

BREAKING BARRIERS

Improving Health Insurance Enrollment and Access to Health Care in Mississippi

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MISSISSIPPI IMMIGRANT
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**ALLIANCE
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The ACA should have been a godsend for Mississippi. Instead, due at least in part to claims by Governor Phil Bryant that the federal government might do away with the ACA¹ and to the state legislature's refusal to expand Medicaid, 138,000 uninsured Mississippi residents missed out on Medicaid coverage and only 61,494 of the almost 300,000 people eligible to purchase insurance in the new ACA health insurance marketplace actually did.

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THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (ACA), SIGNED INTO LAW in March 2010, aimed to bring the uninsured more fully into the health care delivery system, improve access to health care providers, spur new approaches to patient well-being and disease prevention, attack racial disparities in health care and outcomes in communities of color, and hold providers accountable with respect to costs.

The ACA should have been a godsend for Mississippi. Instead, due at least in part to claims by Governor Phil Bryant that the federal government might do away with the ACA¹ and to the state legislature's refusal to expand Medicaid, 138,000 uninsured Mississippi residents missed out on Medicaid coverage and only 61,494 of the almost 300,000 people eligible to purchase insurance in the new ACA health insurance marketplace actually did. In the first ACA enrollment period from October 2013 to April 2014, the proportion of uninsured Mississippi residents decreased only slightly, by 1.8 percent. And, as our survey respondents revealed, a significant portion of Mississippi's low-income population has not benefited from the ACA's promise to address racial disparities and bring the uninsured more fully into the health care delivery system.

Funded by the Kellogg Foundation, this report, part of a 10-state study, reviews Mississippi's enrollment efforts and consumers' attempts to access health care in the state's low-income communities. The methodology includes key actor interviews with Mississippi-based navigators, policy and health care professionals, and advocates, as well as 179 surveys with low-income community residents at food pantries, health clinics, and homeless service centers and door-to-door surveys with residents in the Mississippi Delta. The report compares and contrasts the enrollment and "coverage-to-care" trends shown through the interviews and surveys to reported Mississippi outcomes and, when appropriate, to national trends. Analyses of these results serve as the basis for the report's recommendations.

RACE AND HEALTH CARE OUTCOMES IN MISSISSIPPI

Mississippi ranks 48th in the nation in the incidence of diabetes and 50th in infant mortality and premature death.² Racial disparities largely account for the state's low rankings: African Americans with diabetes in Mississippi have a mortality rate 264 percent higher than whites.³ And, while the state has the highest rate of leg amputations, the amputation rate for African Americans is more than four times that of whites: 4.41 per 1,000 Medicare enrollees versus 0.92 for non-blacks. As for medical insurance coverage, one in four nonelderly African Americans is uninsured, compared to one in ten whites. Marino Bruce, professor of criminal justice and sociology at Jackson State University, observes that "the ACA has been framed in a way that has been racialized. For

instance, when it comes to Medicaid expansion, the discourse in the media is ‘we are against it, and we don’t want handouts.’ ‘Handouts’ is racialized language that goes back to the Reagan era. People equate Medicaid to welfare.”⁴ Lelia Keys, retired department director for medical social services at Northwest Mississippi Regional Medical Center, agrees: “Medicaid is not seen as a program or a benefit for people in *general* who are uninsured. It is seen as aid to African Americans... as a handout or welfare, not as something that they should advocate for. That’s part of the public understanding and why it’s so difficult for people to get their arms around the ACA.”⁵ Both the coded language of many ACA opponents and the reality of health care inequities suggest a very basic question: does the ACA, as currently structured, lessen or exacerbate racial inequities in health care enrollment and access to care? While it is too early for a definitive answer, examining trends in both enrollment and access to care for whites and African Americans can offer some preliminary conclusions.

MEDICAL COVERAGE, BY RACE

Do you have medical coverage?

Race/Ethnicity	Percentage Yes
ALL MS RESPONDENTS	62.9%
African American	62.4%
White	61.0%

Did you get medical coverage in the last 12 months?

Race/Ethnicity	Percentage Yes
ALL MS RESPONDENTS	22.6%
African American	25.0%
White	9.1%

While the Gallup-Healthways Well-Being Index credits Mississippi with a modest 1.8 percent reduction over the course of the first enrollment period,, one estimate suggests that the overall rate actually increased from 18.1 percent to 21.5 percent, an increase of 3.4 percentage points.⁶ Why did so few Mississippians gain insurance coverage? According to a survey conducted by the Center for Mississippi Health Policy in 2013, three out of five Mississippians said they knew little or nothing about the ACA and 70 percent knew little or nothing about the health insurance marketplace, while only 37 percent felt they had enough information to understand how the law would affect them or their families. However, two-thirds or more of respondents supported subsidies for low-income people, requiring large employers to provide health insurance, and eliminating higher costs for people with pre-existing conditions.⁷

In the survey conducted by the Alliance for a Just Society, approximately 63 percent of respondents had medical insurance, with no significant difference between African Americans and whites. Of survey respondents

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who had insurance, a quarter of African Americans and 9.1 percent of whites got coverage in the last 12 months. Overall, the Department of Health & Human Services reported that 59.5 percent of enrollees in the Mississippi ACA marketplace were African American and 33.3 percent were white, as of mid-April 2014.⁸ One reason for the low rates of insurance was that many people who wanted insurance were not able to qualify for it or afford it. In Mississippi, “the parent/caretaker in a family of three would be ineligible for Medicaid if he or she earned more than \$384 a month.”⁹ According to the Kaiser Family Foundation, two-thirds of Mississippi adults who fall into the Medicaid “coverage gap” (with earnings too high to qualify for Medicaid but too low to qualify for marketplace subsidies) are part of working families.¹⁰ Explains Alice Graham of the Mississippi Interfaith Partnership, “if you are a single woman with no children, you can be ineligible for Medicaid and if you make under \$12,000 you don’t qualify for the marketplace.”¹¹ Rims Barber, Director of the Mississippi Human Services Coalition, agrees: “People who fall below the poverty line are too poor to qualify for the ACA. Parents under 24% of the poverty line are also too poor to qualify for insurance yet at the same time are too wealthy to qualify for Medicaid.” Using a specific municipality as a concrete example, Angel Greer, Executive Director of Coastal Family Health Center, pointed to East Biloxi, where “22,000 individuals are uninsured and only 200 out of that number were eligible, signed up, and chose a health plan. Two thirds were not eligible because they didn’t make enough money for the marketplace.”¹²

ELECTRONIC ACCESS

Do you have an email address?

Race/Ethnicity	Percentage Yes
ALL MS RESPONDENTS	40.4%
African American	38.3%
White	42.5%

Do you have Internet access at home?

Race/Ethnicity	Percentage Yes
ALL MS RESPONDENTS	55.9%
African American	52.9%
White	66.7%

Many of the new health plans are pretty complicated; do you know which services are included in your coverage and which you’ll have to pay extra for?

Race/Ethnicity	Percentage Yes
African American	42.0%
White	57.1%

When you enrolled in a health plan, were you informed that financial support was available for low-income people?

Percent Yes



Did you find the enrollment process easy, somewhat difficult, or very difficult?

Percentage somewhat or very difficult



“Technology was the absolute biggest challenge,” said Angel Greer, Executive Director of Coastal Family Health Center. “The marketplace lost people because of technological issues. A lot of people who couldn’t finish their application online would come in for help and it created a backlog of people trying to get enrolled. People had issues with customer service. Clients figuring out how to pay their premium once enrolled was also an issue. Sometimes people didn’t receive their letters saying that they were in fact beneficiaries of the ACA.”¹³

Four of ten survey respondents reported having an email address: 42.5 percent of whites and 38.3 percent of African Americans, a difference of 4.2 percentage points. There was a larger racial divide on the question of Internet access at home: 66.7 percent of white respondents reported home Internet access versus 52.9 percent of African Americans. Mario Bruce at Jackson State noted that 41 percent of Mississippians do not have access to computers in their homes. Retired health care professional Lelia Keyes went on to point out that “some areas are not even linked to the Internet. We’ve been working on broadband access, but it’s slow in coming.”¹⁴

When asked if they knew which services are included in their plan, 57 percent of white respondents and 42 percent of African Americans answered in the affirmative, disturbingly low percentages for both groups. “Literacy was a challenge,” said Alice Graham of the Mississippi Interfaith Partnership. “With people who haven’t had insurance it takes time to explain the process in a way that they don’t leave confused and feeling like they are being taken advantage of.” “You have two levels of literacy,” explained Keyes, “one is in the reading level. The second layer is the professionalized language – health care jargon, which doesn’t help people reading on the 3rd, 4th or 5th grade level. Even if you have a college degree, understanding the complexity of insurance, and eligibility for Medicaid, is difficult. We need plain language.”

In addition to complex language, few respondents were informed about the availability of financial support: 52.4 percent of whites and 20 percent

of African Americans. In a state where 22.7 percent of residents live below the poverty line, financial support is an important issue for potential ACA enrollees. “The high deductible is still an issue. There are only two vendors in the state and only one in some rural areas that clients have not had the most positive experience with. Hopefully we’ll have more next year,” said one advocate. “And with a high unemployment rate (at 7.2 percent, Mississippi has the second highest rate in the country) there is no way people can afford to purchase insurance. Medicaid not being expanded is the biggest failure in the state.”

In addition to the cost barriers, both surveyors and interviewees pointed to specific obstacles for people in rural Mississippi. Antron McKay-West from the student group Upgrade Mississippi recounted an afternoon going door to door in the Mississippi Delta where “very few people had heard of the ACA and only three people had insurance.” Amplifying the point, one advocate observed that “we have not supported centers where people can get information about these resources/opportunities that would benefit them in the rural areas.” Angel Green elaborates, “along the coast it was much easier to get people enrolled and to talk about the marketplace. In rural areas it was not that easy. We had to go to Head Start Centers to talk with parents, faith-based organizations, libraries, grocery stores... anywhere where people would congregate.” Over a fifth of African American respondents and 4.3 percent of white respondents found the enrollment process “somewhat or very difficult.”

Another obstacle to enrollment is what one interviewee described as the “Mississippi Attitude.” “Mississippi is a red state,” explained Jarvis Dortch of the Mississippi Health Advocacy Program. “People are adamantly opposed to anything dealing with the President. We have to get to the person. People don’t want Obamacare but want to know how to get coverage.”¹⁵

FROM COVERAGE TO CARE

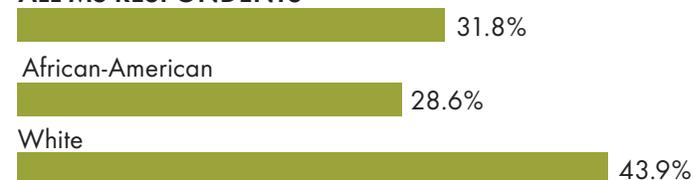
Insurance coverage does not necessarily translate into quality care, which includes access to providers, a relationship with a personal doctor, and access to both medication and other forms of treatment. Although the ACA infrastructure is still developing, in this section we examine some key issues related to access and treatment.

STATE OF HEALTH

Do you have one or more medical conditions that have affected you for more than 3 months?

Percentage of Respondents reporting one or more condition

ALL MS RESPONDENTS



Chronic diseases cause seven of every 10 deaths. In addition, health care costs for an individual with one or more chronic diseases are five times those for an individual without chronic disease.¹⁶ According to the United Health Foundation, Mississippi ranks 50th in adolescent immunizations, cardiovascular deaths, and infant mortality and 49th in obesity, cancer deaths, and availability of primary care physicians.¹⁷ Forty-four percent of white respondents and 29 percent of African American respondents reported that they were living with one or more chronic conditions. Bill Chandler, Executive Director of the Mississippi Immigrant Rights Coalition (MIRA), points out that “immigrants working in Mississippi also have high rates of chronic diseases, but have even less access to health care facilities than other Mississippians.”

IMMIGRANTS EXCLUDED FROM ACA ARE CHARGED “NO INSURANCE” PENALTY

In a series of house meetings with immigrant workers in Biloxi and Laurel, Mississippi Immigrant Rights Alliance (MIRA) organizer Aida Martinez-Bone was surprised to learn that undocumented immigrants were being charged a penalty for not enrolling in the ACA when they file tax returns. (Undocumented people who have earned income are legally required to file tax returns, and many do so using an ITIN, or individual taxpayer identification number.) “I first heard about it in Laurel, said Martinez-Bone. “An undocumented family showed us their tax forms and pointed to the line where they had been charged \$204.00 for not signing up for the ACA. They said they were told that the penalty was \$204 if you are undocumented and \$300 if you were documented. I thought it was a scam. We all know that undocumented people can’t even apply to get insurance through the ACA marketplace.”

Martinez-Bone called the tax preparation company, Mega Service, a small independent business in Hattiesburg. The owner apologized, said that he had probably made a mistake, and agreed to file an amendment to the tax document at no charge. “But this was not an isolated incident; it was something that came up in every meeting we organized. One woman was told that she would have to pay a penalty of \$100 for every member of her family. Another woman from Biloxi was told that she would not have to pay a penalty this year, but next year she needs to find coverage.” In addition, observed Martinez, “when I talked to my siblings who live in California, they were also charged a penalty.”

After a series of conversations with tax preparers, Martinez found that “a lot of the tax services don’t really seem to understand the law.” One of the tax preparers with whom she spoke did not know if those who qualified for Deferred Action for Childhood

Arrivals (DACA) (which exempts from deportation certain undocumented immigrants who entered the country before their 16th birthday and before June 2007 and allows them to receive a renewable two-year work permit) were exempt from the penalty. Another asserted that the system automatically calculates the amount of the penalty and he has no say. “There is a lot of confusion about this issue,” says Martinez. “And where there is confusion undocumented people to be taken advantage of.” She continued, “there needs to be extensive outreach that let’s people know what the rules are. If people have been unduly charged a penalty, they need to be guaranteed that the tax amendment they need to file is filed by the tax preparer for free.”

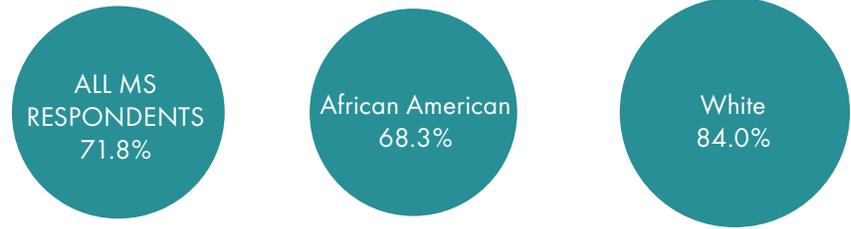
“Honestly, people are not necessarily upset about paying taxes, or if they owe it, the penalty. What they are upset about is that they still don’t have access to affordable health care.”

“Biloxi Regional Hospital has a triage process where they refer people along the coast to nurse practitioners. Mississippi has limited Medicaid/ACA providers.”

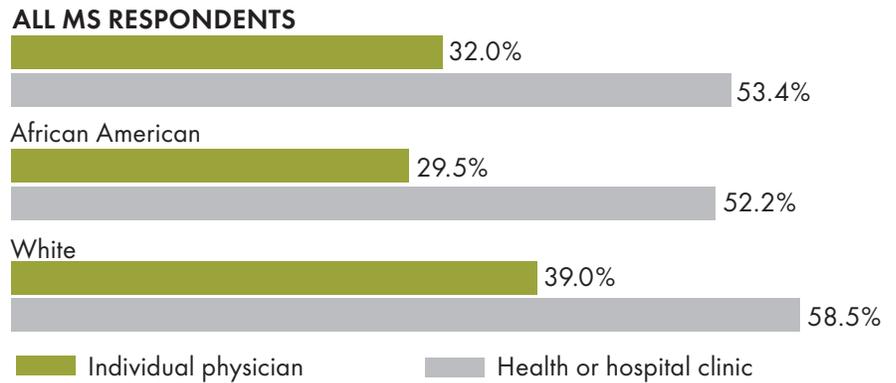
PROVIDER ACCESS

A personal doctor (also called primary care provider) is the one you would regularly see if you need a check-up, want advice about a health problem, or get sick or hurt. Do you have a personal doctor?

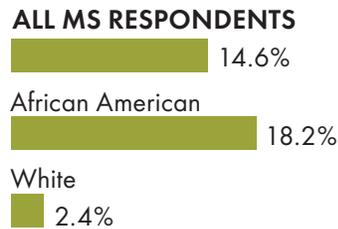
Percentage Yes



Where do you go for your primary health care needs?

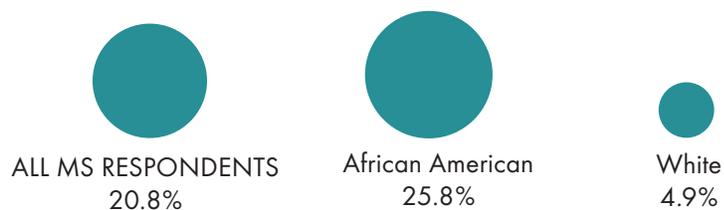


ER or “no regular place”



When was the last time you saw your doctor or health care provider?

More than a year ago



Although seven of 10 Mississippi respondents overall (71.8 percent) reported having a personal doctor, the gap between whites (84 percent) and African Americans (68.3 percent) was 15.7 percentage points. However, when asked where they go for primary health needs, only 39 percent of whites and 29.5 percent of African Americans went to an individual physician while 58.5 percent of whites and 52.2 percent of African Americans used hospital or health clinics. Significantly, 18.2 percent of African American respondents versus only 2.4 percent of whites had no medical home, using either a hospital emergency room or having “no regular place to go.” In line with these findings, 25.8 percent of African Americans and 4.9 percent of whites had not seen a doctor or health care provider for more than a year. “Mississippi doesn’t have Medicaid expansion and some hospitals have restricted access,” said Alice Graham. “Biloxi Regional Hospital has a triage process where they refer people along the coast to nurse practitioners. Mississippi has limited Medicaid/ACA providers.”¹⁸

ACCESS TO URGENT CARE

In the last 6 months, did you have an illness, injury or condition that needed care right away?

Race/Ethnicity	Percentage Yes
ALL MS RESPONDENTS	27.1%
African American	27.4%
White	23.8%

URGENT CARE ACCESS

In the last 6 months, when you tried to get an appointment for care you needed right away, how long did you usually have to wait between trying to get an appointment and actually seeing someone?

Race/Ethnicity	Percentage over one week
ALL MS RESPONDENTS	9.4%
African American	10.3%
White	8.0%

In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed it?

Race/Ethnicity	Percentage sometimes or never
ALL MS RESPONDENTS	25.5%
African American	25.7%
White	24.0%

Approximately one-fourth of both whites and African Americans reported having an illness, injury or condition that needed care right away within the last six months. More than one in 10 African Americans and 8 percent of whites had to wait for more than a week to get urgent care, and 25.5 percent of respondents (25.7 percent of African Americans and 24 percent of whites) felt that they did not get urgent care as soon as they thought they need it.

ACCESS TO ALTERNATIVE MEDICAL MODALITIES

In the last 6 months, how often did a doctor or other health provider talk with you about non-medical things like diet, exercise, meditation, or chiropractic care to treat or prevent illness?

Race/Ethnicity	Percentage that responded sometimes or never
African American	30.4%
White	20%

If your doctor discussed non-medical methods and strategies, which ones did he/she mention?

Percentage whose doctors discussed methods/strategies besides diet/exercise



Although the ACA makes provision for insurance networks to include alternative modalities, 20 percent of white respondents and 30.4 percent of African American respondents did not have any discussion with a doctor or health provider about non-medical modalities like acupuncture, chiropractic care, meditation, diet, or exercise in the last six months. Significantly, while the percentage of providers who mentioned alternative modalities is relatively small, of those who did so at all, for 81 percent of African American respondents and 34.8 percent of whites the discussion was limited to the two most common “self-care” practices: diet and exercise.

SUMMARY OF FINDINGS

Low enrollment. Survey respondents reported a low overall insured rate (only 62.9 percent overall) and particularly low percentages of new enrollment among those with insurance: 25 percent of African American respondents with coverage and 9.1 percent of whites with coverage.

Medicaid expansion is a pivotal issue. The biggest obstacle to increasing the number of people in Mississippi with access to health care is the state's failure to expand Medicaid.

Race plays a significant role in determining health coverage and outcomes in Mississippi:

- Rejection of Medicaid expansion disproportionately denies health care to African Americans;
- Enrollment difficulties in terms of physical distance and electronic glitches were exacerbated by the racial divide between whites and African Americans who had email addresses (42.5 percent and 38.3 percent, respectively) and home Internet access (66.7 percent and 52.9 percent, respectively).
- The racial gap in knowledge of what was included in their health plans was 15 percentage points – 57 percent of whites versus 42 percent of African Americans.
- Over half of white survey respondents (52.4 percent) versus 20 percent of African American survey respondents were informed about the availability of financial support at the time of their enrollment.
- More than one-fourth of African Americans had not seen a doctor in over a year, a rate more than five times that of whites.
- Providers discussed alternative medical approaches with 80 percent of whites versus 70 percent of African Americans.

Premiums and other out-of-pocket costs. Although this study did not focus on premium costs specifically, our inquiries about extra costs elicited many comments about the high cost of insurance premiums and other out-of-pocket costs. In addition, Mississippi survey respondents were not well informed about the availability of financial support for ACA enrollees. As interviewee Lelia Keys noted, “They don’t explain the limits and cost of prescription drugs for instance. For those that are being covered, the out of pocket expense becomes an issue.”¹⁹

The shortage of health care providers could exacerbate the problem of limited health access in the near future. Increasing the number of people with medical insurance without expanding the health care infrastructure could lead to difficulties in obtaining care – particularly for new enrollees.

To improve enrollment and care options in Mississippi, we recommend the following:

SAFEGUARDING ACCESS TO HEALTH INSURANCE

Expand insurance coverage in the state with federal funding by expanding Medicaid.

Target for enrollment low-income residents already enrolled in income-based programs. The state should immediately increase low-income health insurance enrollment by automatically enrolling in Medicaid people who already receive need-based benefits like SNAP (food stamps), Supplemental Security Income (SSI), WIC, or free or reduced-price school

meals, as well as people released from incarceration with no immediate source of income or assets.

Improve language access. Complete multilingual application materials and website access are not readily available. Approximately 4 percent of Mississippi's population is Latino or Asian. To facilitate access for this population, Mississippi should establish a right to enroll in health coverage in the enrollee's primary language. Implementing this policy would require multilingual applications, literature, websites, and interpreters, consistent with the requirement in § 1311(i)(3)(E) of the Act to "provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges." The state should require plans to give enrollees notice of their right to language services, as California does (Cal. Code Regs. tit. 10 § 2538.3), and regularly assess plans' compliance with language access requirements, as New York mandates (N.Y. Pub. Health Law § 4403). Mississippi should expand its pool of interpreters and require plans to continually update information about which providers are in their networks. Provider directories must be available in multiple languages and list addresses, phone numbers, languages spoken, hospital affiliations, and specialties.

Simplify the insurance-shopping experience and keep provider information current. The state should simplify print and electronic descriptions of plans and benefits, especially deductibles, co-pays, preventive services available at no cost, and the significance of providers being in- or out-of-network, making costs transparent and ensuring easy comparison of services available with no co-pay. It should also require plans to continually update information about which providers are in their networks.

Make faster decisions on enrollment applications. The state should require decisions on ACA and Medicaid applications within two weeks of filing.

MOVING CONSUMERS FROM COVERAGE TO CARE

Expand and extend the role of community health outreach workers. Many enrollees are new to health insurance coverage. Not only are they unfamiliar with medical terminology, they have had little interaction with the medical system or the insurance system and may need both an introduction and an acclimation. Navigators are in an ideal position to perform this role. The state should extend the role of outreach workers to encompass teaching new enrollees how to use insurance coverage and recruiting enrollees to participate in marketplace-sponsored evening and weekend clinics focusing on health education, specific mobile services (exams, immunizations, etc.), and access to different medical modalities (e.g., acupuncture, chiropractic care).

Address racial health disparities. Mississippi should enforce ACA statutory provisions that require insurers to act to reduce racial disparities and continually monitor implementation of insurers' disparity-reduction plans and programs, especially outreach and outcomes. The state should impose penalties, including exclusion from the exchange, against plans that do not succeed in reducing disparities within established target timeframes.

Require plans to include in their networks at least one full-time primary care provider for every 2,000 patients and ensure that enrollees are able to make appointments with their primary care providers within 10 business days of seeking an appointment, as do California and Washington.

Require that new enrollees have the opportunity for a free physical exam and appropriate screening tests within 60 days of enrollment.

Require plans to adopt geographic access standards ensuring that, for at least 90 percent of enrollees, primary care providers are available within 10 miles or 30 minutes average driving or public transit time and specialists within 45 miles or one hour, whichever is less, as New Jersey does (N.J. Admin. Code § 11:24A-4.10). Vermont imposes similar requirements. Enrollees who live farther from providers should be offered free transportation.

Reinforce the ACA-mandated women’s right to no-cost “well-woman preventive” care by ensuring that all plans available through the marketplace include reproductive health care services, including all FDA-approved forms of contraception.

Expand and standardize preventive services, ensuring that non-grandfathered plans offer preventive services (yearly check-ups, immunizations, counseling, and screenings) at *no out-of-pocket cost* and penalize plans in which fewer than 70 percent of enrollees receive these services.

Require plans to track health outcomes, disaggregated by race, ethnicity, primary language, gender, disability, and sexual orientation.

BUILDING AN INFRASTRUCTURE TO PROMOTE PREVENTIVE HEALTH CARE

Offer incentives to plans that adopt a broad view of health benefits and tackle underlying social determinants of health. Mississippi is a poor state with 22.7 percent of its residents living in poverty. Insurance is one step toward better health, but in order to address the prevalence of chronic diseases, the state must encourage innovation and experimentation to address the underlying causes of poor health – particularly in low-income rural communities.

Expand medical-legal partnerships as an avenue toward the broad array of issues that lead to poor health in low-income communities (e.g., mold in housing, domestic violence). While three-quarters of states and seven of the 10 states studied already have at least one such partnership, through which medical and legal professionals collaborate to look holistically at barriers to health and wellness and work jointly to remove the barriers, the partnerships already in place cannot begin to meet the need.

Invest in school-based health centers. Seek funds from HHS’ Health Resources and Services Administration or use state funds to expand school-based health centers, especially in medically-underserved communities (where 31.3 percent of state residents reside) to mitigate the lack of other health care options (Section 4101 of the ACA, 42 U.S.C. § 280h-4).

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