Health Care Financing Task Force Vision: Sustainable, quality health care for all Minnesotans

Seamless Coverage Workgroup

Recommendations Package

January 4, 2016

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Health Care Financing Task Force
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A. Removing Barriers to Access to Coverage and Care and Addressing Disparities

Minnesota leads the nation in providing coverage for its residents, offering a robust continuum of coverage programs through Medical Assistance, MinnesotaCare, subsidized Qualified Health Plan coverage offered by MNsure, and coverage offered through Minnesota's individual and small group market more broadly. However, there remain significant and often technical barriers to access based on disparities in geography, language, culture, and health and financial literacy. Differences in coverage program rules and features of Minnesota's multiple, and often complex, pathways for health insurance coverage programs also impede consumer understanding of, and access to, coverage. In addition to the recommendations of the Barriers Workgroup, the Seamless Coverage Workgroup made several additional recommendations to address barriers to coverage and care access for Minnesotans.

Recommendation 1:

Rationalize affordability definition for families with access to employer sponsored insurance (ESI) (i.e., fix the "family glitch").

JUSTIFICATION: Under the ACA, individuals who have access to affordable health coverage may not access MinnesotaCare or federal subsidies for QHP coverage through the Marketplace. Employer-sponsored insurance (ESI) – for employed individuals as well as their spouses and dependents – is defined as affordable where the contribution for ***employee only*** coverage is less than 9.66% of annual income. This is true even when family coverage exceeds the 9.66% threshold[1] and as a result, some low- to moderate-income Minnesota families are not able to qualify for MinnesotaCare or APTC/CSR to purchase affordable health insurance coverage[2]. This issue has been well documented by State and national policymakers. Attempts to fix the family glitch through federal legislative or regulatory change have not gained traction to-date. Minnesota Senator Al Franken Senator Franken (D-MN) introduced the Family Coverage Act (S. 2434) in June 2014 to resolve the glitch but legislation is unlikely to advance. The Departments of Health and Human Services and Treasury, which some perceive as possessing the authority to address the affordability definition administratively, have also declined to act.

COSTS/SAVINGS: Based on Milliman estimates, fixing the "family glitch" would cost roughly $1.9M per month to cover an average of 820 additional Minnesotans in either MinnesotaCare or QHP coverage. [Updated numbers will be provided by Milliman.]

STATE/FEDERAL AUTHORITY: The State would need to seek a 1332 waiver to define affordability for ESI for dependents based on the cost of dependent/family coverage as opposed to the cost of employee coverage. An amendment to the Minnesota statutes that authorize MinnesotaCare eligibility criteria would also be required to initiate this change.

OTHER OPTIONS CONSIDERED: The Workgroup also discussed seeking 1332 waiver approval to allow families to use their APTC/CSRs for their employer sponsored insurance as another mechanism for encouraging and rationalizing family coverage. This would allow families to enroll in the same employer plan using available APTCs to offset the cost of that coverage in cases where the employer provides affordable coverage for the working member of the family, but not his or her spouse and dependents. Conversely the State could consider seeking 1332 approval to use a premium aggregator to allow families to pool employer contributions to coverage and APTC/CSRs to

[1] IRS 36B(c)(2)(C)(i)
[2] IRS 36B(c)(2)(C)(i)

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purchase family coverage through the individual market. Both alternatives were rejected due to the administrative complexity.

Recommendation 2:

Adopt 12 month continuous eligibility for Medical Assistance & MinnesotaCare enrollees.

JUSTIFICATION: The State is required to re-determine Medical Assistance eligibility every 12 months and if an enrollee experiences a change in circumstances any other time during the year that may affect eligibility, he or she is obligated to report the change and the State must re-determine his or her eligibility mid-year. Changes that could affect eligibility include changes in: income (e.g., a new job, a pay raise), household size (e.g., new baby, marriage), and age (e.g., turning 19). One study estimated that 48% of consumers within the income eligibility range for Medical Assistance, MinnesotaCare, or subsidized QHP coverage through MNsure will experience a change in program eligibility during each coverage year.[3] Consumers who are within the income eligibility range for Medical Assistance and MinnesotaCare are particularly prone to experiencing income fluctuations due to instability and seasonality in employment. Further, income volatility has increased over the last decade, exacerbating this problem[4]. Income fluctuations may result in significant churning, meaning consumers transitioning from one coverage program to another or off or on coverage entirely.

Adopting 12 month continuous eligibility for Medical Assistance and MinnesotaCare enrollees increases stability in coverage, consistency of patient-provider relationships, and continuity of care, care management, and quality improvement, particularly for people with chronic conditions. Longer periods of eligibility also reduce administrative cost and burden for the Department of Human Services, counties, plans, and providers and improves stability in revenue for plans and providers. At least 23 states have implemented 12 month continuous eligibility for children in Medicaid and 2 states have authority to implement 12 month continuous eligibility for adults in Medicaid.[5]

COSTS/SAVINGS: The State estimates that providing 12 month continuous eligibility for all Medical Assistance enrollees whose eligibility is based on their Modified Adjusted Gross Income (MAGI)—generally, non-elderly, non-disabled Medical Assistance enrollees—and all MinnesotaCare enrollees would cost $61 M in FY 2018 and $70 M in FY 2019.

STATE/FEDERAL AUTHORITY: Legislation would be needed for the State to pursue these changes to both Medical Assistance and MinnesotaCare. This would require the State to seek a Medicaid State Plan amendment for children and a Section 1115 waiver for adults in Medicaid. It would also require the State to amend its Basic Health Program blueprint in advance of implementation to effectuate this change for MinnesotaCare enrollees.

OTHER OPTIONS CONSIDERED: The Seamless Coverage Workgroup considered establishing continuous eligibility for all Medical Assistance and MinnesotaCare MAGI populations as well as subsets of those populations (specifically, only children, all Medical Assistance MAGI populations, and the MinnesotaCare population). Ultimately providing continuous coverage for all populations considered won broad Workgroup support. Notably, there was broadest support for implementing continuous eligibility for children in Medical Assistance, with 12 month continuous eligibility for the entire Medical Assistance MAGI population ranking as a second highest priority population among Workgroup members.

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[3] Sommers, B., Graves, J., Swartz, K., Rosenbaum, S.; Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options Can Ease Impact; Health Affairs; April, 2014.

[4] Dynan, K.; The Income Rollercoaster: Rising Income Volatility and Its Implications; Brookings; April 2010. http://www.brookings.edu/~/media/research/files/articles/2010/4/01-income-volatility-dynan/0401_income_volatility_dynan.pdf

[5] kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-elgibility-for-childrens-medicaid-and-chip/

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B. Improving Affordability of Coverage and Care for Consumers

Currently, individuals transitioning from MinnesotaCare to qualified health plans (QHPs) offered through the Marketplace face a significant financial "cliff" or an increase in premiums, cost-sharing, and deductibles. Specifically, annual premiums for a household of one increase from $960 at 200% FPL to $1,509 at 201% FPL. Similarly, deductibles for individuals enrolling in a silver-level plan increase from $34.20 to an average of $1,450. These significant increases in premiums and cost-sharing may cause gaps in coverage related to the ability of families to maintain adequate and affordable coverage as they move up the income ladder.

Recommendation 3:

Improve affordability and reduce the cliff in premiums, cost-sharing and deductibles for health coverage at 200% FPL in Minnesota's coverage continuum by establishing a Minnesota-tailored health coverage affordability scale and provide enhanced subsidies to consumers with incomes 200-275% FPL (pre-ACA MinnesotaCare eligibility levels).

JUSTIFICATION: Minnesota has long used a combination of state and federal funding for its Medical Assistance and MinnesotaCare programs to ensure access to comprehensive and affordable health insurance coverage for its residents. In fact, Minnesota's approach to health insurance affordability has historically been more comprehensive than the affordability standards under the ACA.

Minnesota's robust coverage continuum ensures access to affordable coverage for individuals with incomes up to 200% FPL. But these subsidies also create "cliffs" in both premiums and cost-sharing for individuals as they transition to ACA premium and cost-sharing levels above 200% FPL. See Figures 1 and 2 below for a comparison of Minnesota's current affordability scale to the one established under the Affordable Care Act.

Fig. 1

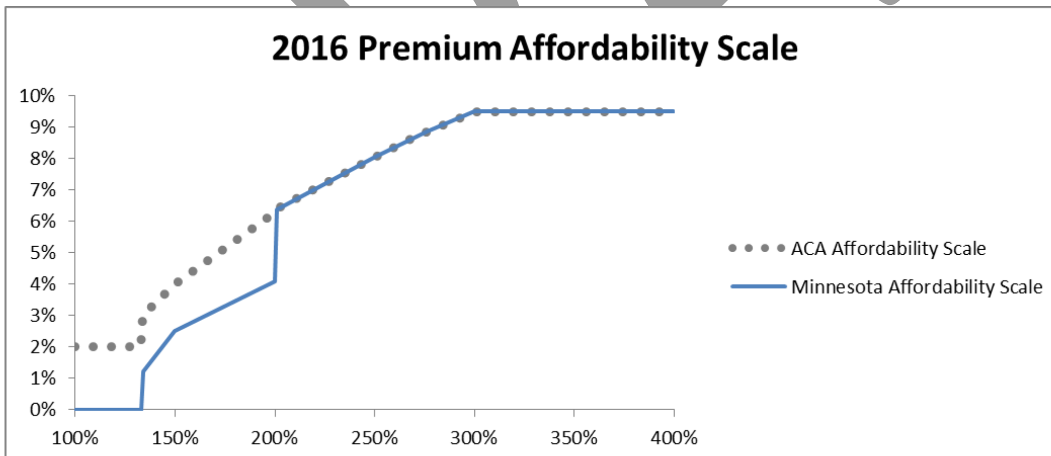

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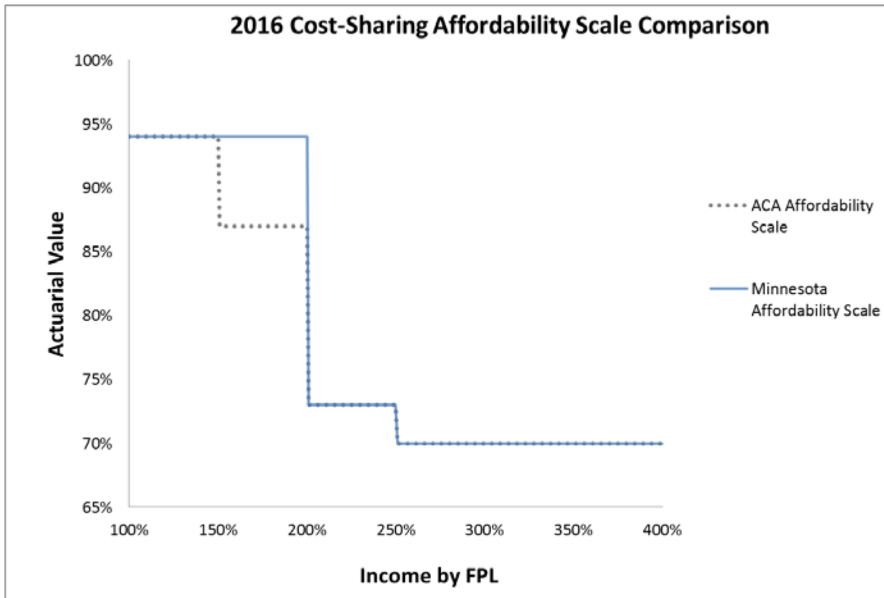
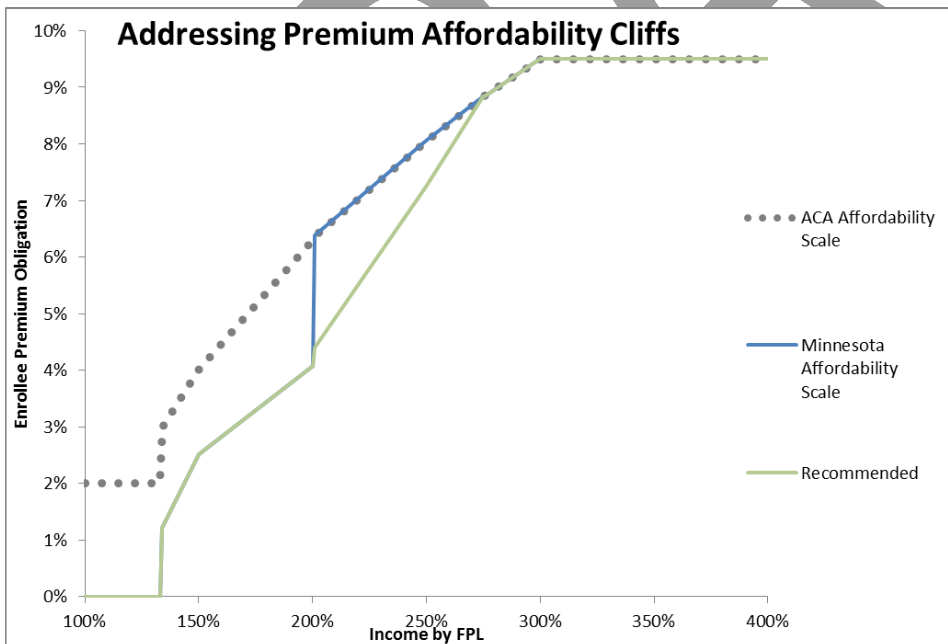
Fig. 2



To reduce the "cliffs" in premiums and cost-sharing, the Workgroup recommends increasing premium subsidies and reducing cost-sharing obligations for Minnesotans with incomes from 200 to 275% FPL. In addition to minimizing the cost-sharing cliffs at 200% FPL, expanding access to subsidies would improve coverage affordability for consumers from 200 to 275% FPL—a population currently eligible to enroll in QHPs through the Marketplace and the most sensitive to changes in price compared to other QHP enrollees due to their relatively lower income.

Fig. 3



Improving affordability for consumers at this income level would be expected to improve insurance coverage rates among individuals who have declined enrollment to date due to concerns about affordability. Additionally, making point-of-service cost sharing more affordable would be expected to improve consumer access to health services. Smoothing the premium and cost-sharing cliffs also may help with the State's efforts to reduce rates of

health disparities among priority populations, such as racial and ethnic minorities, low-income groups, residents of rural areas and inner cities, and individuals with disabilities and special health care needs.[6]

COST-SAVINGS: The estimated costs related to implementing the Minnesota affordability scale range from a savings of $24 M per year to a cost of $35 M per year, depending on the availability of federal dollars for delivering the subsidies through an expansion of the MinnesotaCare program. The cost estimates are discussed further in Recommendation 4.

STATE/FEDERAL AUTHORITY: Increasing subsidies for individuals from 200-to-275% FPL would require state legislation and as discussed in Recommendation 4 below, may also require a 1332 waiver. Finally, if the State seeks federal Medicaid funding to cover a portion of the cost of enhanced subsidies, an 1115 waiver would be required.

OTHER OPTIONS CONSIDERED: Several Workgroup members supported reducing the premium cliff at 200% FPL by increasing premiums and cost sharing in MinnesotaCare for the population from 138-200% FPL. Some Workgroup members further suggested that the State should not provide any additional subsidies for populations above 138% FPL, which would shift the premium and cost-sharing cliff from 200% FPL to 138% FPL. Several other members, however, objected to these proposals based on Minnesota's long-standing commitment to providing low-cost coverage to populations below 200% FPL. Still others believed that these alternatives were incompatible with improving affordability of and access to coverage. Additionally, numerous public commenters expressed to the Task Force strong support for maintaining MinnesotaCare's current affordability levels and urging for MinnesotaCare to be expanded.

Workgroup members also discussed reducing premiums and co-payments for the population from 139 – 200% FPL (the current MinnesotaCare population) by eliminating the premium and cost-sharing increase established in legislation passed last session to further improve affordability, but ultimately rejected this option because it did not address the cliff at 200% (and if not paired with increased subsidies above 200% FPL would worsen this cliff). Additionally, several Workgroup members raised concerns about the longer-term financial sustainability of further subsidizing coverage for the population from 139 – 200% FPL.

Recommendation 4:

Expand MinnesotaCare up to 275% FPL, using the recommended affordability scale under recommendation 3 for those between 200 and 275% FPL, and maintain Marketplace coverage for consumers >275% FPL.

JUSTIFICATION: Expanding MinnesotaCare up to 275% FPL would improve the affordability of coverage and smooth the premium and cost-sharing cliffs at 200% FPL. By offering coverage based on the affordability scale described in Recommendation 3 and in Appendix A., individuals with incomes from 200 to 275% FPL would save on average $1,100 per year, when compared to the average silver-level product sold in the Marketplace. Under this option, individuals with incomes between 200 and 275% FPL would also have access to the MinnesotaCare benefit set.

Workgroup members supporting this option acknowledged the opportunity for the State to better align and streamline eligibility and coverage for families, especially those in "mixed" households where they are split between private and public market products based on varying income eligibility requirements. For example, today, children between 200 and 275% FPL in Minnesota are covered under Medical Assistance, while parents are eligible for separate private products in the Marketplace.

COST/SAVINGS: Milliman modeling shows that an expansion of MinnesotaCare up to 275% FPL would cover an additional 42,700 Minnesotans for a cost of $70M per year. If the State were to seek federal funding through

[6] *See* Agency for Healthcare Research & Quality, Disparities in Healthcare Quality Among Racial and Ethnic Minority Groups, *available at* http://archive.ahrq.gov/research/findings/nhqrdr/nhqrdr10/minority.html

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either an 1115 or a 1332 waiver for this option, the net fiscal impact to the State for 2016 would range from a savings of $24 M (under 1332 waiver) to a cost of $35 M (with an 1115 waiver). This figure does not include any administrative or start-up costs that may be associated with implementation of such an expansion.

According to Milliman's analysis, the low capitation payments in MinnesotaCare play a key role in the potential savings associated with this option. When compared to the cost of covering enrollees in private market products, MinnesotaCare is less expensive due to its lower administrative costs and provider reimbursement rates.

STATE/FEDERAL AUTHORITY: To expand MinnesotaCare from 200 to 275% FPL, the State would need to obtain a 1332 waiver. Under the 1332 waiver, individuals with incomes from 200 to 275% FPL would be ineligible for federal APTC/CSRs, but would be eligible for MinnesotaCare. The State may also apply for an 1115 waiver to seek additional federal funding for individuals enrolled in an expanded MinnesotaCare program. The Minnesota statutes that authorize MinnesotaCare income limits would also need to be amended to initiate this change.

OTHER OPTIONS CONSIDERED: The Workgroup considered two other options for covering the population from 200 to 275% FPL. First, the Workgroup considered the "private model," under which all individuals with incomes from 138-to-275% FPL would purchase coverage through the Marketplace and the State would provide additional subsidies to reduce premiums and cost-sharing.[7] Additionally, the State would provide separately any benefits included in the MinnesotaCare benefit package but not otherwise covered by Qualified Health Plans offered through MNsure. Several workgroup members noted that, while the public model would cut MNsure/Marketplace enrollment in half, the private model would strengthen it by increasing QHP enrollment numbers. Milliman estimated significant costs to implement this model—more than $425 M[8] in additional costs for 2016. The Workgroup did not ultimately favor this option.

Second, the Workgroup considered a "hybrid model." In this model, individuals with incomes from 138-to-200% FPL would continue to receive coverage through the MinnesotaCare program, while individuals with incomes from 200 to 275% FPL would continue to purchase coverage in MNsure/Marketplace with the State providing additional premium and cost-sharing subsidies to meet the recommended affordability scale for this population. Workgroup members noted that this model preserves the existing size of MNsure/Marketplace, while increasing affordability for individuals with incomes from 200 to 275% FPL. Additionally, this model was less expensive than the private model, with an estimated additional cost of $55 M for 2016.[9] However, the hybrid model may be complex to administer, since the State would need to maintain one program for individuals with incomes from 138 to 200% FPL and create a second subsidy program for higher-income populations. Despite these limitations and the Workgroup's clear preference for expanding MinnesotaCare, the hybrid model remains a viable option for increasing affordability for individuals with incomes between 200 and 275% FPL in the event that the State is unable to obtain the 1332 waiver necessary to expand MinnesotaCare up to 275% FPL through a single public program.

Finally, the Workgroup briefly discussed the option of enrolling all Medical Assistance and MinnesotaCare enrollees in private coverage, as well as the option of establishing a single payer system in Minnesota. Both of these options were not considered for further evaluation, as the Workgroup concluded that they were beyond the scope of the Task Force and would require further study by the State.

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[7] The affordability scale used for this option was the same as that provided under the expanded MinnesotaCare option. This included the current MinnesotaCare affordability scale for those between 138 and 200% FPL, and the recommended affordability scale for those between 200 and 275% FPL.
[8] Up to half of this amount, or $212.5 M, could funded through an 1115 waiver.
[9] Up to half of this amount, or $27.5 M, could be funded through an 1115 waiver.

C. Sustainably Financing the Coverage Continuum

Minnesota has traditionally used multiple, discrete funding sources to finance each program in its coverage continuum. Namely, the general fund paid for Medicaid, known as Medical Assistance in Minnesota, while the Health Care Access Fund covered the cost of providing subsidized coverage options for those eligible for MinnesotaCare. (Note: At times, the Health Care Access Fund has also been used to fund the Medical Assistance program.) Minnesota's 2% provider surcharge—the largest source of dollars into the Health Care Access Fund—is scheduled to expire at the end of 2019, which has created uncertainty as to how the State will continue to fund or sustain its public coverage programs in the future.

The State also must consider how to fund its Marketplace—be it MNsure or a successor. Currently, MNsure is funded through three sources: (1) establishment grants provided by the federal government, (2) state and federal Medicaid dollars to cover the administrative costs for eligibility and enrollment activities for enrollees determined eligible for MinnesotaCare or Medical Assistance, and (3) a 3.5% premium withhold on products sold through MNsure. With federal grant funding not available beyond CY 2016, Minnesota is reexamining how best to fund MNsure, including considering options related to expanding the premium withhold to apply more broadly to health insurance products sold outside of MNsure.

Recommendation 5:

Seek Medicaid match to provide additional federal funding for enhanced subsidies to the population with incomes from 138 – 275% FPL.

JUSTIFICATION: The State previously received federal Medicaid dollars under an 1115 waiver to offset a portion of the costs of MinnesotaCare for individuals with incomes up to 275% FPL. In 2015, MinnesotaCare became the State's Basic Health Plan (BHP). Under the BHP, the State receives 95% of the value of the APTCs/CSRs that BHP enrollees would have received had they purchased coverage through the Marketplace. The State no longer receives federal dollars through an 1115 waiver for the MinnesotaCare population. Both Massachusetts and Vermont, however, continue to receive federal funding through an 1115 waiver to offset the cost of increased subsidies for populations with incomes from 138 – 300% FPL. These 1115 waiver dollars are in addition to the federal APTC/CSRs that Bay Stater's and Vermonter's access when purchasing coverage through the Marketplace. Like Minnesota, both Massachusetts and Vermont had previously expanded coverage beyond Medicaid levels, and thus Minnesota is well positioned to request additional federal support to provide expanded coverage in addition to the APTC/CSR funding it receives through the BHP program.

COST/SAVINGS: The federal government could provide up to half any program costs over and above federal APTC/CSR funding to increase affordability for individuals with incomes from 138-to-275% FPL.

STATE/FEDERAL AUTHORITY: The State would need to apply for an 1115 waiver. The Legislature would need to pass a statutory directive to initiate this option.

OTHER OPTIONS CONSIDERED: None.

Recommendation 6:

Repeal the sunset of provider tax to continue a dedicated state funding stream to support health care for low-income Minnesotans. With continuation of the provider tax, establish more stringent parameters for: (a) uses of Health Care Access Fund revenue and (b) the mechanism for contingent tax reduction based on program funding needs.

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JUSTIFICATION: The Health Care Access Fund has long supported subsidized health coverage for eligible low-income Minnesotans. A dedicated funding stream provides more funding certainty year-to-year for this purpose. Without the 2% provider tax, current projections show revenue into the Health Care Access Fund would fall short of projected uses by 2021. Workgroup members expressed concerns, however, that the Health Care Access Fund has been used for purposes other than MinnesotaCare. For this reason, the Workgroup also recommends the State establish more stringent limits on the use of Health Care Access Fund dollars and a more reliable mechanism to reduce the provider tax when the Health Care Access Fund has a considerable surplus. The law establishing the Health Care Access Fund currently provides for a contingent tax reduction in the event of a surplus, but a reduction has never been implemented given some of the rules surrounding its current structure.

COST/SAVINGS: N/A

STATE/FEDERAL AUTHORITY: Legislation would be needed to repeal the sunset on the provider tax so that it would continue to be collected beyond its scheduled expiration date in 2019.

OTHER OPTIONS CONSIDERED: Some Workgroup members favored allowing the provider tax to sunset and using general funds, rather than a dedicated fund, to support health coverage for low-income Minnesotans. Specifically, these Workgroup members believe the general fund would be more transparent, enabling legislators and other stakeholders to weigh funding needed for MinnesotaCare, against funding for other state priorities each year, like education and infrastructure. The Workgroup, as a whole, ultimately did not approve using general funds alone to fund health coverage for low-income Minnesotans, concluding that a dedicated and sustainable funding source enables the State to maintain its longstanding commitment to MinnesotaCare.

Recommendation 7:

Expand the MNsure user fee to on- and off-Marketplace products, provided that the Legislature statutorily reduces the user fee/premium withhold level.

JUSTIFICATION: Expanding the user fee/premium withhold that funds MNsure operations to on- and off-Marketplace products has been debated in many states with stated based marketplaces (SBMs) and adopted in eight states. States with Marketplace-only user fees are encountering sustainability challenges that force them to curtail consumer outreach and technology upgrades that adversely impact their ability to grow enrollment or even maintain enrollment in a market sector where roughly a third of enrollees move back into group coverage or otherwise churn off the Marketplace every year. These problems are likely to be even more pronounced for MNsure, given the significant enrollment in MinnesotaCare that would be Marketplace enrollment in every other state except New York, which also has a Basic Health Program.

The case for a broad-based fee is rooted in the fact that Marketplaces have proven their value as a public good by playing a pivotal role in reducing the number of uninsured and lessening the many adverse consequences to individuals and to society when people are uninsured. Marketplaces also enhance health literacy by expanding transparency, including by providing easily accessible and comparable information on health insurance products, regardless of whether individuals ultimately purchase coverage inside or outside of the public Marketplace. Broader application of the user fee also reduces the incentive for insurers to favor or steer customers to off-Marketplace coverage and thus levels the playing field in terms of competing for enrollees. Further, this option would stabilize MNsure funding, because it would no longer vary based on the number of enrollments through MNsure. Additionally, the Workgroup recommended that if the State is to expand the user fee to products sold outside MNsure, the State would need to reduce the level of the premium withhold in statute.

COST/SAVINGS: Assuming the size of Minnesota's individual market were to remain constant, applying the premium withhold to both on- and off-Marketplace coverage would yield $22 M in revenue, even if the withhold were reduced by 2 percentage points to 1.5% of premium. By contrast, the current premium withhold of 3.5% of premium applied only inside the Marketplace generates $10.7 M in revenue.

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STATE/FEDERAL AUTHORITY: The State would need to pass legislation to reduce the premium withhold level and to expand the user fee to apply to individual market coverage purchased off of the Marketplace.

OTHER OPTIONS CONSIDERED: During the Workgroup's conversation about Recommendation 4, there was an acknowledgement by some members that if the State pursues an expansion of MinnesotaCare, it would also likely need to expand the premium withhold to products off the Marketplace to stabilize the funding stream for MNsure.

D. Assessing the Future of MNsure

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In the fall of 2013, Minnesota launched its State Based Marketplace (SBM), pursuant to legislation passed in early 2013. Since that time, technical and operational difficulties and lower-than-expected enrollment have fueled concerns regarding MNsure's operational stability and financial sustainability.

MNsure has faced a number of unique policy and technical challenges in its early years of operation. Specifically, premiums in 2014 were the lowest in the nation. In addition, the carrier with the largest enrollment exited the Marketplace after 2014, causing disruption for many consumers. Premiums increased in 2015 but were still among the lowest in the nation, offering some bargains for Minnesotans but also having the unintended consequence of reducing the value of federal premium tax credits to Minnesotans. As a result, many individuals did not qualify for subsidies (or qualified only for nominal subsidies) and had little or no financial incentive to enroll through MNsure. Specifically, in 2015, only 55% of MNsure enrollees were eligible for subsidies, compared to 85% of Marketplace enrollees nationwide.

Over the past two years, MNsure has actively addressed many of its early challenges by: (1) improving the web portal to better serve consumers, augmented by a robust and well-funded consumer assistance infrastructure including Navigators, consumer assistants, agents and brokers; (2) communicating more transparently with the Legislature, State agencies and the public regarding its performance; and (3) improving the IT project governance structure and process to reflect shared responsibility for the mix of programs served by the IT platform. The Marketplace reports a smooth and positive 2016 open enrollment period in which many of the web portal functionality issues of years past have been resolved.[10] Additionally, premium increases for 2016 have enhanced the value of the subsidies and are expected to drive additional enrollment through MNsure. As of December 31, roughly 70% of individuals enrolling in coverage through MNsure during the 2016 open enrollment period were eligible for subsidies. Despite these efforts, significant back-end functionality at MNsure related to enrollment transactions with the carriers has yet to be fully implemented.

Given ongoing concerns about MNsure's functionality and cost, combined with the emergence of new alternatives to the SBM model, the Workgroup discussed potential alternatives to its current model, taking into account lessons learned from its experience with MNsure and other states' experiences with alternative marketplace models.

Recommendation 8:

Develop framework to evaluate MNsure's 2016 open enrollment period performance.

JUSTIFICATION: In the course of their discussions, the Workgroup identified several goals for Minnesota's marketplace to inform their discussions regarding the future of and potential alternatives to MNsure.

[10] Rao, A., White, J., Allen, K.; 2016 Health Insurance Exchanges: The Good, the Bad, and the Ugly; Policy Recommendations to Improve Consumer Choices; Clear Choices; December 2015.

The Workgroup also discussed potential alternatives for Minnesota's marketplace and for each alternative considered the benefits and drawbacks against those of retaining the state-based marketplace. A brief summary of considerations related to each Marketplace model discussed by the Workgroup is reflected in the chart below:

Marketplace Goals

Ranked in Order of Priority

1) Enable a streamlined process for eligibility determinations, plan selection, and enrollment
2) Provide readily available, culturally-competent consumer assistance to support informed plan selection and enrollment
3) Offer a consumer-facing portal that is user-friendly and supports efficient navigation
4) The IT and governance of the Marketplace be cost-efficient and supported by a sustainable funding and
5) The Marketplace allows for easy integration with health plans
6) Provide a single access point for determining one's eligibility to public benefits
7) Have the ability to support a Minnesota-specific affordability scale.

Fig. 4

	SBM "Stay the Course"	Partially Privatized SBM	Supported SBM	FFM
Flexibility to administer MinnesotaCare	✓	✓	✗	✗
Flexibility to administer additional subsidies	✓	✓	✗	✗
Flexibility to administer portable subsidies	✓	✓	✗	✗
State cost for completing QHP-related systems development	$	?	$$	$$
State cost for completing QHP- and public program-related systems development	$	?	$$$	$$
Flexibility to invest in Navigator program	✓	✓	✗	✗

A more detailed description of each of the Marketplace models is contained in Appendix B.

Based on evaluation of the benefits, drawbacks and costs of each Marketplace option, the Workgroup did not ultimately endorse a recommendation to transition Minnesota's Marketplace to a different Marketplace model. The supported state based marketplace (SSBM)[11] and the federally facilitated marketplace (FFM) both rely on the HealthCare.gov platform for eligibility and enrollment functionality. These models ultimately garnered very little support as viable alternatives to MNsure because of HealthCare.gov's lack of flexibility to have a streamlined eligibility system with Minnesota's public programs and its inability to administer MinnesotaCare or additional subsidies needed for a Minnesota-specific affordability scale. Additionally, Workgroup members expressed concerns about the potential loss of State control over the Minnesota Navigator and assister programs in the FFM model, as well as the new SSBM fees proposed to be 3% of premiums for products sold through HealthCare.gov.

[11] In the proposed Notice of Benefit and Payment Parameters for 2017, the federal government proposed referring to this as a State-Based Marketplace using the federal platform or SBM-FP

The partially privatized SBM, through which a private vendor is contracted to provide some or all Marketplace functionality, had more support among Workgroup members as a viable option for future consideration, since it could have similar flexibility to the current version of MNsure. The partially privatized model fell slightly short of majority support because it ultimately was viewed as untested nationally with limited information on cost. If any when other states bring privatized models on line (Oregon has a pending request for proposals to test whether a private vendor can beat the federal platform price), there may be good reason for Minnesota to revisit this model.

The Workgroup therefore recommends that the State develop a framework to evaluate MNsure's performance following completion of the 2016 open enrollment period on January 31, 2016. The Workgroup recommends that the evaluation framework include:

- Assessment of how MNsure's QHP experience fits into the health coverage landscape in Minnesota, including QHP enrollment trends, percentage of enrollees accessing tax credits, effectiveness of consumer outreach/education strategies, and adequacy of MNsure financing
- Assessment of consumer QHP enrollment experience, including comparisons to Healthcare.gov and selected SBMs, potentially with the assistance of an independent expert
- Progress report on meeting benchmarks in IT development and modernization plan, including timeline and cost for completing remaining functionality to support QHP enrollment

COST/SAVINGS: The Workgroup considered the comparative costs to the State of "staying the course" against pursuing alternative models. There is no cost information available for potential transition to a partially privatized Marketplace. However, MN.IT, DHS, MNsure, and Commerce estimated the additional costs of transitioning to an SSBM or an FFM as follows:

Fig. 5 (Figures are in 000's)

State Funding Needs under Federal Exchange	If moved to FFM	If Moved to SSBM
Funds to complete current scope of IT system (Replacing CCIIO Grants, Etc.)	$2,563	$2,563
Funds to address new IT project for account transfers	$1,579	$1,579
Unfunded State Marketplace Needs		$1,700
Additional DHS Administrative Costs	$705	$584
Additional Department of Commerce Costs	$255	$255
Total	$5,102	$6,681

STATE/FEDERAL AUTHORITY: The Legislature and/or Governor would direct development of an evaluation framework in the first quarter of 2016.

OTHER OPTIONS CONSIDERED: Although the Workgroup recommends evaluating the performance of MNsure during the 2016 open enrollment period, the Workgroup did not endorse any recommendation with regard to transitioning to an alternative Marketplace model (partially privatized SBM, an SSBM, or an FFM.).

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E. Recommendation 9:

Codify the current IT executive steering committee structure for overseeing the IT modernization plan, including MNsure's IT system.

JUSTIFICATION: Although MNsure is most closely associated with QHP coverage, it also shares the integrated eligibility and enrollment IT system with the Department of Human Services, through which Minnesotans apply for and are determined eligible for Medical Assistance, MinnesotaCare and APTC/CSRs subsidized QHP coverage. Further, the vast majority, (roughly 80%) of individuals applying for coverage through MNsure, qualify for Medical Assistance or MinnesotaCare—meaning that the Department of Human Services covers a significant portion of the expense of this shared IT system through a Medicaid cost-allocation with federal and state dollars.[12]

The legislation establishing MNsure does not provide specifics on how IT projects for this shared system are governed or prioritized. Therefore, in late 2014 an informal multi-agency structure was formed to act as an executive steering committee for setting IT priorities and overseeing IT modernization and implementation. Consistent with the recommendation of the Office of the Legislative Auditor (OLA), the Workgroup recommends codification of the IT executive steering committee in statute, thereby ensuring that the IT executive steering committee remains a part of MNsure's overall IT governance even as leadership at MNsure and other agencies changes over time.

COST/SAVINGS: N/A

STATE/FEDERAL AUTHORITY: The State would need to enact legislation, preferably in the 2016 session, to codify the IT executive steering committee structure.

F. Ensuring Stability of the Insurance Market

Although Minnesota's individual marketplace premiums were among the lowest in the nation in 2014 and 2015, there were significant rate increases for 2016 as a result of financial impacts experienced by the health insurance companies from higher claims than expected and significantly lower reimbursement under the federal risk corridor stabilization program. The 2016 increases raised concerns about future premium increases and sparked a conversation about whether Minnesota should take affirmative steps to stabilize premiums in the individual insurance market.

Recommendation 10:

The Department of Commerce should explore options to stabilize Marketplace premiums by:

- Studying and modeling potential Minnesota-tailored rate-stability mechanisms for the individual market, such as a reinsurance program
- Studying and modeling merging Minnesota's individual and small group markets

[12] Using a methodology developed in consultation with actuaries, **[Confirm developed with actuaries]** a portion of costs for MNsure's IT system that are attributable to Medical Assistance and MinnesotaCare are allocated to the Department of Human Services. The Department of Human Services receives federal matching funds to cover the administrative costs for its public programs.

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- Considering the impact of establishing maximum limits on health plan carriers' excess capital reserves or surplus[13]
- Studying options for making Minnesota's rate review process more transparent with public information or hearing.

JUSTIFICATION: Significant increases in premiums in 2016 illustrate the continued volatility in the individual insurance market, even with the federal government's premium stabilization mechanisms (i.e., risk corridors, reinsurance, and risk adjustment) in place. In addition, Minnesota's high risk pool, the Minnesota Comprehensive Health Association (MCHA) which provided guaranteed issue to those with pre-existing health conditions has been phased out with the 25,000+ enrollees now seeking coverage in the individual market. Finally, federal risk corridor and reinsurance programs expiring after 2016 adding to the ongoing concerns about sustainability. There are also concerns about payments under the risk corridors program, as well as concerns that volatility—and corresponding premium increases—will continue.

The Department of Commerce presented several options for Minnesota to achieve more stability in individual market premiums. Several Workgroup members thought a Minnesota-tailored reinsurance program (or similar rate-stability mechanism) might be an effective tool to reduce volatility, though questions remain about how to fund a rate-stability mechanism and whether it would be too complex to administer. Additionally, some Workgroup members expressed interest in merging the individual and small group markets to create a larger, and more stable, risk pool. Workgroup members were reluctant to recommend market merger without further study of how it would impact individual and group rates, since a merger would not be easy to undo if it caused too much rate disruption. The group also discussed limiting excess capital or surplus, since Minnesota has had experience with this as a way to level the playing field across carriers in the past. Finally, while not proposed by the Department of Commerce, there was consensus among Workgroup members that the State should further study options for making Minnesota's rate review process more transparent by releasing more information earlier in the process and potentially holding public hearings on rate increases. Any study would need to evaluate whether transparency could have unintended consequences in terms of how carriers structured their rate proposals.

COST/SAVINGS: Cost/savings associated with this recommendation were not modeled.

STATE/FEDERAL AUTHORITY: The Department of Commerce, working in conjunction with other agencies, should begin studying the market stabilization mechanisms and report back to the Governor and Legislature regarding its findings.

OTHER OPTIONS CONSIDERED: None.

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[13] Further study is only necessary to the extent an issue is not addressed in the March 2014 study by the Minnesota Department of Health entitled "Study of Capital Reserve Limits in Minnesota" *available at* .http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/capitalreservesreport0314.pdf.

Appendix A

Recommended Premium Affordability Scale for 200-to-275% FPL

Income Level (FPL)	Current/ACA Scale (% of income)	Recommended Scale (% of income)
201% - 250%	6.42% - 8.18%	4.09% - 7.25%
251% - 275%	8.19% - 8.92%	7.26% - 8.92%

Recommended AV Affordability Scale for 200-to-275% FPL

Income Level (FPL)	Current/ACA AV for Silver Product (% of income)	Recommended AV Scale (% of income)
201% - 250%	73%	87%
251% - 275%	70%	73%

Appendix B

Overview of Marketplace Models

- **State-Based Marketplace (SBM):** State retains MNsure, continuing to improve its functionality.
- **Supported State-Based Marketplace (SSBM):** The State would rely on Federally Facilitated Marketplace (FFM) for certain core functions, especially eligibility and enrollment determinations. Federal marketplace would hand off Medicaid-eligible individuals to the State, and thus the State would need to maintain an IT system for Medicaid eligibility and enrollment and build account transfer functionality to accept application hand-offs of Medicaid-eligible individuals from healthcare.gov. The FFM cannot currently be customized to account for MinnesotaCare, and recent guidance on 1332 waivers clarifies that healthcare.gov will not be able to accommodate customized coverage programs for FFM and SSBM states. Under the SSBM model, the State would retain full responsibility for plan management functions within the IT constraints and certain other plan management conditions of the FFM. With respect to consumer assistance, the federal government's call center would handle questions about eligibility and enrollment, while the State would control and be responsible for funding consumer outreach and navigators. In its proposed payment notice for 2017, HHS has proposed that its fee for providing the federal platform would be a 3% carrier user fee. This fee is deemed as high by many states adopting or considering adopting this model; the State of Oregon, which transitioned to the SSBM model in 2015 has recently issued an RFP to transition again to the privatized Marketplace model.

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- **Federally Facilitated Marketplace (FFM):** The State would replace MNsure with the FFM, which would handle all Marketplace functionality, including consumer assistance and plan management, though HHS has encouraged FFM states to handle plan management duties on an advisory basis. The State would continue to maintain a Medicaid eligibility and enrollment system, and it would need to build a new account transfer functionality to receive application handoffs of Medicaid-eligible individuals from healthcare.gov. As with the SSBM model, the FFM would not be able to accommodate MinnesotaCare, at least for the near future. The annual fee for the FFM is proposed to remain as 3.5% carrier user fee for 2017.
- **Privatized Marketplace:** Under this model, the State would contract with private vendors to provide much of the eligibility and enrollment functionality. The State could purchase either “off-the-shelf” products, customized solutions, or both, potentially enabling the State to achieve full functionality more quickly than if it retains MNsure. The private model, however, is largely untested and requires diligent ongoing state oversight to ensure proper implementation. The costs of the private model are unknown absent a procurement process.

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