Mississippi's Navigator Program, which is to assist individuals in shopping for and enrolling in coverage, should target communities and populations that have historically been disconnected from coverage. The program should have a robust network that leverages the

expertise and best practices of existing community-based organizations that currently assist individuals in connecting to coverage. Both planning and implementation activities should be guided by a broad range of stakeholders.

3. Align Benefits to Reduce Impact of Churn. It will be critical for the state to play an active role in creating incentives for health plans to participate in Medicaid and as a Qualified Health Plan (QHP) on the Exchange. As families experience fluctuations in income, they may "churn" on and off Medicaid. Alignment of benefits across Medicaid and QHPs will help ensure continuity of coverage and provider networks. In turn, this continuity will support reliable, high quality and accessible care, delivered in an efficient and cost-effective manner.

4. Plan for Changes in Eligibility Determinations. In preparation for changes that are slated for 2014, Mississippi should begin to implement changes to its eligibility determination process. Starting with the elimination of the face-to-face interview for Medicaid eligibility determinations, which will be prohibited in 2014, Mississippi can signal the beginning of the culture shift that focuses on eliminating barriers to coverage. Such a culture shift could be further supported by the implementation of presumptive eligibility. Under presumptive eligibility, individuals may be enrolled in Medicaid or CHIP pending the completion of their application, if the state determines that they would be income-eligible based on preliminary information. Implementing presumptive eligibility would reduce gaps in coverage and support seamless transitions across programs.

5. Private Insurance Monitoring and Oversight. Mississippi must take an active role in ensuring that the private insurance market complies with the new ACA provisions that eliminate discriminatory practices, such as refusing to insure those with pre-existing conditions. The state should also embark on an outreach and education campaign to increase awareness of the expansion of dependent coverage for young adults on their parents' coverage up to the age of 26.

6. Incorporate Consumer Feedback in Exchange Development. Given that the purpose of developing the state-based Exchange is to ensure consumers easier access to coverage, a comprehensive and meaningful stakeholder process which invites consumer feedback is crucial. Consumer feedback must inform and guide a transparent process to design and implement required IT systems.

Successful implementation of federal health care reform is essential to making affordable and comprehensive coverage available to all of Mississippi's residents. With more than 100,000 uninsured children in the state, federal health care reform presents a tremendous opportunity to find and enroll uninsured children and their families. We call on our state's leading decision makers to turn the promise of health care reform into a reality and ensure that the state builds a consumer-focused, seamless and coordinated health care enrollment system.

INTRODUCTION

Background. In March 2010, the Affordable Care Act (ACA) made sweeping changes to the way Americans will access and use health care. As a result of federal health care reform, it is estimated that over 500,000 uninsured children and adults will be able to obtain affordable coverage.[2] Some projections indicate that Mississippi's Medicaid program will have as many as 320,748 new enrollees by 2019[3], with federal dollars largely funding their coverage.

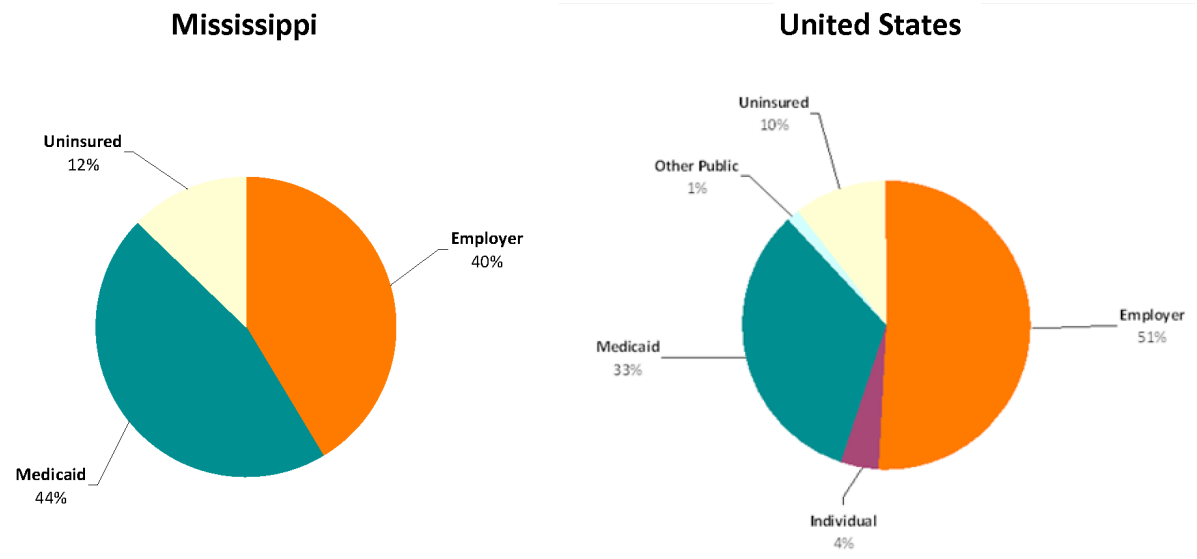
Health coverage expansion efforts will be accomplished through: (1) expanding Medicaid eligibility levels, with federal funding; (2) providing tax credits to help moderate-income Mississippi residents purchase private insurance; (3) eliminating discriminatory practices in private insurance; (4) establishing a state Health Benefit Exchange as a marketplace to screen families for public program eligibility and shop for and enroll in coverage; and (5) allowing children to remain on their parents' insurance plans up to age 26. While the most significant coverage expansion provisions will take effect in 2014, several critical private insurance changes are already in effect for children and young adults – for example, children may not be denied coverage due to pre-existing conditions.

This Issue Brief is intended to summarize the important opportunities federal health care reform provides in improving coverage for Mississippi children and families. It is designed to highlight key changes to the federal law, describe how these changes impact Mississippi's current enrollment requirements, and identify child- and family-friendly priorities to help inform decision makers who are charged with implementing health care reform in the state.

MISSISSIPPI'S COVERAGE LANDSCAPE

Sources of Coverage: Today, Medicaid is the leading source of health insurance coverage for children in Mississippi, followed by employer-sponsored coverage. As **Figure 1** indicates, compared to the national average, Mississippi has a higher rate of uninsured and a lower rate of employer-sponsored coverage.[4] In fact, 40 percent of children in Mississippi, or 329,000, access coverage through employment, compared to just over half (51%) of children nationally. Health care reform provides an opportunity for children by expanding coverage.

Figure 1. Sources of Coverage, Children Ages 0 – 18, Mississippi compared to the U.S.



Source: Kaiser Family Foundation, Mississippi: Health Insurance Coverage for Children 0-18, states (2009-2010), U.S. (2010), available at http://www.statehealthfacts.org/profileind.jsp?cmprgn=1&cat=3&rgn=26&ind=127&sub=39.

In fiscal year 2011, over 559,600 Mississippi children were at some point enrolled in either Medicaid or the state's Children's Health Insurance Program (CHIP).[5] Estimates from the most recent data show that well over half of Mississippi's uninsured children, about 65,000, live in income-eligible households for public coverage, yet continue to go uninsured.[6] Mississippi's Medicaid program currently covers children under age one up to 185 percent of the Federal Poverty Level (FPL), children ages one to five years old up to 133 percent of the FPL, children ages 6 to 19 up to 100 percent of the FPL and parents up to 44 percent of the FPL **(see Figure 2)**. Mississippi covers low- to moderate-income children with family incomes up to 200 percent of the FPL through its CHIP program.

Mississippi's Uninsured. For children at or below 200% of the FPL, Mississippi's uninsurance rate of 12 percent for children is above the national average of 10 percent.[7] The majority of uninsured children, 62.9 percent, are school-aged (between the ages of 6 and 18). As **Figure 3** reflects, 14 percent of the state's White children and 9 percent of the state's Black children are uninsured. Among Mississippi's Hispanic children, 36 percent are uninsured, as are 49 percent of the state's Asian/ Native Hawaiian/Pacific Islander children.

Figure 2. Income Eligibility for Mississippi Medicaid

	Monthly Income Limits *(family of 4)*	% Poverty *(family income cannot exceed)*
Children Under Age 1	$3,446	185%
Children Ages 1 - 5	$2,478	133%
Children Ages 6 - 18	$1,863	100%
Parents	$819	44%
Pregnant Women	$3,446	185%

Source: Eligibility Guidelines for Mississippi Health Benefits, March 2011

Figure 3. Uninsured Children by Race

	Number of Uninsured	Percent Uninsured
White	50,460	14%
Black	40,005	9%
Hispanic/Latino	9,323	36%
Other/Multiple Races	4,392	18%
American Indian/ Alaska Native	1,016	35%
Asian/Native Hawaiian/ Pacific Islander	444	49%

Source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008-2010. Custom tabulations by Manatt Health Solutions, as included in www.kidswell.org.

THE AFFORDABLE CARE ACT: TRANSFORMING OUR HEALTH COVERAGE SYSTEM

Overview. The ACA changes the way Mississippi will make public and private insurance available to its residents. The new rules include:

- Medicaid income eligibility for all individuals under the age of 65, with incomes up to 133% of the Federal Poverty Level (FPL);
- Extension of the Children's Health Insurance Program (CHIP) through 2019, with funding through 2015;
- Income tax credits to help moderate-income Mississippi residents purchase private insurance;
- The establishment of state-based Health Benefit Exchanges as the entryway for consumers to purchase and enroll in coverage;
- The requirement for states to develop streamlined and consumer-friendly eligibility determination and enrollment processes for consumers across public programs
- Elimination of discriminatory practices in private insurance, such as denying coverage for pre-existing conditions, and imposing annual and lifetime caps on coverage; and
- Children's eligibility to remain on their parents' insurance up to age 26.

Purchasing Coverage Through Exchanges: Qualified Health Plans and Tax Credits. The vision for Health Benefit Exchanges is that they serve as a marketplace where individuals may shop for and purchase private coverage. Private coverage options may be most appropriate for children in families with moderate incomes and adults who are ineligible for Medicaid or CHIP. Exchanges must offer health plans in four main benefit levels: platinum, gold, silver and bronze. Benefit levels vary based on actuarial value (i.e., a standardized way of assigning value to services offered by health insurers). Platinum plans cover the most significant percentage of care – 90 percent – with the remaining costs to be paid for through premiums and co-pays. Gold, silver and bronze plans cover 80, 70 and 60 percent of the cost of care, respectively. All health plans and insurers participating in the Exchange must offer plans in each of the aforementioned benefit levels.

The ACA established income tax credits to subsidize certain consumers in purchasing coverage. Subsidies are based on taxpayer's monthly household income compared to the monthly premium for the second-lowest-cost plan within the "silver" tier of plans. Individuals with at least 100 percent, but not more than 400 percent of FPL, will receive a refundable and advanceable tax credit for a percentage of the premium cost for coverage. Credits are scaled, using six income bands: at the lowest level, for consumers up to 133 percent of FPL, premiums are less than 2 percent of income; and at the highest level, between 300 to 400 percent of FPL, premiums would not be more than 9.5 percent of income.

The federal government has already issued regulatory guidance to assist states in the Exchange planning process. This guidance requires coordination by Medicaid and CHIP with private insurance enrollment. It also creates a clear implementation roadmap for Mississippi, discussed in further detail below.

Simplified Enrollment Pathway. The ACA, and state planning efforts around its implementation, includes a major focus on streamlined eligibility and enrollment for all Insurance Affordability Programs through the Exchange. As a result, Mississippi will have to engage in a planning process to design, develop and implement a consumer-friendly system that enables a single point of entry for determining eligibility for any public health insurance program along with eligibility for tax subsidies to purchase coverage via the Exchange. Through a series of planning and establishment grants, the federal government has made available funding to assist states in these activities.

The ACA and its implementing regulations envision a paperless and streamlined enrollment system where eligibility determinations are primarily made in real time. There should be "no wrong door" to access coverage; individuals seeking to enroll in the Exchange and all Insurance Affordability Programs must be able to apply for coverage online, by telephone, in-person or by mail.

The ACA requires states to implement streamlined and consumer-friendly enrollment systems for Medicaid and other programs.

Enrollment Support. As Mississippi designs its "no wrong door" approach, the ACA requires states to consider multiple pathways to coverage. Pathways must take into consideration the assistance that individuals and families need to understand their options and enroll in coverage. For example, while online enrollment may work for some, not all individuals have access to the internet, or have the computer skills to use an online enrollment system. Mississippi will be required to provide assistance in-person, over the phone, and online.

Health care reform requires Exchanges to create Navigator programs to assist uninsured residents in understanding their coverage options and to provide assistance in completing an application. In addition to Navigators, community education and a robust outreach and application assistance network will be essential components in connecting the uninsured to coverage. Outreach and education materials must be consumer-friendly, easy to understand, and designed to meet the needs of individuals with limited English proficiency and/or cultural or linguistic barriers to coverage.

Maintenance of Effort: Holding Steady on Kids Coverage. The ACA's Maintenance of Effort (MOE) requirement prohibits states from establishing Medicaid or CHIP eligibility rules or approaches to enrollment that are more restrictive than requirements that were in place when the ACA was enacted (March 23, 2010). For children enrolled in Medicaid or CHIP, the MOE is in effect through October 1, 2019. For adults, it is in effect until 2014, the time when state Exchanges are to be operational. As a result, Mississippi may not change current eligibility and enrollment practices that would result in new coverage limitations for children and adults (i.e., using more restrictive eligibility criteria).

Medicaid Expansion. Effective 2014, the expansion of Medicaid eligibility levels for non-elderly residents up to 133 percent of the FPL will result in an alignment of eligibility levels for all populations and will fundamentally increase access to coverage for children and adults. For many Mississippi adults, coverage expansion efforts will result in their ability to obtain subsidized health insurance for the first time in their lives. The following summarizes the Medicaid expansion of eligibility levels to 133 percent of the FPL and the impact it will have on Mississippi's children and adults:

Figure 4. Federal Financing

% Federal Financing for Medicaid Expansion (2014 – 2020)	
2014 - 2016	100%
2017	95%
2018	94%
2019	93 %
2020 and beyond	90%

Coverage Changes for Children:

- Children between the ages of 6 to 19 with incomes below 133 percent of the FPL will move from CHIP to Medicaid (Mississippi will continue to receive enhanced federal matching funds for the CHIP program);
- Children with incomes between 133 and 200 percent of the FPL will remain eligible for CHIP;
- Children above 200 percent of FPL will be eligible for tax subsidies through the Exchange as discussed in further detail below; and
- Foster children who have aged out of the system will be eligible for Medicaid up to the age of 26.[8]

Coverage Changes for Adults:

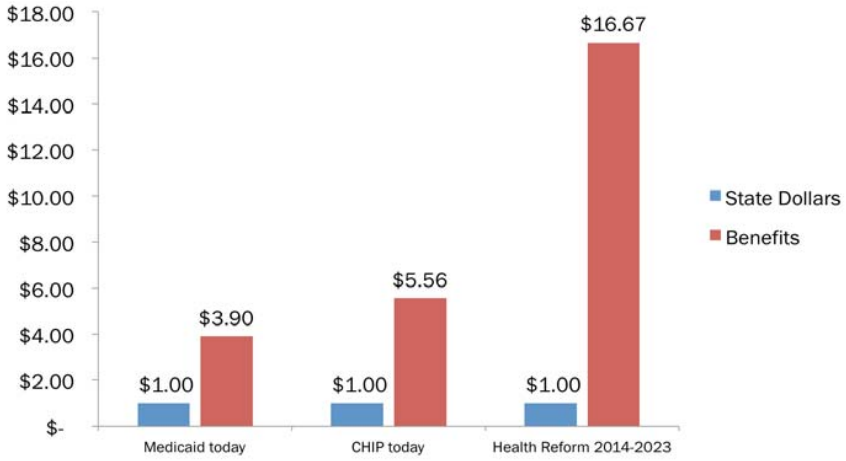
- Parents with incomes above 44 percent of the FPL and below 133 percent of the FPL will become newly eligible for Medicaid; and
- Childless adults who previously were not eligible for Medicaid at any income level (unless disabled) will become newly eligible for coverage if their income is below 133 percent of the FPL.[9]

Federal Funding for Medicaid Expansion. Mississippi will receive 100 percent federal financing to provide Medicaid coverage for those becoming newly eligible from 2014 through 2016. Starting in 2017, enhanced federal funding will be reduced to 95 percent; by 2020, it will gradually decline to 90 percent (see **Figure 4**). According to the Center for Budget and Policy Priorities, this expansion is anticipated to have a limited impact on states, increasing Medicaid costs by less than two percent (1.25%) between 2014 – 2019.[10] This increase does not reflect savings that states are anticipated to experience as a result of reducing reliance on emergency room care and the impact of other ACA provisions. From 2014-2023, Mississippi is projected to receive $16.67 in benefits for each dollar of its own investment in the Medicaid expansion (see **Figure 5** on page 8).

Uniform Household Composition Rules. As part of efforts to simplify the process of determining who is eligible for Medicaid and other Insurance Affordability Programs, health care reform requires programs to use common terms and definitions. One example of this is the establishment of a new uniform household definition. In determining household composition, each state's Exchange must define households consistent with Internal Revenue Service (IRS) definition: the household for whom the taxpayer claims as dependents. The definition is important because it determines whose income is counted for the purposes of applying for an Insurance Affordability Program. The composition rules will apply to all individuals with a few exceptions to ensure that vulnerable populations are not at risk of losing coverage.[11]

Simplified income calculations. By requiring states to use the same methodology to calculate income across programs, the ACA simplifies income-counting rules and replaces them with a single federal standard: Modified Adjusted Gross Income (MAGI).[12] MAGI is basically the amount of household income that families report on their annual federal tax return. Applying a uniform and simplified income test across all programs will eliminate confusion and facilitate consumer access to and enrollment in coverage.

Figure 5. Benefits in Mississippi per state dollar spent



Figures are calculated based on current federal match rates for Medicaid and CHIP, and an average federal match of 94% for 2014-2023 for the Medicaid expansion population. Graph courtesy of Center for Children and Families, Georgetown University.

Elimination of the face-to-face interview. As a result of the enrollment requirements, the final regulations **explicitly prevent** states from requiring face-to-face interviews as a condition of eligibility.[13] Therefore, Mississippi must change its current face-to-face enrollment policies. Mississippi is the only state that still has a face-to-face interview requirement for both Medicaid and CHIP at both enrollment and renewal.

Elimination of paper documentation. The regulations also require a shift from a paper-based verification process (e.g., pay stubs, employment letters or copies of W2 forms to prove income) to electronic data matching with federal and state databases, including birth certificates. With database verification, self-attestation will be allowed and paper documentation will be a means of last resort when data match verification is not deemed "reasonably compatible." Accordingly, Mississippi must establish self-attestation and verification policies and eliminate current documentation requirements for income, residency, and pregnancy.

Mississippi must eliminate its current face-to-face enrollment policy.

Uniform application. The federal government is in the process of creating a uniform model application to be used for all Insurance Affordability Programs. Mississippi may adopt the federal model or develop its own application. Those opting out of the federal application will have to get approval of their state-specific alternative.

Simplified Eligibility Redeterminations. The federal regulations establish a simplified administrative renewal process. This change would result in an automatic yearly (i.e., every 12 months) eligibility verification process accomplished through automated database matching. This will replace the current system that requires consumers to complete new forms and submit documentation. The yearly eligibility verification process is meant to increase retention and reduce the burden on individuals and families; however, recipients are required to correct any inaccurate information.

Promoting Continuity of Coverage. As family incomes fluctuate, children and adults may transition between Medicaid and private insurance. To minimize disruptions in providers and coverage, it will be critical for the state to play an active role in creating incentives for health plans to participate in Medicaid and as a Qualified Health Plan on the Exchange. This will reduce the likelihood that families will experience gaps in providers or care during a coverage transition.[14]

Reforming Private Insurance. The ACA enacted a series of requirements for health plans and insurers to eliminate discriminatory practices and increase access to coverage for children, young adults and vulnerable populations. These changes became effective for children on September 23, 2010 and will become effective for adults in 2014.

Expansion of Dependent Coverage. Plans are required to extend dependent coverage for young adults up to age 26. To remain on their parents' coverage, dependents are not required to reside in the state, live with their parents or be unmarried. Extending coverage will have a considerable impact on young adults in Mississippi because the state had previously only provided dependent coverage while their parents could claim them as dependents on their tax returns.

Private insurance plans must extend dependent coverage for children up to age 26. Plans must also offer well-baby and well-child visits, along with other preventive services, without charging a co-pay or deductible.

Elimination of annual and lifetime limits and pre-existing conditions exclusions. Currently, children cannot be denied coverage based on any pre-existing condition. Beginning in 2014, adults will be afforded the same protection, and plans will be prohibited from imposing lifetime dollar caps and restricted in establishing annual dollar caps.

Elimination of co-payments for preventive services. The ACA also requires plans to cover recommended preventive services without charging beneficiaries co-pays, co-insurance or deductibles. Covered services include well-baby and well-child visits, screenings and vaccinations. This provision applies to new plans (i.e., those created after March 23, 2010) in the employer-sponsored and individual markets.

IMPLEMENTING THE AFFORDABLE CARE ACT: OPPORTUNITIES AND COSTS

While concerns have been raised about the impact of the ACA on state and federal spending, there are a number of factors to consider. First, it is estimated that federal health care reform will reduce the federal deficit by $210 billion from 2012 to 2021.[15] Second, the ACA will produce savings to states by reducing reliance on emergency room care, and improving the care and management of chronic and costly conditions. The anticipated cost to states is small: according to the Center for Budget and Policy Priorities (CBPP), the Medicaid expansion is anticipated to have a limited impact on states, increasing Medicaid costs by only 1.25% between 2014 and 2019.[16] Thus, the anticipated result is improved health outcomes at a lower cost. Finally, Mississippi will receive 100 percent federal financing to provide Medicaid coverage for those becoming newly eligible from 2014 through 2016. Starting in 2017, enhanced federal funding will be reduced to 95 percent; by 2020, it will gradually decline to 90 percent and stay at that level for those in new eligibility categories.

In addition to federal Medicaid matching funds, there is a broad range of funding opportunities available to the State of Mississippi to assist with implementing ACA provisions and, more generally, improving the way care is delivered. The federal government has made available a number of funding opportunities, including planning and establishment grants, to support startup activities, planning work to design technology requirements for streamlined eligibility and enrollment systems, and policy making related to Exchange operations. Mississippi has already received significant funding as described below, and has the opportunity to apply for more.[17]

HEALTH CARE REFORM IMPLEMENTATION IN MISSISSIPPI

Mississippi's Health Benefit Exchange Development. Mississippi is moving forward in its health care reform implementation and Exchange planning. Mississippi's ACA planning efforts began in 2010, when an Insurance Exchange workgroup was established by the Legislative Commission on Health Care Access. Comprised of legislative members and private sector representatives, the workgroup's charge is to investigate funding and implementation options. Planning efforts were also guided by the Mississippi Health Insurance Exchange Study Committee, comprised of key stakeholders, to explore governance, implementation, and operational requirements. The Mississippi Insurance Department has taken the lead in planning and implementation efforts. Outreach was a focus of work in 2011, with 13 town hall meetings hosted in all regions of the State (drawing a total of 500 participants), in-depth interviews with over 60 stakeholders, and online surveys targeting employers.

On September 30, 2010, Mississippi received a $1 million HHS Exchange Planning grant and a $266,000 grant to establish a Consumer Assistance Program. Funded by the planning grant, Utah-based Leavitt Partners and Cicero Group were selected to research the current insurance market. Completed in May 2011, their reports offered data on Mississippi's demographic, social, and economic composition of the uninsured and general population, as well as growth projections to inform Exchange planning.

On August 12, 2011, the Department of Insurance received a $20,143,618 Level 1 Exchange Establishment grant. The grant will be used primarily to ". . . conduct an extensive public education and outreach program to inform consumers about access to health insurance through the exchange; continue to coordinate with Medicaid, CHIP and other appropriate programs regarding eligibility determination and other Exchange activities; and provide assistance to individuals and small businesses." The Establishment Grant will also be used to support the State's work in developing its streamlined eligibility and enrollment system.

In August 2011, the Mississippi Insurance Commissioner Mike Chaney selected the not-for-profit Comprehensive Health Insurance Risk Pool Association to operate the State's Exchange. A subgroup of the Association's current Board of Directors will oversee the Exchange. In addition, House Bill 377 extended the operation and reporting deadlines of the Health Insurance Exchange Study Committee by one year, to July 1, 2012. In the 2012 session, the state legislature passed legislation to expand the Board to include a small business representative and an additional representative of medical providers.

In December 2011, the Insurance Department appointed a 13-member Advisory Board and 11 Advisory Board Subcommittees, which are charged with providing "recommendations, suggestions, advice and consultation" on the establishment of the Exchange. The Advisory Board and Subcommittees represent a variety of stakeholder groups. To date, however, the process for making policy decisions, and the governance structure for the Exchange, are unclear.

RECOMMENDATIONS

In order to ensure health care reform is implemented successfully and Mississippi families are able to access coverage, the Mississippi Center for Justice makes the following recommendations:

1. Simplify the enrollment pathway and prioritize the development of consumer-friendly systems. Mississippi must design the state's Exchange and make policy decisions in a way that will support simplified and consumer-friendly pathways to coverage by offering options for enrollment online, in person, by telephone and by mail. Each enrollment pathway must have guided application assistance, use plain language, and be available in multiple languages for those with limited English proficiency. Information technology (IT) systems should support real time eligibility determinations; paper documentation for verification of eligibility may be used only as a last resort. Planning and implementation work must be guided by a stakeholder engagement process that includes consumer advocates.

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5. Private Insurance Monitoring and Oversight. Mississippi must take an active role in ensuring that the private insurance market complies with the new ACA provisions that eliminate discriminatory practices, such as refusing to insure those with pre-existing conditions. The state should also embark on an outreach and education campaign to increase awareness of the expansion of dependent coverage for young adults on their parents' coverage up to the age of 26.

6. Incorporate Consumer Feedback in Exchange Development and Governance. Given that the state-based Health Exchange is required to be consumer friendly, a comprehensive and meaningful stakeholder process which invites consumer feedback is crucial. Consumer feedback must inform and guide a transparent process to design and implement all aspects of the Exchange, including the required IT systems. Once the Exchange is established, it is vital that consumers also have strong, ongoing representation in its governance and decision-making.

Successful implementation of federal health care reform is essential to making affordable and comprehensive coverage available to all of Mississippi's residents. With more than 100,000 uninsured children in the state, federal health care reform presents a tremendous opportunity to find and enroll uninsured children and their families. We call on our state's leading decision makers to turn the promise of health care reform into a reality and ensure that the state builds a consumer-focused, seamless and coordinated health care enrollment system.

[1] An estimated 270,000 Mississippians will be newly eligible for Medicaid in 2014. Center for Mississippi Health Policy (September 2010). An Overview of Health Reform (pg 4): http://mshealthpolicy.com/documents/GHPCMSOverviewBriefSept10.pdf. An additional 275,000 are projected to be eligible for participation in the state's health insurance exchange. Center for Mississippi Health Policy (January 2012). Building Mississippi's Health Insurance Exchange (pg 5): http://mshealthpolicy.com/documents/Health-Insurance-Exchange-Report-Jan-2012-FINAL.pdf.
[2] See Center for Mississippi Health Policy, supra note 1.
[3] Kaiser Commission on Medicaid and the Uninsured. (May 2010). Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL (pg. 43): http://www.kff.org/health reform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and- State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf.
[4] In Figure 1, Medicaid percentages are inclusive of the Children's Health Insurance Program (CHIP). Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements).
[5] U.S. Department of Health and Human Services. 2011 CHIPRA Annual Report (Appendix 2): http://insurekidsnow.gov/chipraannualreport.pdf.
[6] U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2011. Data extracted using the CPS Table Creator using selected variables: Mississippi, Ages 0-18, Health Insurance Coverage, Household Income, All Persons.
[7] Estimates are based on a 3-year average of the U.S. Census Bureau's Current Population Survey data using the 2008-2010 Annual Social and Economic Supplement. Tabulations include health insurance coverage at or below 200% FPL, for ages 0-18.
[8] 42 C.F.R. § 435.118 (2012).
[9] 42 C.F.R. § 435.119 (2012).
[10] Angeles, J. (2010, October 21). Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law. Accessed (November 9, 2011) from: http://www.cbpp.org/cms/index.cfm?fa=view&id=3310.
[11] The ACA allows Medicaid household rules to remain in effect for the following categories: caretaker relatives (e.g., grandparents caring for grandchildren); children claimed as a tax dependent of a noncustodial parent (income of parents whom they are living with are included); married couples and children of parents not filing jointly; and pregnant women (counted as a family of 2).
[12] The MAGI calculation is used by the IRS to determine taxpayer eligibility for income tax deductions, credits, and other adjustments.
[13] 42 C.F.R. § 435.907(d) (2012) ("The agency may not require an in-person interview as part of the application process for a determination of eligibility…").
[14] Somers, B.D. & Rosenbaum, S. "Issues in Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." Health Affairs, 30, no.2 (2011):228-236.
[15] CBO's Analysis of Major Health Care Legislation Enacted March 2010 (March 30, 2011).
Available at http://www.cbo.gov/ftpdocs/121xx/doc12119/03-30-HealthCareLegislation.pdf.
[16] Angeles, J. (2010, October 21). Some Recent Reports Overstate the Effect on State Budgets of the Medicaid Expansions in the Health Reform Law. Accessed (November 9, 2011) from: http://www.cbpp.org/cms/index.cfm?fa=view&id=3310.
[17] The ACA makes available to states sizeable grants to plan and implement their Exchange, in addition to Medicaid funds to reflect the cost of streamlining eligibility and enrollment systems for Medicaid recipients. Beyond these funding sources, there are a host of pilot projects and other programs designed around delivery system redesign – such as the Multipayer Advanced Primary Care Pilot program, that states may leverage to test potential innovations. Many of these programs have been promulgated by Center for Medicare and Medicaid Innovation (CMMI), established by the ACA. The CMMI is specifically geared toward "revitalizing and sustaining Medicare, Medicaid, and [CHIP]."