



Health Reform in Mississippi

Mississippi Economic Policy Conference
Annual Policy Conference
October 22, 2010

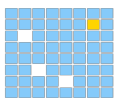




The Patient Protection and Affordable Care Act



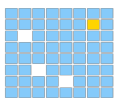
- The Patient Protection and Affordable Care Act was signed into law on March 23, 2010.
- Estimated to insure 32 Million of the projected uninsured Americans over the next decade.
- The law includes temporary and long-term provisions with some elements enacted immediately and then phased out, and others enacted on a delayed timeline.





Major Components

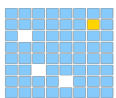
- Coverage Expansions
 - Public Programs
 - Health Insurance Exchanges
- Health Insurance Reform
- Health Care Delivery System Changes
- Prevention/Public Health Initiatives



Changes to Public Health Coverage



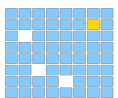
- Changes to public coverage will affect Medicaid, the Children's Health Insurance Program (CHIP), Medicare, Indian Health Services, and the U.S. Department of Veterans Affairs.
- The legislation attempts to address certain aspects of each public program, including:
 - access,
 - enrollment,
 - benefits,
 - prescription drug coverage,
 - quality and efficiency of services offered,
 - funding to hospitals caring for a disproportionate share of the uninsured,
 - program integrity, and
 - promoting disease prevention and wellness.



Eligibility

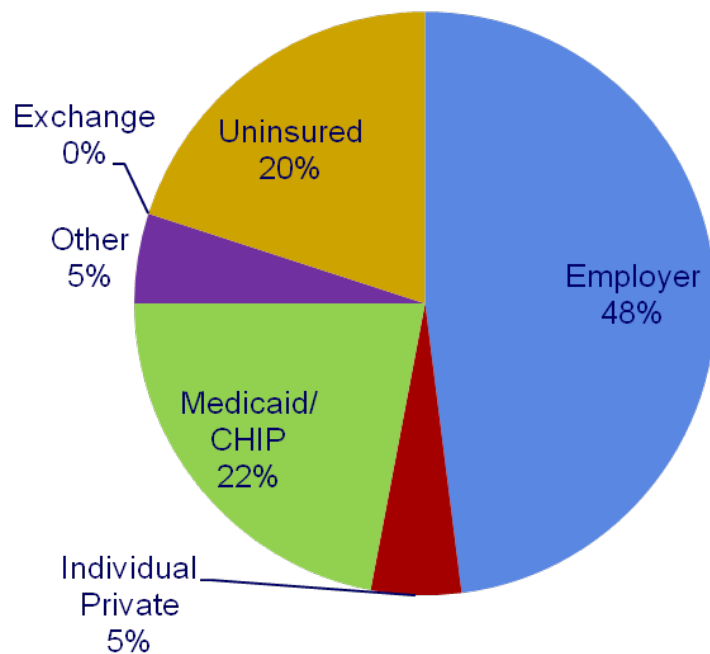


- Beginning in 2014, all individuals under the age of 65 below 133% of the Federal Poverty Level (FPL) will be eligible for coverage under Medicaid.
- As of 2010, 133% of the FPL for a family of four is \$29,327.

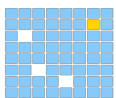
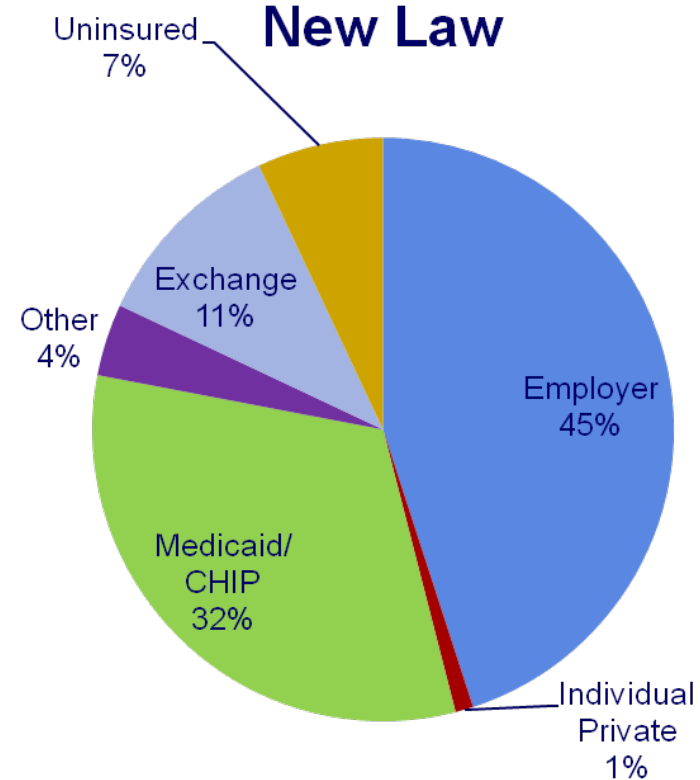


Shifts in Coverage Projected for Mississippi

Current Law



New Law

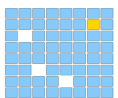




Children's Health Insurance Program (CHIP)



- CHIP covers children up to 200% FPL who are not eligible for Medicaid.
- Requires states to maintain current eligibility levels for CHIP through September 30, 2019.
- States are prohibited from implementing eligibility standards and procedures that are more restrictive than those in place on March 23, 2010 (date of enactment).

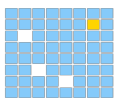




CHIP Provisions



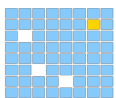
- CHIP-eligible children, who cannot enroll in CHIP due to federal allotment caps, will then be eligible for tax credits in the health insurance exchange.
- From October 1, 2015 to September 30, 2019, states will receive a 23 percentage point increase in the CHIP match rate, up to a maximum cap of 100 percent. (Mississippi will get the full 100%.)
- Matching rates for CHIP after 2019 are not defined.



Benefit Expansions



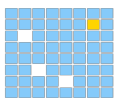
- Covers tobacco cessation for pregnant women through Medicaid.
- Covers preventive services under Medicaid and Medicare that have been proven effective.
- Creates a national, voluntary long-term care insurance program. Premiums will be deducted from every worker's paycheck unless they choose to opt-out.
- Extends Medicaid coverage of prescription drugs through benchmark benefits, rebates, and requirements to cover specific drugs.



Other Medicaid Provisions



- Temporarily increases Medicaid reimbursement rates for primary care physicians in 2013 and 2014.
- Disproportionate share hospital payments will be reduced between FY 2014 - FY 2020.

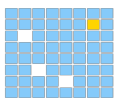




Impact on Medicaid in Mississippi



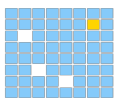
- In 2014, it is estimated that Mississippi will have about 270,000 new Medicaid recipients as a result with Medicaid expenditures of \$1.6 billion annually.
- From 2014 to 2019, state expenditures for the newly eligible Medicaid recipients will be about \$11.4 billion with the Federal government paying 97% of those costs.





Enhanced Federal Medical Assistance Percentages (FMAP) for **New** Medicaid Eligibles

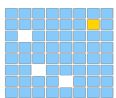
Year	Federal Match
2014	100%
2015	100%
2016	100%
2017	95%
2018	94%
2019	93%
2020 and Beyond	90%



Health Insurance Exchange



- The exchange will allow small businesses and individuals to select from a range of insurance plans.
- Health insurance companies will be able to contract with a government agency or non-profit organization to function as a health insurance exchange.
- Provides premium and cost-sharing assistance to individuals who obtain coverage through the exchange, with incomes up to 400% of the FPL.
- If states do not decide to run their own exchange by 2012, the U.S. Department of Health and Human Services (DHHS) will run the exchange.

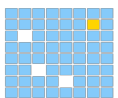




Health Insurance Exchange



- All plans in the exchange must offer coverage for essential benefits, which include:
 - emergency services,
 - hospitalization,
 - maternity and newborn care,
 - mental health and substance use disorder services,
 - prescription drugs,
 - preventive and wellness services, and
 - chronic disease management, and pediatric services (including pediatric oral and vision care).

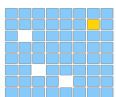




Health Insurance Exchange

- Provides for the following levels of coverage based upon the amount of covered expenses to be paid by the plan:

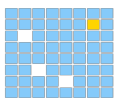
Plan	Percentage of Expenses
Bronze	60
Silver	70
Gold	80
Platinum	90



Exchanges



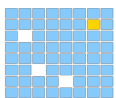
- The law provides for two types of exchanges:
 - Individual and
 - Small Business Health Options Program (SHOP)
- The Individual Exchange will be open to individuals who do not have qualifying coverage through an employer or a public program.
- SHOP will be open to employers with fewer than 100 employees.
- Effective 2014, tax credits will be available on a sliding scale for families with incomes between 133%-400% FPL who have purchased insurance through an exchange to offset premiums and out-of-pocket costs.
(In 2010, 400% FPL for a family of four is about \$88,000/year.)



Dollar Flow in Mississippi

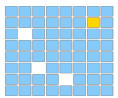


- It is estimated that about 275,000 individuals will purchase coverage through the exchange in 2014.
- Approximately 229,000 individuals will be eligible for subsidies paid by the federal government worth \$912 million in 2014.



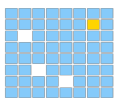
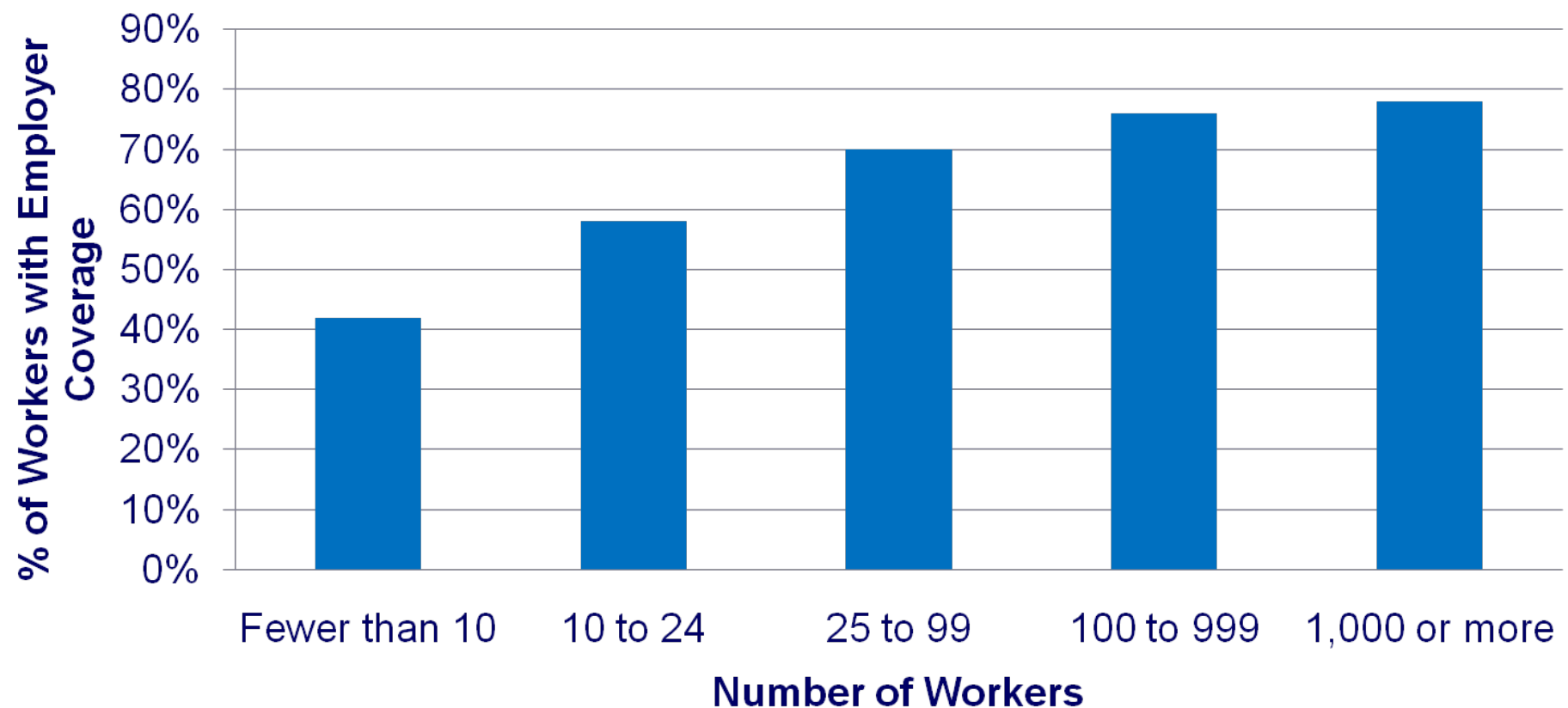


Impact on Employers





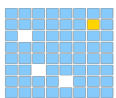
Likelihood of Workers Having Employer-Sponsored Coverage in Mississippi, 2008





Health Reform Implications for Employers by Firm Size

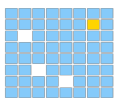
Firm Size	Considerations
Less than 25 FTEs	Potentially eligible for tax credits – full tax credits for low wage firms under 10 FTEs
25-49 FTEs	No tax credits, no fees charged for not offering health insurance
50+ FTEs	Potentially subject to fees if any worker obtains a tax credit
Less than 100 FTEs	Eligible for small business exchange
More than 200 FTEs	Required to auto-enroll all workers in employee-only coverage and notify employees of all other choices available to them





Small Employers Tax Credit

- Provides tax credits to small businesses that have 25 or fewer FTEs with average wages of less than \$50,000 who **offer** coverage that meets minimum requirements as of September 23, 2010.
- Employers with 10 or fewer FTEs and average annual wages of less than \$25,000 are eligible for the maximum credit.
- Employer must contribute at least 50% of the total premium cost to be eligible for a tax credit.
- Dental and vision coverage also qualify for the tax credit.
- *Health Reform Calculator for Small Businesses* is available on the Center's web site.

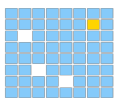




Employers Fees



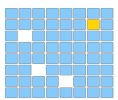
- Employers with ***fewer*** than 50 FTEs are not subject to fees.
- Beginning in 2014, employers with 50 or more FTEs may be charged a fee if an employee obtains subsidized coverage through an exchange.
- Firms with more than 50 FTEs that ***don't offer*** health insurance, will pay the annual fee of \$2,000 per FTE after the first 30 FTEs.





Example

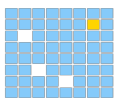
- A firm has 70 FTEs and does ***not*** offer health insurance.
- After the first 30 FTEs, the firm is required to pay \$2,000 per FTE.
- Thus, the firm would be required to pay \$80,000 ($\$2,000 \times 40$ FTEs) starting in 2014.



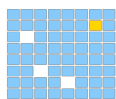
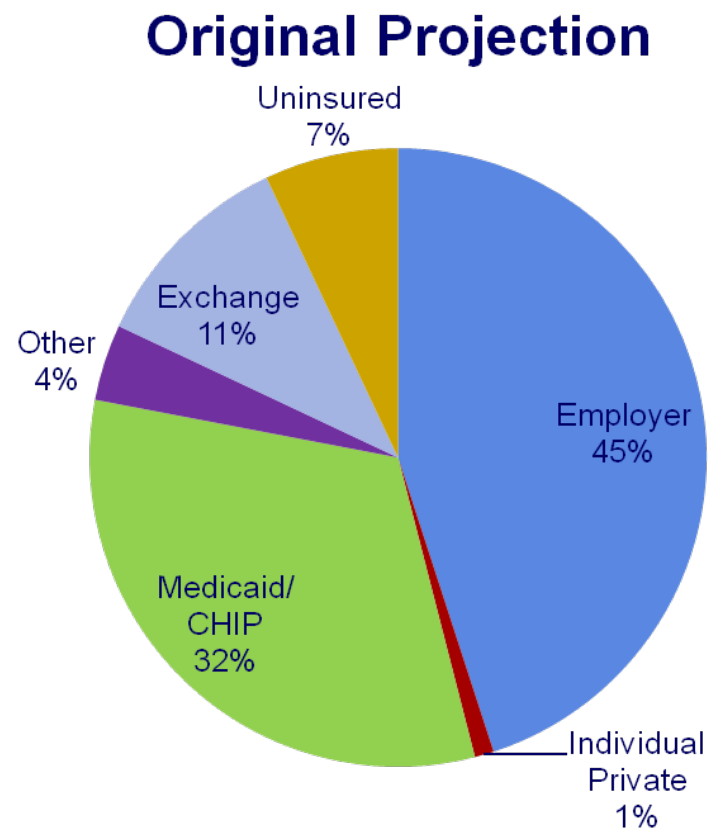
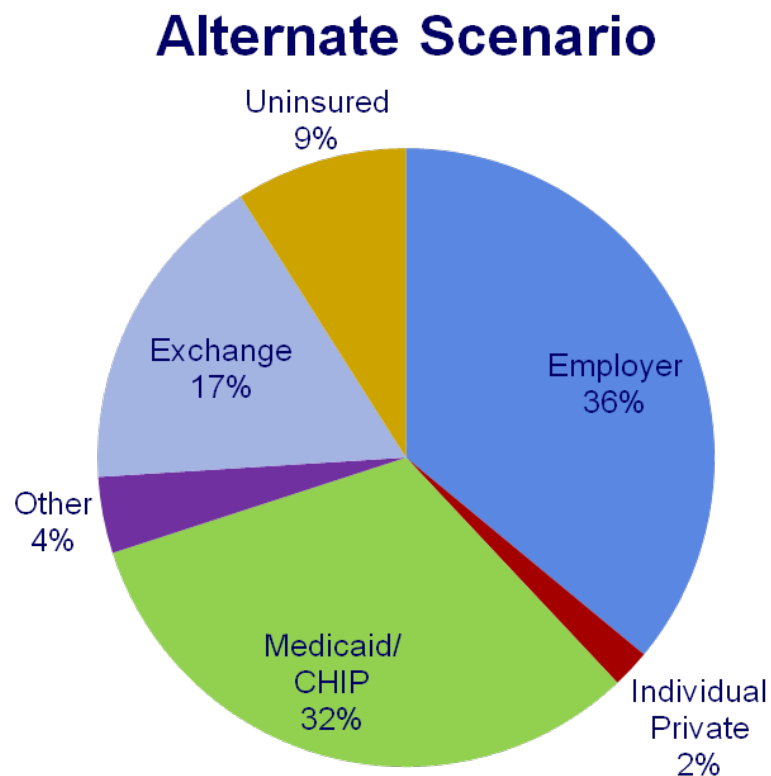
Employer Fees



- Employers that ***offer insurance*** that either pays less than 60% of covered health care expenses or requires contributions for single coverage that exceed 9.5% of an employee's family income would pay a fee that is the lower amount of the following:
 - \$3,000 per worker who obtains subsidized coverage through an exchange; or
 - \$2,000 per worker after the first 30 FTEs.



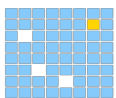
Alternate Scenario: More Employers Drop Coverage





Insurance Reform

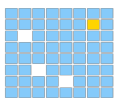
- Changes as of 2010:
 - Coverage cannot be rescinded except in cases of fraud.
 - Children cannot be excluded due to pre-existing conditions.
 - Unmarried children up to age 26 are allowed to stay on a parent's plan, unless offered a choice of plans by their own employer.
 - Access to a temporary, national high-risk pool for those previously unable to obtain insurance due to poor health (ends in Jan. 2014).
 - Lifetime and annual caps are regulated (completely banned in 2014).
- As of 2014, coverage cannot be denied for adults with pre-existing conditions.
- In 2016, insurers will be allowed to sell products across state lines through established health care choice compacts.





Individual Mandate

- By 2014, all individuals must obtain health insurance or pay a penalty, although some exceptions will apply.
- The penalty, in the form of a tax, will first be assessed as 1% of household income, moving to 2.5% in 2016 and beyond. There will be upper income limits.
- Those who can show financial hardship or have religious objections may be exempt.



Issue Briefs



PolicyBrief

DATE 2010



An Overview of Health Reform

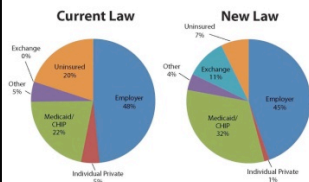
This policy brief takes a look at the Affordable Care Act (Health Reform) in the United States and specifically looks at a comparison for the state of Mississippi.

CHANGES TO PUBLIC HEALTH INSURANCE

The expansion of both public and private health insurance coverage is expected to insure approximately 32 million more Americans in the next ten years. By 2019, as many as 16 million more people may be insured through Medicaid and the Children's Health Insurance Program (CHIP) as a result of the new health reform law.¹ The expected changes in private and public coverage are depicted below.

Changes to public health insurance will also affect Medicare, Indian Health Services, and the U.S. Department of Veterans Affairs. The new legislation attempts to address certain aspects of each public program, including access, enrollment, benefits, prescription drug coverage, quality and efficiency of services offered, options for long-term care resources and supports, and funding to hospitals caring for a disproportionate share of the uninsured. The law includes temporary and long-term provisions with some elements enacted immediately and then phased out, and others enacted on a delayed timeline.

Sources of Coverage in Mississippi: Before and After Full Implementation of Health Reform²



The major changes to public health insurance coverage outlined in the law can be viewed in three categories: expanded and coordinated eligibility, expanded services offered, and changes to payment mechanisms.

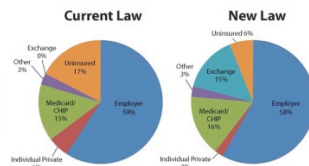
ELIGIBILITY

- Beginning in 2014, extends Medicaid coverage beyond qualified children, their caretakers, pregnant women, the disabled, and certain other groups to cover all individuals under the age of 65 who are at or below 133% of the federal poverty level.
- Continues the Children's Health Insurance Program and allows states to expand eligibility.
- Improves coordination for individuals eligible for both Medicaid and Medicare.

SERVICES OFFERED

- Offers new and expanded services and funding options for special populations including American Indians and Alaska Natives, maternal and child populations, and long-term and elder care.

Sources of Coverage in the United States: Before and After Full Implementation of Health Reform³



¹ Estimated by the Congressional Budget Office, March 20, 2010.

² This shows the non-elderly and is a preliminary estimate, subject to revision.



PolicyBrief

September 2010



In partnership with



Health Reform Implications for Employers

More than 90% of Americans with private health insurance obtain that coverage through employer-sponsored plans. Therefore, the Affordable Care Act (health reform) targets the link between employment and health insurance. Provisions of health reform that affect employer decision making are highlighted in this policy brief.

OVERVIEW

An emphasis of health reform is to create incentives for employers to provide insurance for their employees and for employees to participate in employer-sponsored health insurance plans. The new health reform law aims to do the following:

- Provide tax credits and create exchanges (organized markets) to encourage small firms to offer coverage.
- Assess penalties to larger firms that fail to offer coverage to their full-time workers, and
- Provide options for individuals who do not have employer-sponsored coverage.

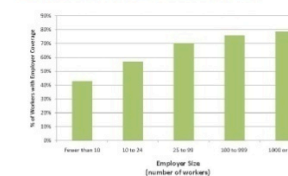
These incentives are important because in recent years the percentage of employees with employer coverage has declined as premiums have increased overall, and the employee share of those premiums has risen. Over the last decade, private insurance coverage for those whose family head works for a small firm has declined by eight percentage points.

BACKGROUND

The link between employment and health insurance has been part of the U.S. health care system since the 1930's. Workers at large businesses benefit from this relationship more than workers at small firms. Large employers are able to offer coverage with stable premiums by combining (or "pooling") the low risks of individuals who maintain coverage (but need little care) with individuals who have a high risk of needing costly care. Large employers can also consolidate administrative costs by concentrating marketing and insurance enrollment activities within human resources departments.

Small employers are less able to pool risk or lower administrative costs due to small numbers of workers. Thus, they are significantly less likely to offer coverage to their employees.

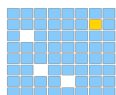
FIGURE 1: LIKELIHOOD OF WORKERS HAVING EMPLOYER-SPONSORED COVERAGE IN MISSISSIPPI, 2008



Source: Georgia State University Robinson College of Business, tabulations of the March Current Population Survey

Employees benefit from the link between employment and health insurance because the employer's contribution is not recognized as income for the purpose of determining income tax liability. However, the cost of coverage has increased faster than wages over the past 20 years, so the employee share of the premium has become a larger portion of take-home pay. As a result, more workers have opted not to enroll. Therefore, many workers (especially small firm employees) do not have health insurance through their jobs.

The Center for Mississippi Health Policy in partnership with the Georgia Health Policy Center, the Georgia State University J. Mack Robinson College of Business, and the Florida Public Health Institute



Center for Mississippi
Health Policy



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