MISSISSIPPI INSURANCE DEPARTMENT

HEALTH CARE REFORM SYMPOSIUM

Reminders

- Internet Access: JCC-PUBLIC-WIFI
- Restroom Location
- Cell Phones on Silent

MISSISSIPPI INSURANCE DEPARTMENT

HEALTH CARE REFORM SYMPOSIUM

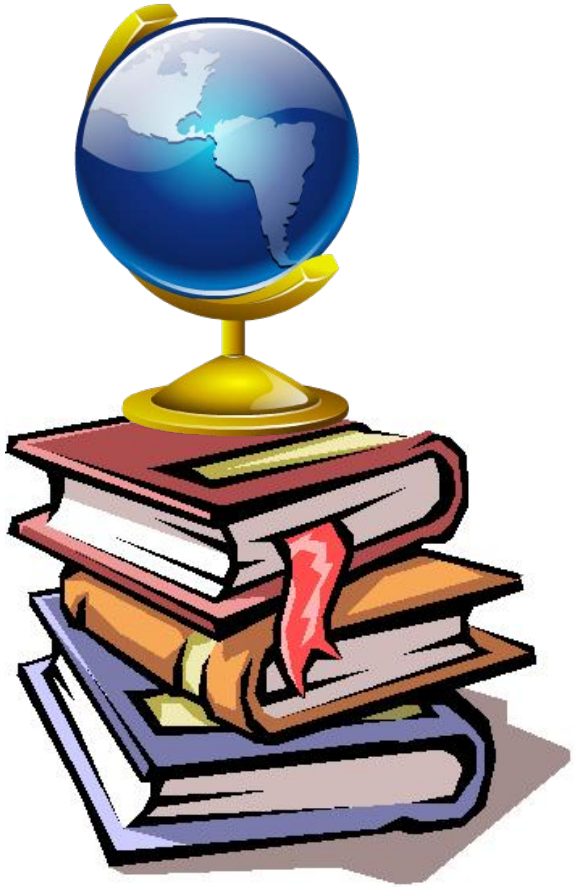
HEALTH INSURANCE UNIVERSITY

Presented by
Aaron Sisk

to attendees of the
Health Care Reform Symposium
sponsored by the
Mississippi Department of Insurance

Jackson Convention Complex
Jackson, Mississippi

December 13, 2012



Test Question

The half-life of radium-226 is 1626 years. What percentage of a given amount of the radium will remain after 1000 years?

A. 65.27%

B. 65.28%

C. 65.30%

D. 65.33%

E. 65.40%

Contents:

- Vocabulary
- History
- Government & Law
- Economics & Statistics
- Current Events

Vocabulary


vocabulary-building
Dictionary
Vocab
approach
English
suggest
practical
Articles
fresh
Tim
American
Macmillan
Perplexed
classroom
aimed
students
BuzzWord
ideas
innovative
tips
comprehensive
panel
exercises
available
various
fantastic
included
unexpected
explanations
corpora
phrasal
authors
lessons
class
looking
put
lesson
new
imagination
articles
find
rescue
Metaphors
Corpora
worksheets
vocabulary
helping
language
complex
useful
learners
perspective
expert
Onestopenglish
developing
teachers
theme-based
resources
issues
help
aspects
knowledge
series
teaching
editor
verbs
plans
archive
suggestions
web
provide
bank
section
anything
reference
British
purpose
Phrasal
training
accompanying
Mystified
metaphors

Vocabulary Quiz

The amount an individual must pay before the insurance kicks in

A. Premium
B. Co-insurance
C. Deductible
D. Co-payment

Cost Sharing

- **Premium** - The periodic payment made on an insurance policy in order to secure insurance coverage

- **Deductible** – The amount an individual must pay before the insurance kicks in.

- **Co-insurance** – A percentage of each claim above the deductible paid by the policyholder.

- **Co-payment** – A predetermined, flat fee an individual pays for health-care services, in addition to what insurance covers.

Vocabulary Quiz

Under which rating practice would health insurers be prevented from varying premiums within a geographic area based on age, gender, health status or other factors?

A. Community Rating
B. Experience Rating
C. Rate Review
D. Rate Banding

Rating Practices

- **Experience Rating** – A method used by insurers to determine pricing of premiums for different groups or individuals based on the group or individual's history of claims
- **Community Rating** – Requires health insurers to offer health insurance policies within a given territory at the same price to all persons without medical underwriting, regardless of their health status.
- **Modified Community Rating** – Allows insurance rate variations based on demographic characteristics such as age, gender, health status or other factors.

Vocabulary Quiz

The process by which insurers select the risks to insure and decide how much in premiums to charge for accepting those risks is known as

A. Pooling
B. Hedging
C. Guessing
D. Underwriting

Consumer Protections

- **Guaranteed Issue** – Health insurance coverage is offered to any eligible applicant without regard to health status.

- **Guaranteed Renewability** – Health insurance issuers offering coverage in the individual or group market must renew coverage at the option of the plan sponsor or individual.

Vocabulary Quiz

For purposes of purchasing insurance, the State of Mississippi defines a "small employer" as someone with

A. Fewer than 25 employees
B. Fewer than 50 employees
C. Fewer than 100 employees
D. None of the above

Insurance Markets

- **Individual Market** – Insurance coverage not associated with a group health plan.

- **Small-group Market** –Group health plan maintained by a small employer

- **Large-group Market** –Group health plan maintained by a large employer

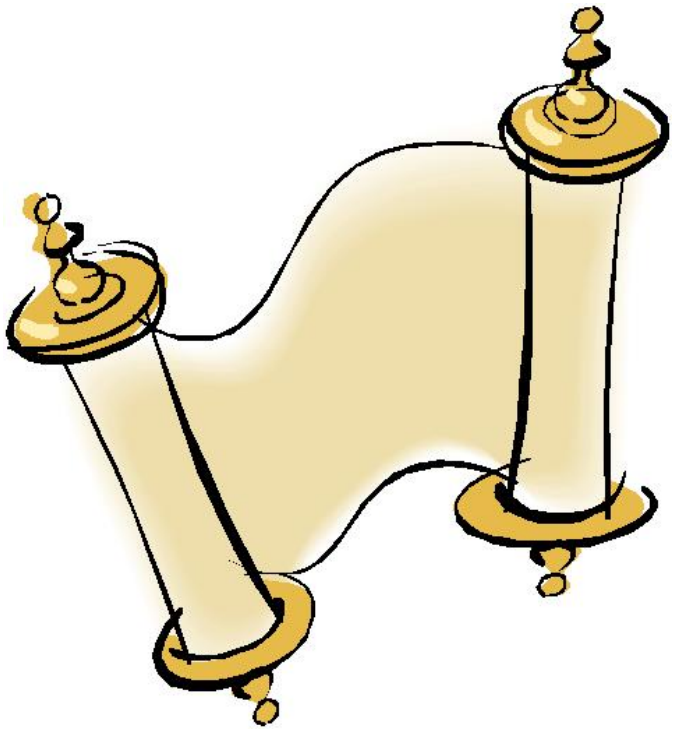
Risk Selection

- **Adverse Selection** – The tendency of those exposed to a higher risk to seek more insurance coverage than those at a lower risk.

- **Favorable Selection** –The tendency of insurance companies to enroll as many healthy people as possible or the tendency to take measures to improve the overall health of the insured population

[1] Insurance Information Institute – "Adverse Selection"; http://www.iii.org/

History



History Quiz

The origin of health insurance coverage is generally associated with growing demand in which industries?

A. Police and Firemen
B. Factory workers
C. Railroad and Steamboat workers
D. Ranchers and Farmers

History Quiz

What was the original and primary purpose of health insurance?

A. A means whereby individuals could pre-pay for medical care
B. A means of protection against asset loss or loss of wages in the event of accident or disability
C. A benefit offered by employers in order to compete in the labor market

Accident and Sickness Insurance

- **1850**s—Franklin Health Assurance Company of Massachusetts begins to offer “accident insurance” against wage loss as a result of injuries arising from railroad and steamboat accidents.

- **1890**s—Emergence of “sickness insurance” to protect against wage loss as a result of unexpected injuries or illness.

Hospitalization Coverage

- **1929** – A group of Dallas-based teachers form a partnership with an area hospital to provide a set amount of sickness and hospitalization days in exchange for a fixed, prepaid fee. Encouraged by the American Hospital Association (AHA), other hospitals and community care organizations join together for the purpose of entering into similar arrangements. They operate under the name of Blue Cross.

Physician Coverage

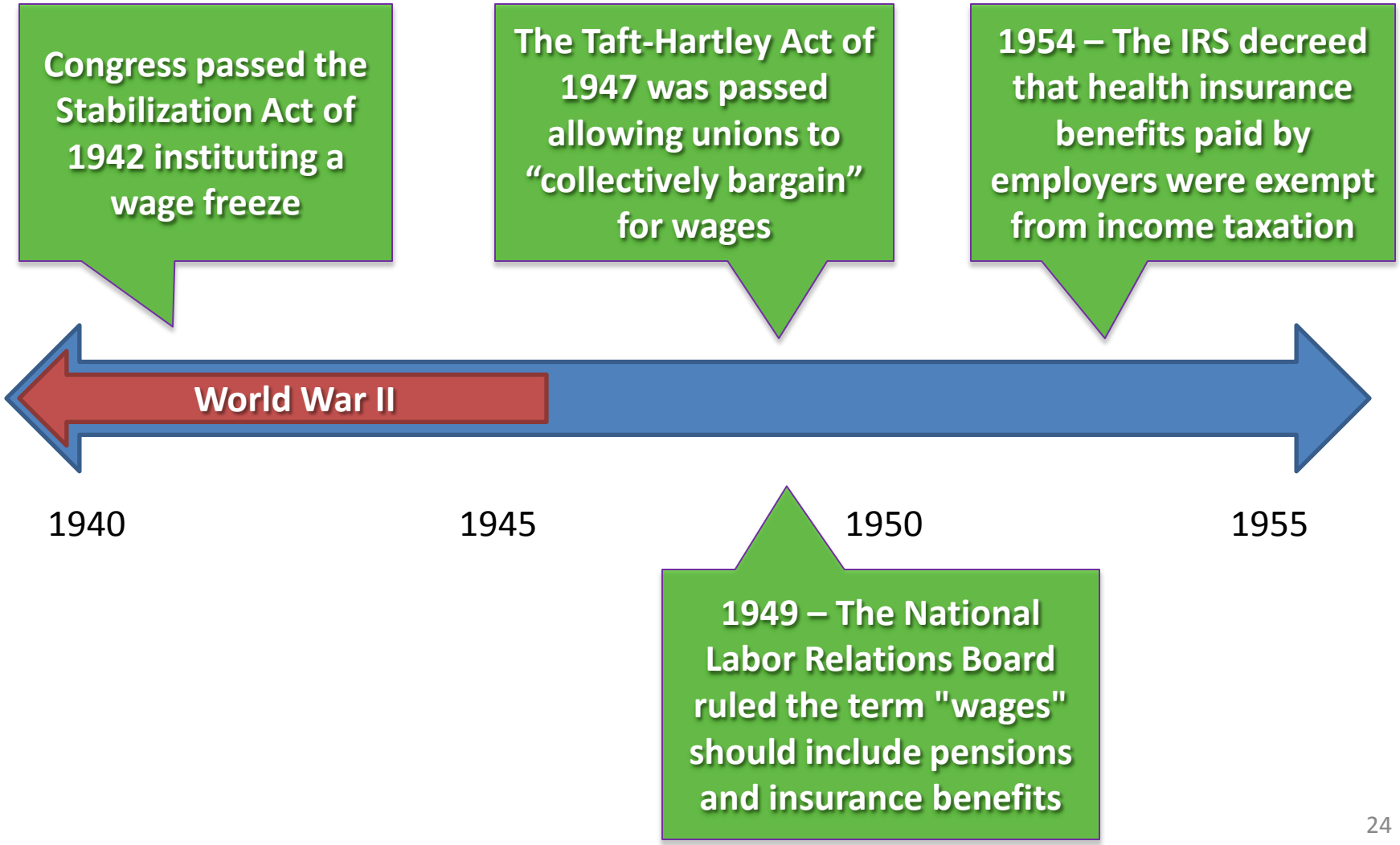
- **1939**—Encouraged by the American Medical Association, physicians formed their own collective in an effort to maintain control of the patient-physician relationship as well as their own incomes . Unlike the hospital arrangement, the physician collective guaranteed the insured would receive a fixed dollar amount as reimbursement for the out-of-pocket cost for treatment; however, physicians retained the ability to price discriminate and could charge more than the reimbursement amount if they wished. They operated under the name Blue Shield.

History Quiz

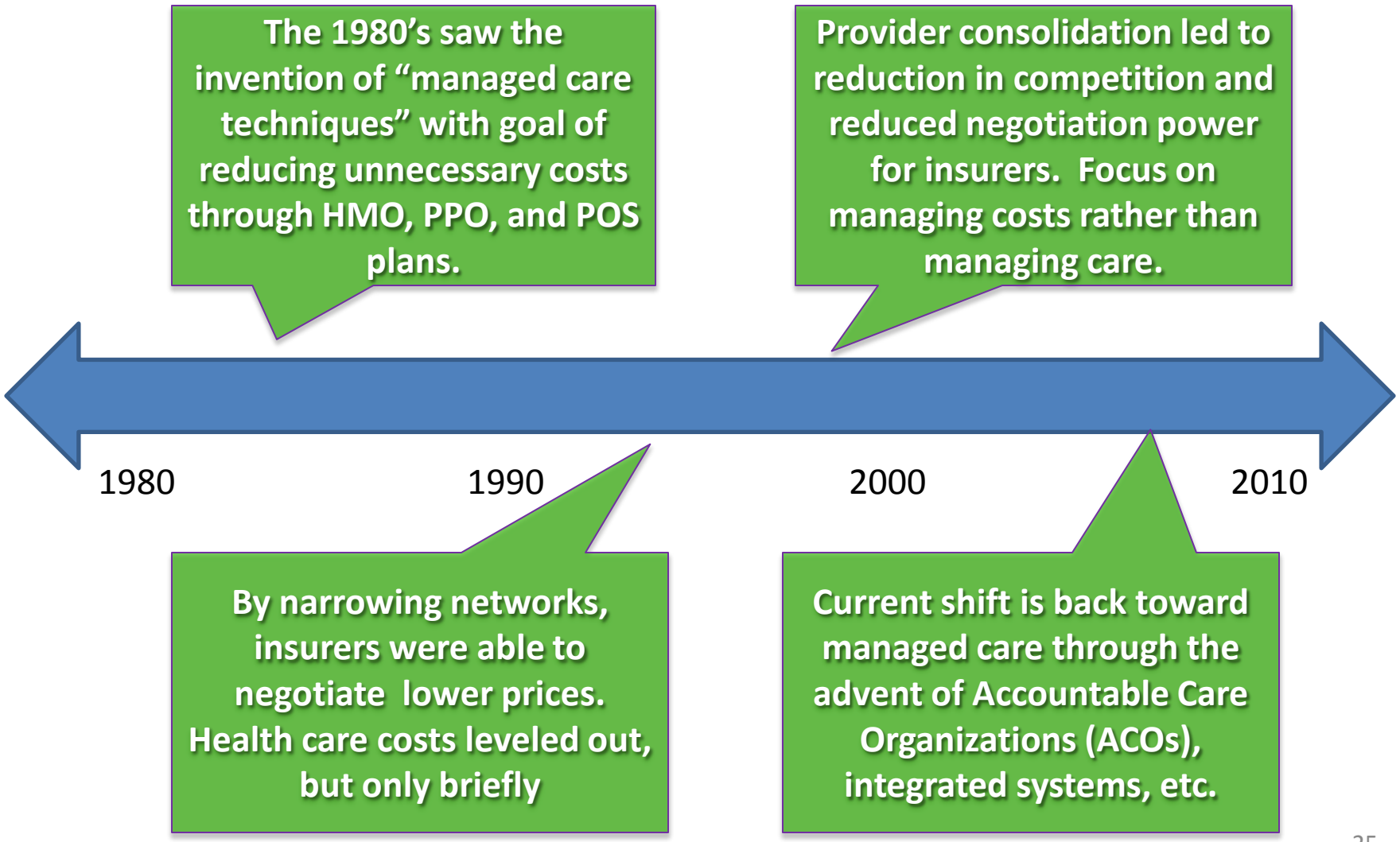
The Stabilization Act of 1942 decreed that health insurance premiums paid by employers were exempt from income taxation.

A. True
B. False

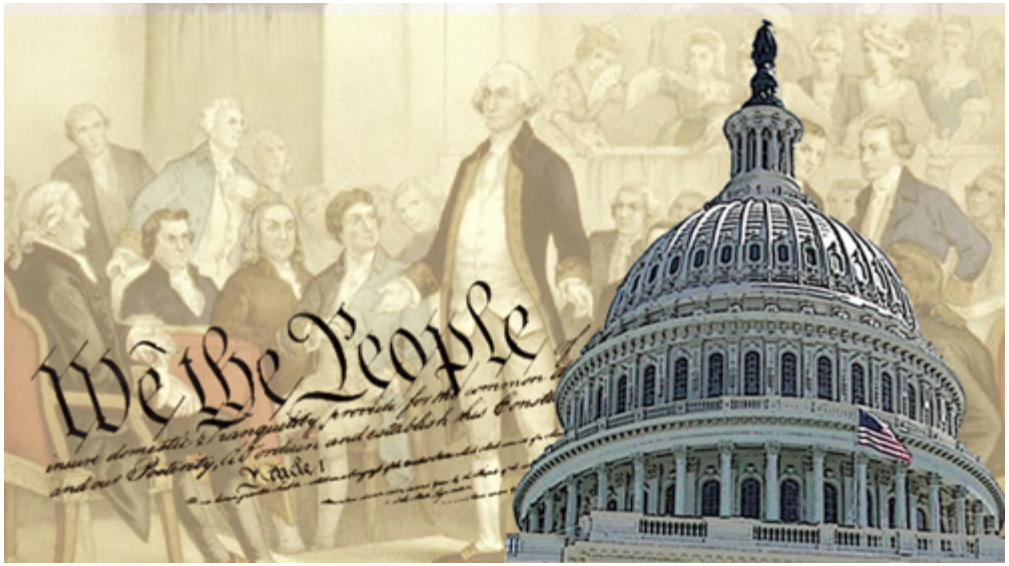
The Evolution of Employer-Sponsored Insurance



The Rise and Fall (and Reinvention) of Managed Care



Government & Law



Government & Law

- The McCarran-Ferguson Act of 1945
  - Declared that states—not Washington, D.C.—should regulate the business of insurance
  - Declared state regulation of the insurance industry was in the public's best interest.

State Insurance Regulation

Mississippi Department of Insurance

- Regulates all insurance companies and examines all insurance products doing business in Mississippi. Including:
    - Agent licensing and examination;
    - Periodic examination of company affairs;
    - Insurance rate approval;
    - Policy form approval;
    - Rating and claims practice investigation; and
    - Complaints investigations.

Government & Law Quiz

Which of the following sequences is correct, based on date of initial passage, beginning with the earliest?

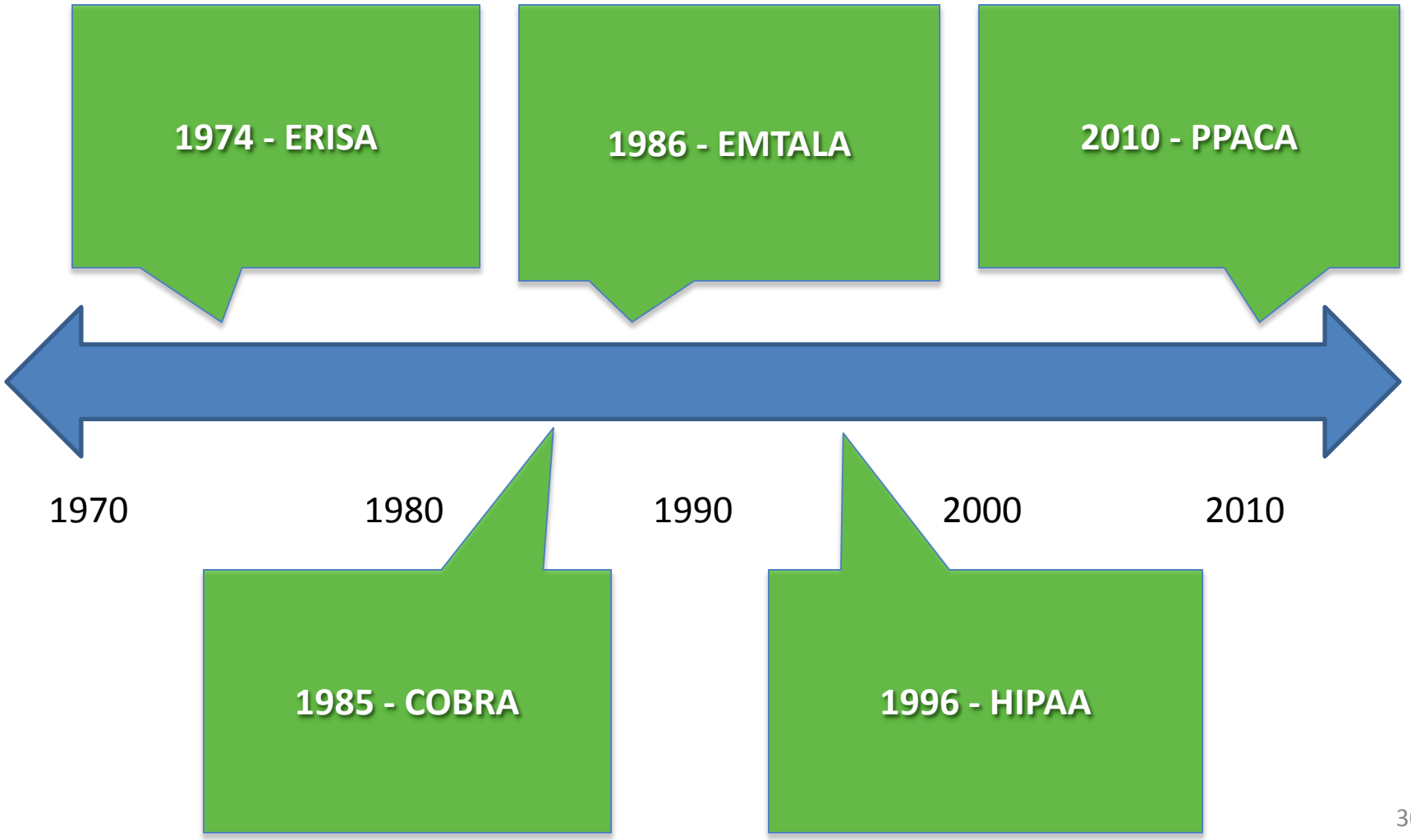
A. **I.** ERISA **II.** COBRA **III.** EMTALA **IV.** HIPAA **V.** PPACA

B. **I.** EMTALA **II.** COBRA **III.** HIPAA **IV.** PPACA **V.** ERISA

C. **I.** PPACA **II.** COBRA **III.** HIPAA **IV.** ERISA **V.** EMTALA

D. **I.** COBRA **II.** HIPAA **III.** ERISA **IV.** EMTALA **V.** PPACA

Federal Laws Governing Insurance



ERISA

- The Employee Retirement Income Security Act of 1974 (ERISA)
  - Sets minimum standards for most voluntarily established pension and health plans in non-government, private industry
  - Requires plans to provide participants with plan information including important information about plan features and funding;
  - Provides fiduciary responsibilities for those who manage and control plan assets; gives participants the right to sue for benefits and breaches of fiduciary duty.
  - Requires plans to establish a grievance and appeals process for participants to get benefits from their plans;

COBRA

- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
  - Provides some employees and beneficiaries with the right to continue their coverage under an employer-sponsored group health benefit plan for a limited time after the occurrence of certain events that would otherwise cause termination of such coverage, such as the loss of employment.

EMTALA

- The Emergency Medical Treatment and Active Labor Act of 1986 (EMTALA)
  - Requires hospitals to provide care to anyone needing emergency healthcare treatment regardless of citizenship, legal status or ability to pay.
  - Participating hospitals may only transfer or discharge patients needing emergency treatment under their own informed consent, after stabilization, or when their condition requires transfer to a hospital better equipped to administer the treatment.
  - There are no reimbursement provisions; largely considered an unfunded mandate.

HIPAA

- The Health Insurance Portability and Accountability Act of 1996 (HIPAA)
  - Prohibits a health benefit plan from refusing to cover an employee's pre-existing medical conditions in some circumstances.
  - Bars health benefit plans from certain types of discrimination on the basis of health status, genetic information, or disability

PPACA

- The Patient Protection and Affordable Care Act of 2010 (PPACA)
  - Together with the Health Care and Education Reconciliation Act, it represents the most significant regulatory overhaul of the U.S. healthcare system since the passage of Medicare and Medicaid in 1965.
  - Key provisions:
    - Medicaid expansion
    - Insurance reforms
    - Individual and Employer Mandate
    - Insurance exchanges

Economics & Statistics

Economics & Statistics Quiz

What percentage of the state's population lives below the poverty line?

A. 21-25%
B. 16-20%
C. 11-15%
D. 10% or less

Poverty

- 22.6% of the state's population is living below the poverty level and the median family income in 2011 was $46,304.[1]

[1] U.S. Census Bureau, 2011 American Community Survey

Economics & Statistics Quiz

What percentage of the state's population is uninsured?

A. 21-25%
B. 16-20%
C. 11-15%
D. 10% or less

Uninsured

- Approximately 516,413 Mississippians (about 17.7% of the population) are uninsured.[1]

[1] U.S. Census Bureau, 2011 American Community Survey

Economics & Statistics Quiz

What percentage of <u>all</u> private-sector employers in Mississippi offer employee health coverage?

A. 46-50%
B. 36-45%
C. 26-35%
D. 25% or less

Economics & Statistics Quiz

What percentage of Mississippi's small employers offer employee health coverage?

A. 45-50%
B. 35-44%
C. 25-34%
D. 24% or less

Employer-Sponsored Coverage in Mississippi

- 46.6% of all private-sector establishments in Mississippi offer health insurance
- 25.8% of Mississippi small businesses offer health insurance.[1]

[1] Agency for Healthcare Research and Quality, Center for Financing, Access and Cost Trends. 2011 Medical Expenditure Panel Survey-Insurance Component.

Economics & Statistics Quiz

What is the average annual health insurance premium for a family in Mississippi?

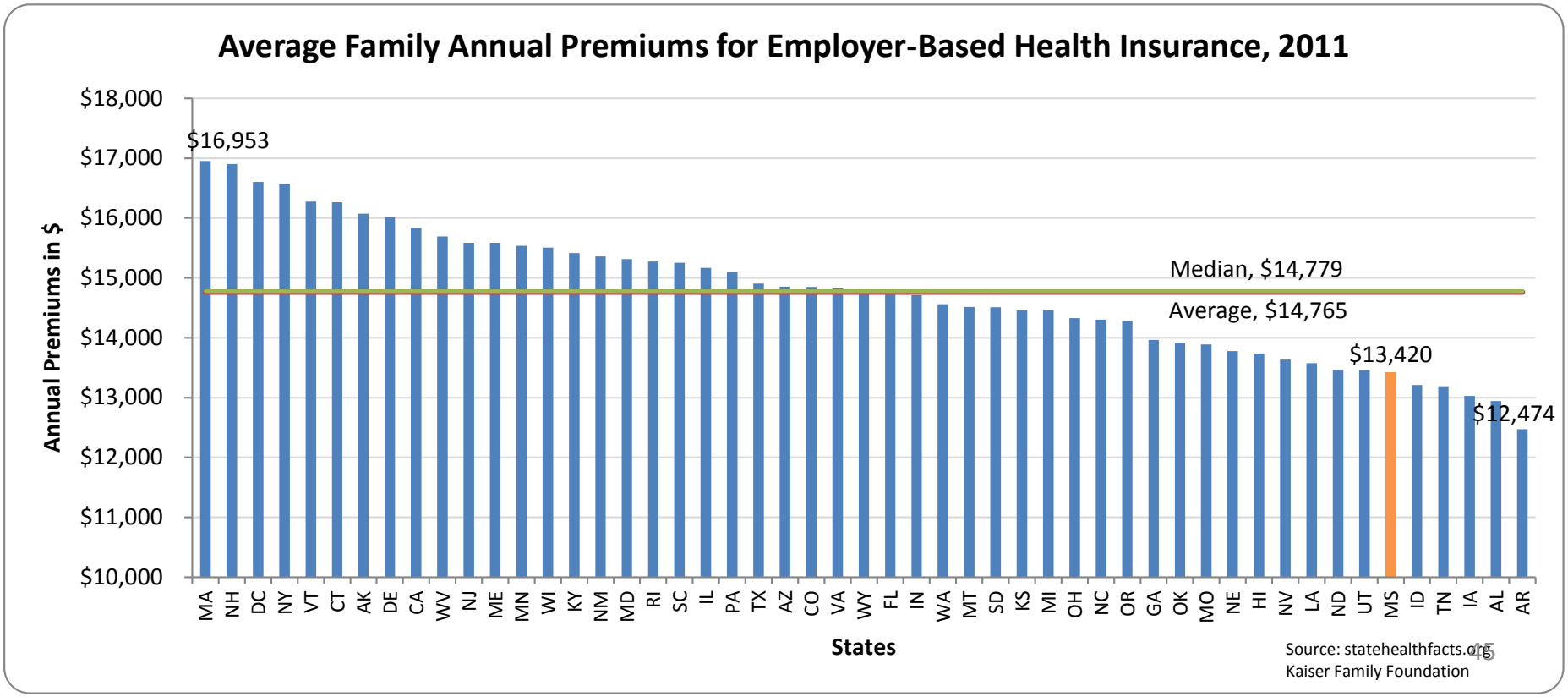
A. $16,000-$18,000
B. $14,000-$16,000
C. $12,000-$14,000
D. $10,000-$12,000

Health Insurance Premiums

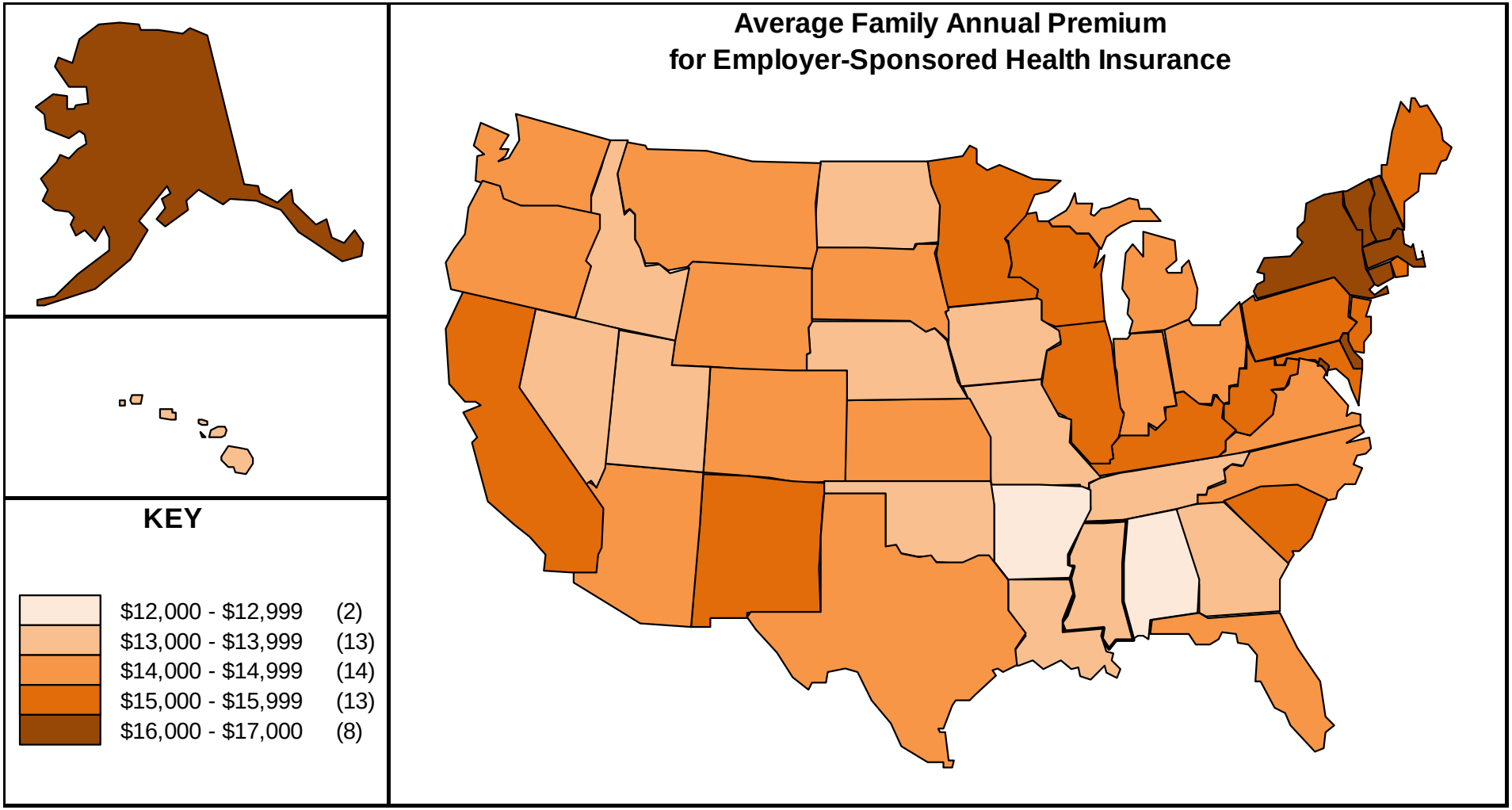
Mississippi: $13,420

Average: $14,765 Min: $12,474

Median: $14,779 Max: $16,953



Health Insurance Premiums



Source: statehealthfacts.org
Kaiser Family Foundation

Cost Drivers of Insurance Premiums

- Medical Technology
- Defensive Medicine
- Healthcare Fraud
- Overuse & Misuse
- Personal Behavior
- Chronic Conditions
- Cost Shifting
- Rx Spending

Uncompensated Care in Mississippi

- For the year 2011, Mississippi hospitals reported approx. $525 Million in uncompensated care. [1]

- How do we compensate for uncompensated care?
  - Taxpayer dollars
    - Disproportionate share hospital (DSH) payments
    - Indirect medical education payments
  - Cost shifting to privately insured families and individuals.

Source: University Research Center, Mississippi Institutions of Higher Learning ; The Fiscal and Economic Impacts of Medicaid Expansion in Mississippi, 2014-2025

Current Events

What is an Exchange?

- Essentially, an Exchange is a marketplace for major medical insurance.

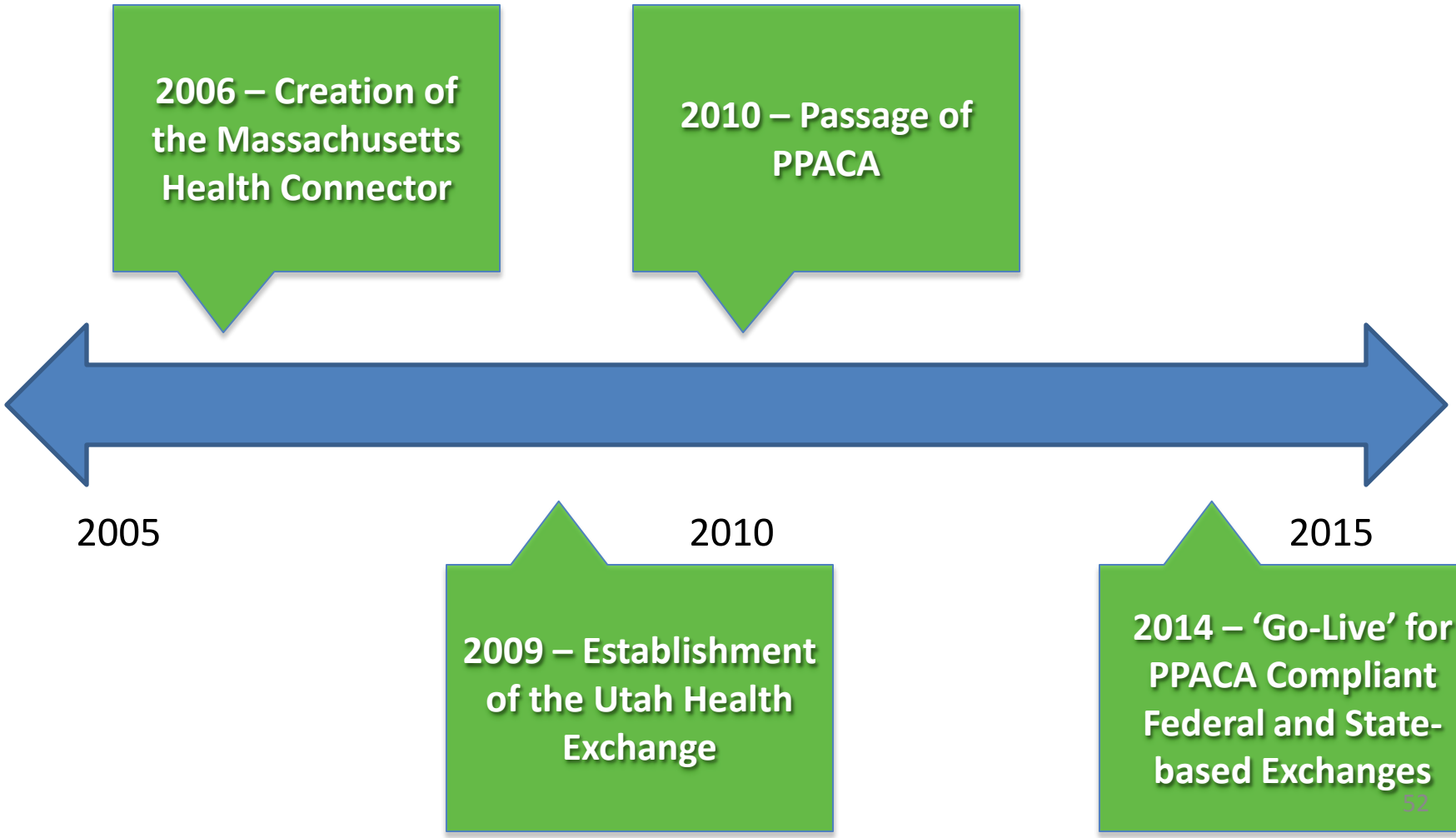
- A one-stop shop for health insurance -- similar to Travelocity, Expedia, or Priceline.

- This is perhaps an underestimate in that the Exchange:
  - Will be a massive undertaking;
  - Will provide many services beyond simply offering different insurance products for sale;
  - The web portal comparison piece is just the “tip of the iceberg”.

The Emergence of Health Insurance Exchanges

- Not a new concept
- Idea was born in the 1970's
- 1990's
  - "Hillarycare" introduced "buying co-ops"
  - Republicans hated it
- Early 2000's
  - Heritage Foundation came up with a health insurance exchange concept
  - Looked very similar to a "buying co-op"
  - Included individual mandate
  - Democrats hated it

The Emergence of Health Insurance Exchanges



Two Types of Exchanges Under PPACA

American Health Benefit Exchange (AHBE)

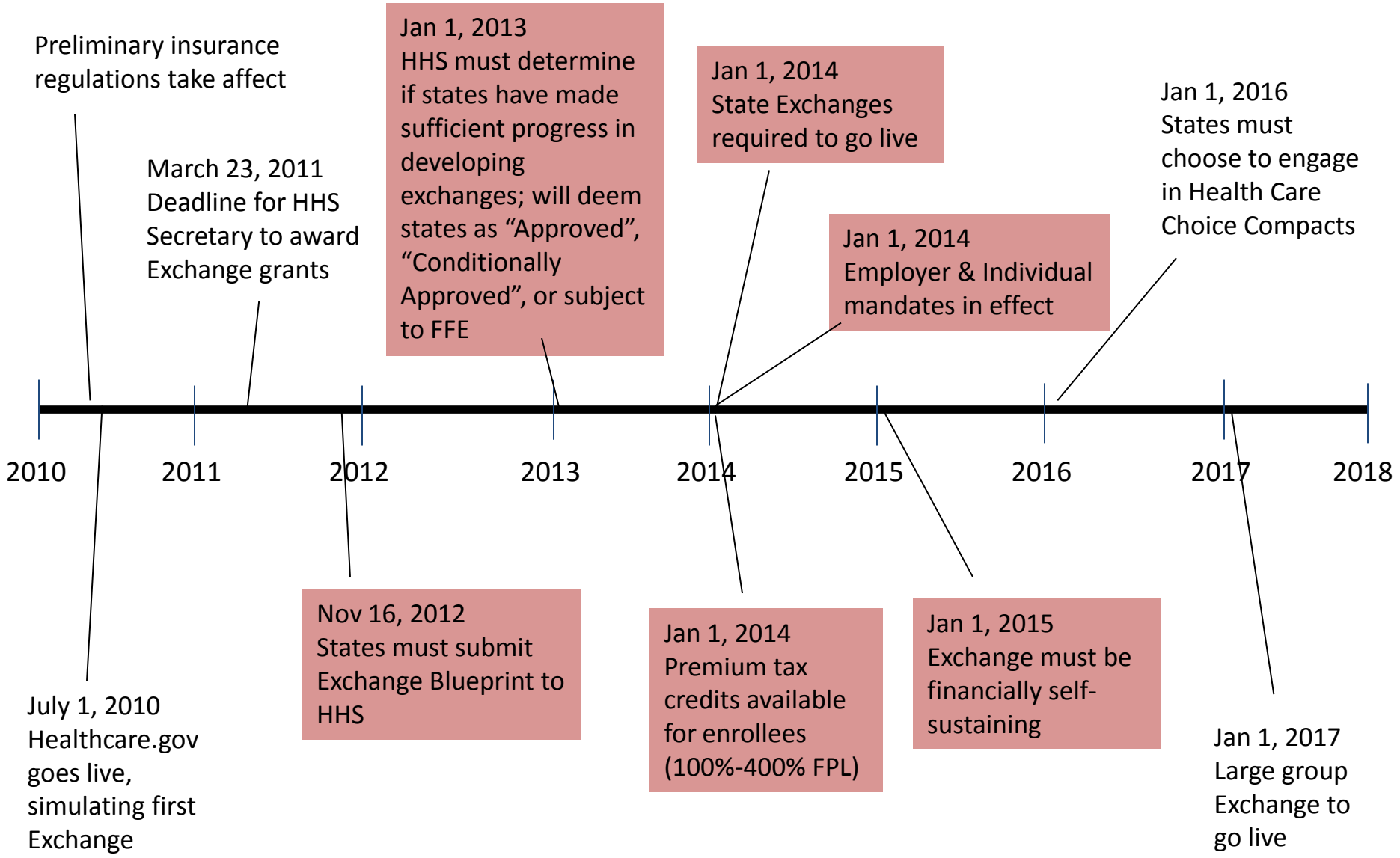
- Individuals and families may purchase qualified coverage through Qualified Health Plans
- Purchaser may be eligible for premium subsides—based on income level

Small Business Health Options Program (SHOP)

- Small businesses with up to 100 employees may purchase qualified coverage
- Premium subsidies are not available through the SHOP exchange (tax credits are available for qualified employers)

States may choose to operate two separate exchanges or combine into a single mechanism

PPACA Exchange Timelines



One, Mississippi

- In Mississippi:
  - The concept of an exchange is accepted across party lines as good public policy
  - Governor Haley Barbour advocated for a market-based, consumer-oriented exchange for 3 years prior to the passage of the Affordable Care Act
  - We are trying to fulfill that vision by creating a state-based market-driven solution
  - Only 7% – 11% of Mississippians have a good understanding of what services an exchange actually provides

For More Information

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MISSISSIPPI INSURANCE DEPARTMENT

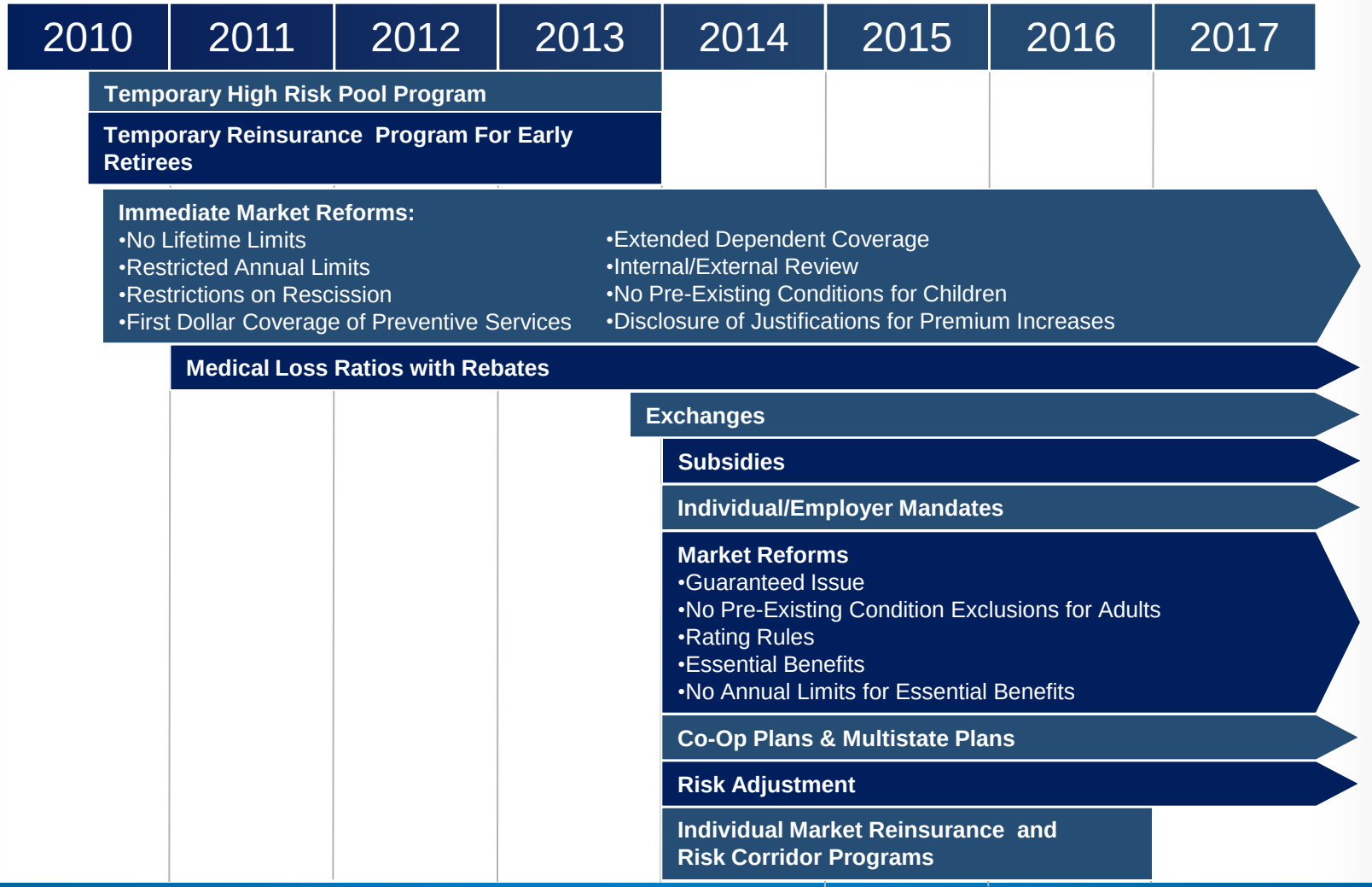
HEALTH CARE REFORM SYMPOSIUM

Health Care Reform – Moving Forward Toward Implementation

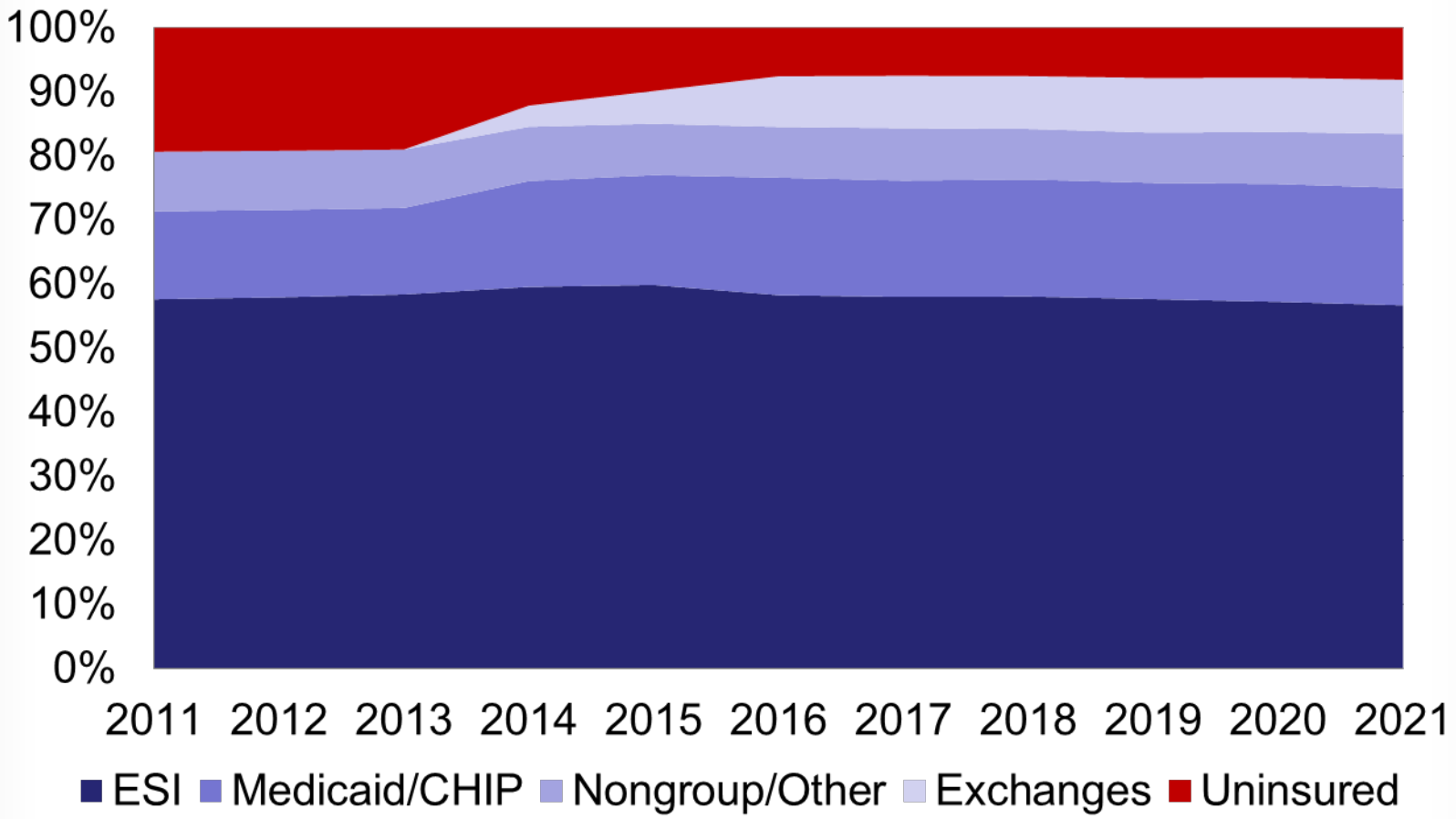
JOLIE H. MATTHEWS
SENIOR HEALTH & LIFE POLICY COUNSEL

- **2014 Market Reforms**
- **Exchanges**

PPACA Implementation Timeline

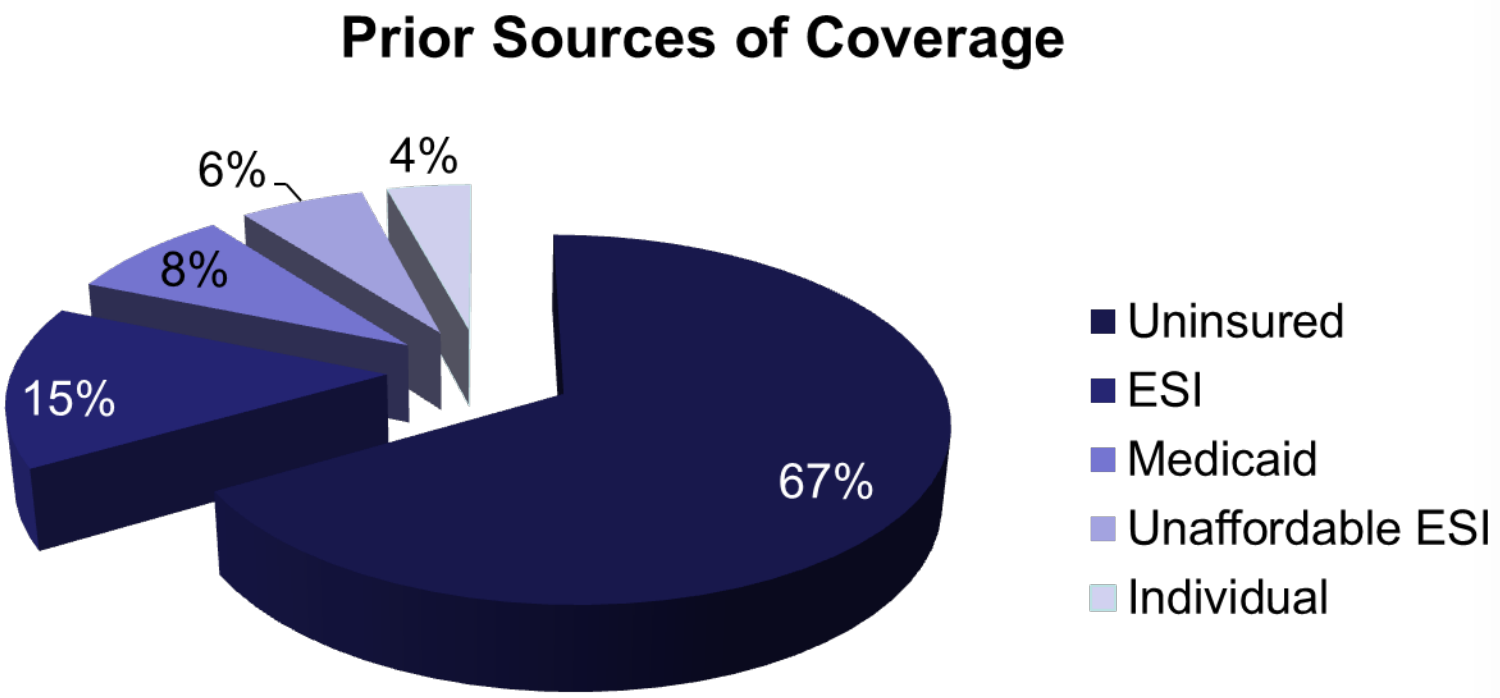


Sources of Coverage, 2011-2019



Source: Congressional Budget Office

Profile of Exchange Enrollees, 2019

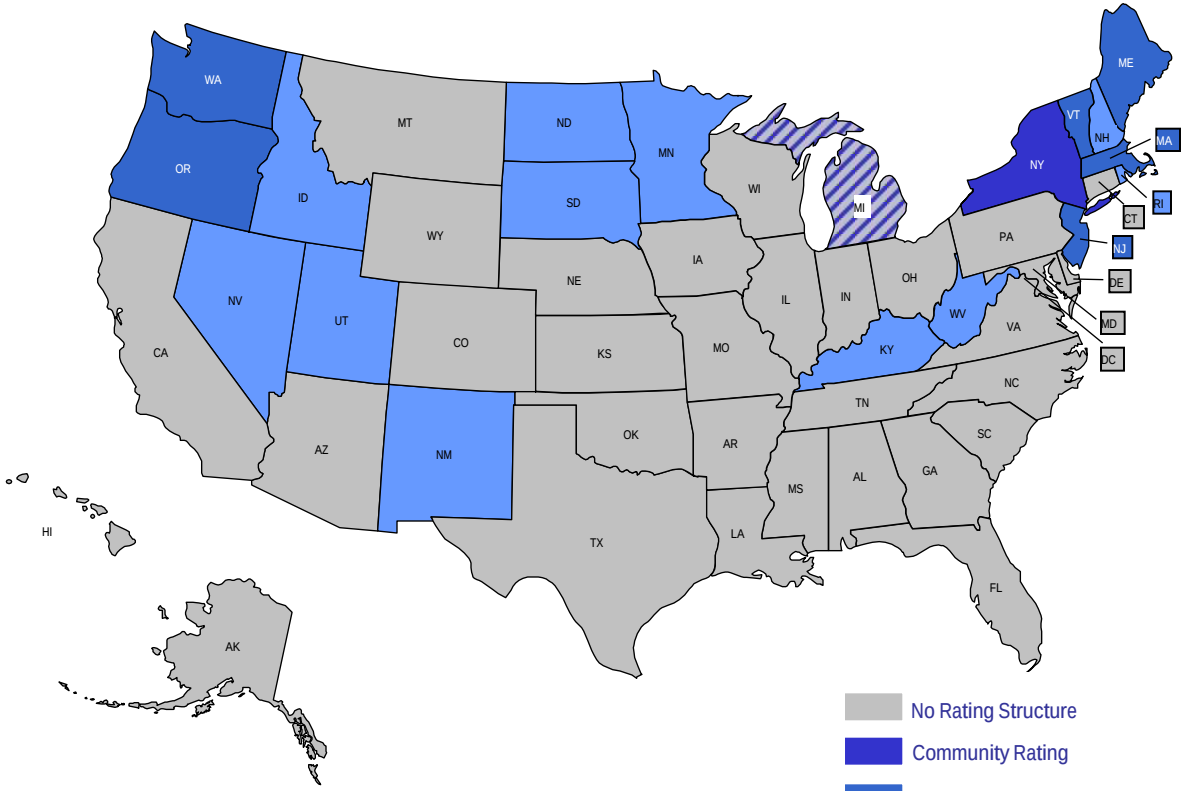


Source: Kaiser Family Foundation

Current Marketplace

- Medical underwriting
- Preexisting condition exclusions and riders
- Fragmented risk pool
- Difficulty obtaining some types of coverage, (e.g. maternity)

Current Individual Market Rating Rules



No Rating Structure

Community Rating

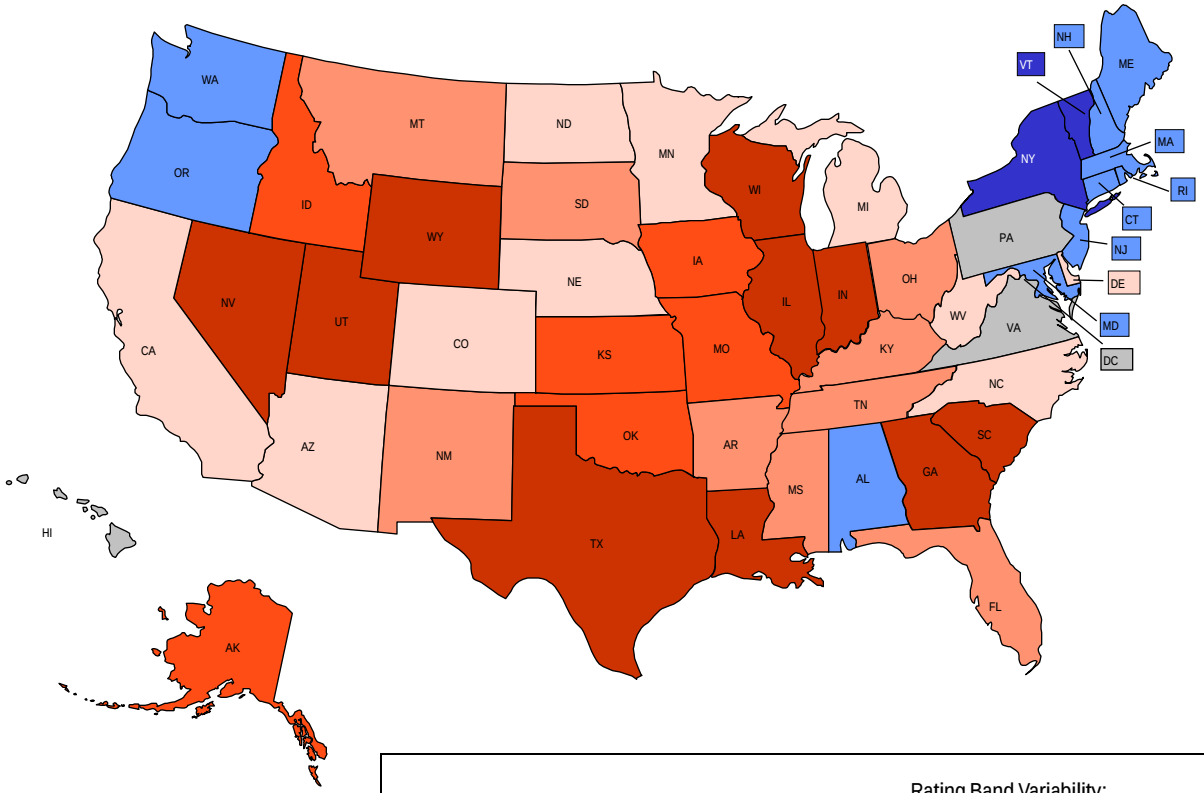
Adjusted Community Rating

Rating Bands

Hybrid

Michigan Blue Cross/Blue Shield must use community rating. There is no rating structure for other carriers.

Small Group Premium Variation



Community Rating

Adjusted Community Rating

No Rating Structure

Rating Band Variability:

13:1 or less

13.1:1 – 19:1

19.1:1 – 25:1

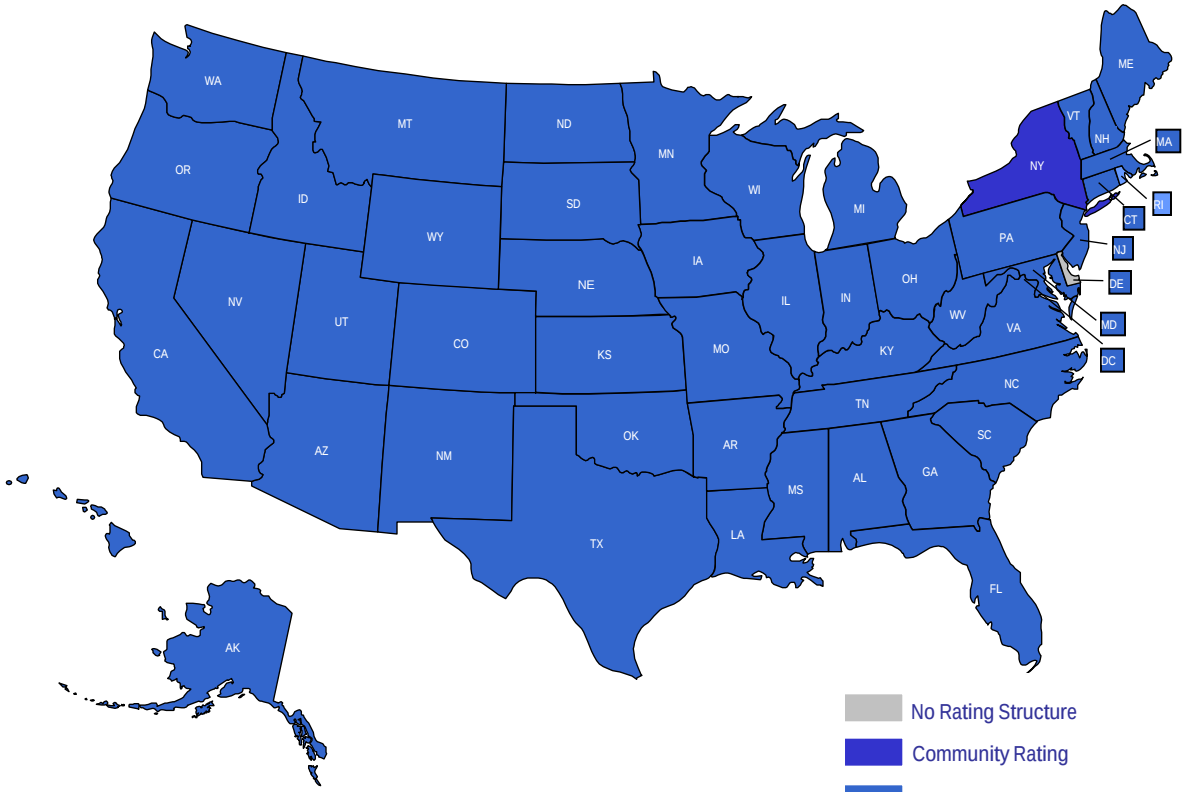
25.1:1 or greater

*Note: Michigan HMOs and Blue Cross/Blue Shield are restricted to 3.12:1 maximum variation. All others may use 3.96 maximum variation

2014 Market Reforms

- Guaranteed Issue
- No Pre-Existing Condition Exclusions for Adults
- Rating Rules
  - No health status
  - 3 : 1 maximum variation for age
  - 1.5 : 1 maximum variation for tobacco use
- Single Risk Pool Requirement
- Essential Health Benefits Package
- Individual Mandate and Subsidies
- Employer Responsibilities

2014 Individual Market Rating Rules



No Rating Structure

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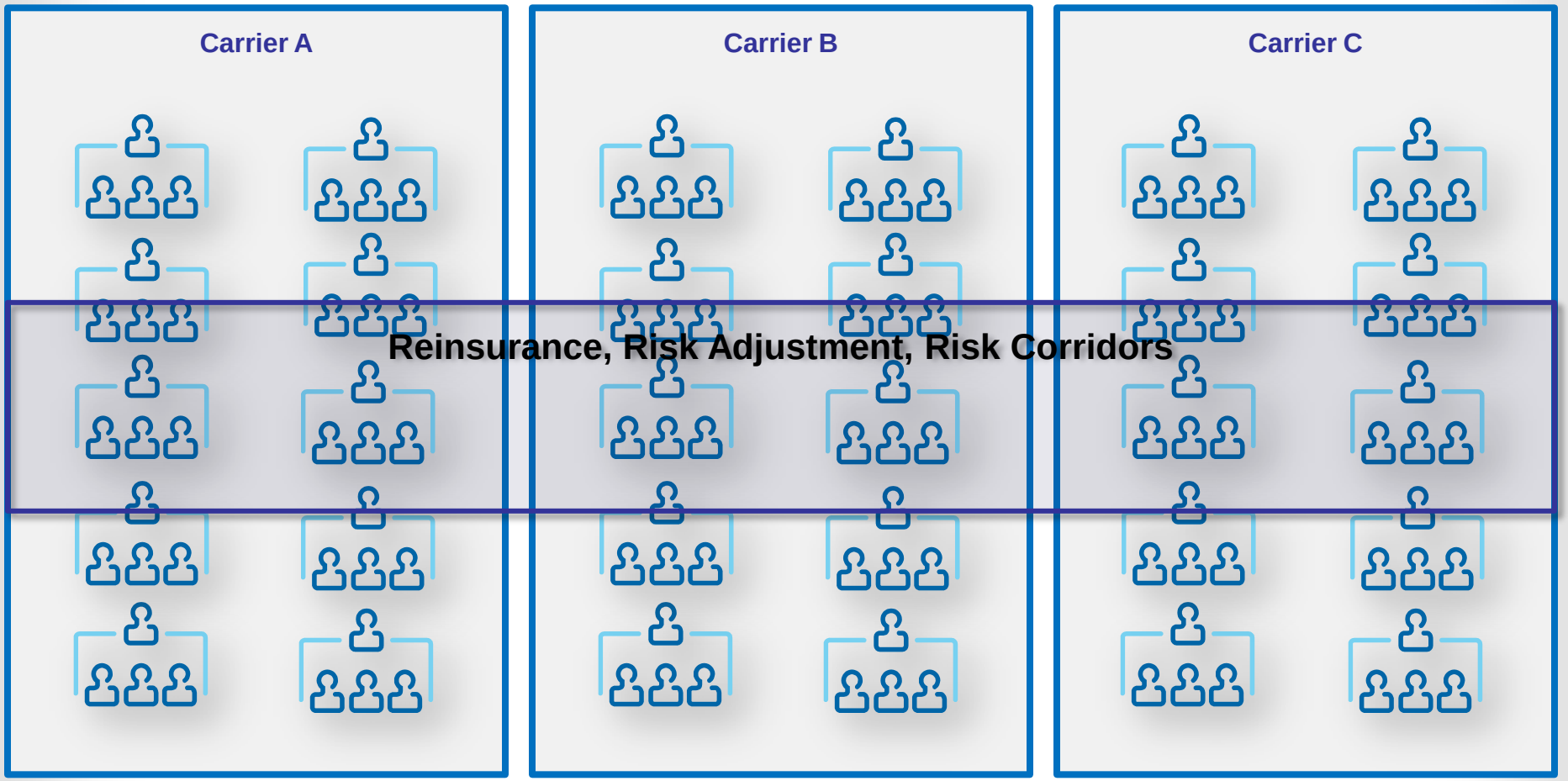
Michigan Blue Cross/Blue Shield must use community rating. There is no rating structure for other carriers.

Reformed Marketplace: Single Pools and Risk Sharing



2014 Market Reforms
Essential Health Benefits

- Carriers offering coverage in the individual and small group markets must provide coverage that includes the essential health benefits package.
- Carriers in the large group market and self-insured plans must offer minimum essential coverage.

2014 Market Reforms: Cost Sharing and Risk Sharing

- **Metal Levels**
  - **Bronze = 60% actuarial value**
  - **Silver = 70% actuarial value**
  - **Gold = 80% actuarial value**
  - **Platinum = 90% actuarial value**
  - **Catastrophic Plan**
- **Reinsurance, Risk Corridors, and Risk Adjustment**

2014 Market Reforms
Individual Mandate

- Requires all individuals to maintain acceptable coverage:
  - Exchange plan
  - Employer-sponsored plan
  - Plans in the individual market
  - Grandfathered plan
  - Government-sponsored plan, such as Medicare, Medicaid and CHIP
- Enforced through the tax code.

2014 Market Reforms
Employer Responsibilities

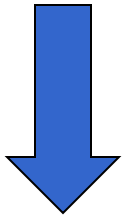
- Employers **over 200 employees** must auto-enroll with opt-out.
- Employers **over 50 employees** must provide essential benefits.

Penalty is $2,000 per employee

- Employers whose employees qualify for subsidies because cost of coverage exceeds 9.5% of income fined $3,000 per employee receiving subsidy up to $2,000 times number of employees.
- First 30 employees disregarded in calculating penalties.

Reformed Marketplace

Competition based upon risk avoidance



Competition based upon cost and quality

Reformed Marketplace

- **Transparency**
  - **More standardization of policies**
  - **Uniform definitions**
  - **Coverage facts labels**
  - **Rate increase justifications**
  - **Medical loss ratios**
- **Streamlined enrollment process**
  - **“*No wrong door*”**

General Implementation Challenges

- Adverse selection
  - Will the mandate be effective?
  - Expansion of small group market could encourage self-insurance
  - Grandfathering regulations create secondary market for grandfathered plans
- Market Disruption
  - No major market withdrawals yet
- Cost control is a major long-term challenge

Health Insurance Exchanges: The Basics

- **Each state will have <u>two</u> Exchanges** (option to combine)
  - **Individual**
    - **Sole source of subsidies for individuals between 133% and 400% of poverty level**
  - **SHOP (small group)**
    - **Employers <u>may</u> select a tier of coverage**
    - **Employees select insurer and plan within tier of coverage**
- **The Exchanges must be operated by a governmental agency or nonprofit entity.**
- **The Exchange may not make available non-qualified plans to individuals or employers.** (Dental plans OK)

Plans Available in Exchange

- "Qualified Health Plans"
  - Fully licensed and solvent
  - Provides Essential Benefits
  - Insurer agrees to offer at least 1 Silver and 1 Gold Plan
  - Insurer agrees to charge same price in and out of Exchange
- Co-Op Plans
  - New, non-profit insurers with consumer focus
  - Receive loans from federal government for initial funding
  - Must be fully licensed - comply with state & Exchange rules
- Multi-State Plans
  - Office of Personnel Management issued proposed regulations Dec. 5.
  - Must be licensed and comply with state regulations

Key Decision Points

- ✓ **Role of State**
  - **State-based Exchange**
  - **Federally-facilitated Exchange**
  - **Partnership (plan management, consumer assistance, Navigators) with Federally-facilitated Exchange**
- ✓ **Participation – open marketplace or selective contracting**
- ✓ **Governance**
- ✓ **Regulation of the Outside Market**
- ✓ **Funding of Operations**
- ✓ **Role of Agents**

Exchange Challenges

Market-wide

- Winners & Losers
  - Young vs. Older
  - Healthy vs. Sicker
  - Low-risk vs. High-risk
- Adverse Selection
- Cost Control

Exchanges:

- Technical hurdles – data from federal sources; IT
- Market churn
- Federal Exchange coordination with State regulators
- Time – must be operational by October 1, 2013
- Money
- Outreach and education
- ***Politics***

Upcoming Deadlines

- **Dec. 14, 2012: States interested in creating a State-based Exchange must submit Declaration letter and Blueprint application to HHS.**
- **Dec. 26, 2012: Comments due on EHB/AV/Accreditation and 2014 Market Reform proposed regulations.**
- **Dec. 31, 2012: Comments due on Draft Payment Notice, which includes details on Risk Adjustment, Risk Corridor and Reinsurance programs; modifies MLR; and establishes various fees.**
- **Jan. 1, 2013: HHS Secretary will approve or disapprove SBE applications.**
- **Jan. 4, 2013: Comments due on Multi-State Plan proposed regulations.**
- **Feb. 15, 2013: States interested in Partnership with FFE must submit Declaration Letter and Blueprint.**
- **March 28, 2013: Carriers begin submitting applications to sell on FFE.**
- **July 31, 2013: All plans to be sold on FFE must have final state approval and HHS.**

Questions?

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MISSISSIPPI INSURANCE DEPARTMENT

HEALTH CARE REFORM SYMPOSIUM

The New Health Care Reform Law

Employer Responsibilities
Challenges

Interactions With Exchanges

The Drivers of Health Care Reform?

- Reform Insurance Laws
  - Mandate certain insurance standards
    - For example, “Essential Health Benefits,” Cost-Sharing Limitations, and “Actuarial Value”
- Coverage - Priority #1
  - Expand Medicaid
  - Provide premium subsidies to help low- to middle-income people purchase health insurance
    - The new health insurance Exchanges created under PPACA became the mechanism through which these subsidies could be accessed

The Exchange Under PPACA

- The original intent of the Exchange created under PPACA was not to deliver the subsidies, but rather to serve as a *marketplace*
  - It was believed that the Exchange would reduce administrative costs
  - In addition, it was believed that the Exchange would attract multiple insurance carriers, which would promote competition
  - Achieving these two goals could translate into lower premiums
- Early on in the drafting process, it was “private” exchanges that served as the model, not the Massachusetts Connector

Two Kinds of Exchanges Under PPACA

- State-based Exchanges
  - The drafters never envisioned the level of resistance to the law and establishing an Exchange
- Federal Exchange (which includes the Federal-State Partnership)
  - Congress intended the "Federally-facilitated Exchange" to step in the shoes of the State-based Exchange and perform all of the same functions
  - Unsurprisingly, the statute is not "clean," and therefore, questions have arisen
    - Can a Federal Exchange deliver the premium subsidies?

The Subsidies Offered Through the Exchange Under PPACA

- GENERAL RULE – An individual is NOT eligible for subsidies offered through the Exchange if he or she is "eligible" for employer-sponsored coverage
  - So, even if your employees are subsidy-eligible, they CANNOT opt out of employer coverage, go to the Exchange, and access the subsidies
- EXCEPTION – The employer-sponsored coverage (1) is "unaffordable" (i.e., the employee's portion of the premium for self-only coverage exceeds 9.5% of the employee's W-2 income) or (2) does NOT provide "minimum value" (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)
  - In this case, depending upon an employee's income, an employee may opt out of employer coverage, go to the Exchange, and access the subsidies.

The "Employer Mandate"

- Beginning in 2014, an employer with 50 or more "full-time equivalent" employees would be subject to a penalty tax if:
  - The employer is NOT offering health insurance coverage to its employees
  - The employer offers coverage, but the coverage (1) is "unaffordable" (i.e., the required *employee* contribution for self-only coverage exceeds 9.5% of the employee's W-2 income) or (2) doe NOT provide "minimum value" (i.e., the employer coverage does not pay for at least 60% of the benefits provided under the plan)
- The penalty tax is ***only*** triggered if the employee purchases health insurance through the Exchange and accesses the premium subsidy
  - Currently, this would include purchasing coverage through the "Federally-facilitated Exchange" ("FFE"), where Treasury regulations indicate that the subsidy *will* be delivered through the FFE

Court Challenge

- "Strict Construction"
  - The rules for the premium subsidy (Code section 36B) only cross-reference the rules for the State-based Exchanges (PPACA section 1311), *not* the Federally-facilitated Exchange (PPACA section 1321) = the government LOSES
- Effectuating Congressional Intent
  - Federal agencies responsible for implementing the law have the authority to effectuate Congressional intent = the government WINS
    - While others argue to the contrary, based on my experience, Congress always intended the FFE to "step in the shoes" of the State-based Exchange and deliver the subsidy
- Which way will the court decide?

Issues For Small Employers

- Cost of offering health insurance will likely go up
  - The new minimum standards (e.g., “essential health benefits” and “actuarial value”) and premium rating rules will increase the cost of fully-insured plans – CBO says so
  - “Fee” on health insurance providers – 2% to 2.5% increase for fully-insured plan in 2016, according to JCT and CBO
  - “User fees” on carriers – 3.5% of the monthly premium increase for fully-insured plans in 2014, according to HHS (user fees could be imposed on carriers operating both inside *and* outside of the Exchange)
  - Reinsurance assessment – $63 per head for 2014, according to HHS

Issues For All Employers

- Cost
  - For small employers, see last slide
  - For large employers, cost may increase to ensure health plan is “affordable” and provides “minimum value”
- Taxes
  - Cap on FSA contributions (January 1, 2013)
  - Increased Medicare payroll tax on high-earners (January 1, 2013)
  - Reinsurance assessment - $63 per covered life (January 1, 2014)
  - “High-cost” plan tax (January 1, 2018)
- New Notice and Disclosure Requirements
  - Reporting the cost of health coverage on the W-2 (effective now)
  - Summary of Benefits and Coverage (“SBCs”) (basically, effective now)
  - Exchange notice (March 23, 2013)
  - Reporting health coverage to (1) to the IRS and (2) employees and dependents (January 1, 2014)

Questions?

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MISSISSIPPI INSURANCE DEPARTMENT

HEALTH CARE REFORM SYMPOSIUM