
The Impact of the ACA and Exchange on Minnesota

Prepared for Minnesota Department of Commerce

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Introduction

The passage of the Affordable Care Act of 2010 (ACA) is a watershed event that will have wide-reaching implications for health insurance markets, businesses and households. An important feature of the ACA is the wide latitude it leaves states to implement key provisions of the legislation, including the establishment of an Exchange. As such, it is critical that states understand how the ACA will impact their states in order to assess state policy leading up to and after the implementation of the major ACA provisions in 2014.

The Minnesota Department of Commerce has commissioned Gorman Actuarial and Dr. Jonathan Gruber to assess the impact of the ACA on the state and project the effect on insurance coverage, pricing, and budgets in Minnesota. An important element of our analysis is to consider the implications of establishing a Basic Health Plan (BHP) for both low income households and the state government. This report presents the results of this actuarial and economic modeling. This report also includes an Appendix summarizing assumptions and approaches on the various modeling and simulation exercises.

1. Key Findings

The Minnesota Department of Commerce requested two scenarios for us to consider in our modeling exercise.

- Scenario 1: Assume child eligibility at a lower bound income limit of 150% of the federal poverty level (FPL) for a public health insurance program.
- Scenario 2: Assume child eligibility at an upper bound income limit of 275% FPL for a public health insurance program.¹

This section outlines key findings from this study. In both cases, we compare the impacts of the ACA in 2016 with the alternative scenario where healthcare reform was not enacted:

➤ **By 2016, the number of uninsured is projected to decrease by 290,000, or almost 60%**

Due to the individual responsibility requirement, the expansion of public health insurance program eligibility, and the premium tax subsidies, the number of uninsured will drop by 290,000 leaving 210,000 uninsured. Under the 150% FPL case, roughly 37% of this population will receive premium tax subsidies through the Exchange and 28% of this population will receive coverage through a public health insurance program. Another 27% are covered through employer sponsored insurance (ESI) and the remaining 8% will receive unsubsidized coverage through the Exchange.

¹ Eligibility scenarios for children under the 150% FPL and 275% FPL cases also include pregnant women.

➤ **There will be a large rise in non-employer insurance coverage, with little change in employer-provided coverage**

The number of individuals purchasing insurance outside the employment setting will double, rising to between 400,000 and 510,000 enrollees. There will be little change in employer sponsored insurance (ESI) as those who exit due to new insurance options are offset by new enrollment among those previously eligible for ESI.

➤ **The Exchange will enroll over 1.2 million persons**

While there is some uncertainty about who will ultimately purchase insurance through the new state insurance Exchange, we project that between 415,000 and 640,000 privately insured persons will enroll in coverage through the Exchange, either as individuals purchasing on their own or through small group insurance purchase. In addition, another 590,000 to 820,000 publicly insured individuals will be enrolled in public health insurance through the Exchange.

➤ **After the application of tax subsidies, overall premium costs for those in the individual market will fall by 20% on average; approximately 70% of the individual market will experience either no change or premium decreases**

The tax credits available to low income families through the ACA and the Exchange will offset overall premium increases resulting from more comprehensive plan design standards, higher morbidity of new entrants in the market, and the merger of the state's high risk pool into the broader individual market, and lead to net premium cost reductions for those who remain in the individual market.

➤ **Minnesota household budgets will improve by roughly \$500 to \$700 per household in 2016**

This is due to the net effect of larger benefits to households in the form of higher wages, Exchange tax credits, and free public health insurance coverage offset by smaller costs due to the dropping of ESI coverage, a rise in individual market spending, and new net costs due to taxes. Low income households will receive the majority of the benefits of the ACA, while benefits to the middle class are modest.

2. Overview of Modeling Approach

The results of this report represent the coordination of economic (by Jonathan Gruber) and actuarial (by Gorman Actuarial) modeling. In this section we provide a brief overview of those modeling approaches.

GMSIM Overview

The Gruber Microsimulation Model (GMSIM) uses a combination of 2009 data from the Minnesota Health Access Survey (MHAS) and state administrative data to establish a 2011 insurance coverage baseline for the non-elderly (under 65) population. By utilizing population growth projections from the U.S Census Bureau and insurance enrollment projections from the Congressional Budget Office (CBO) and the state of Minnesota, we are able to project forward from this 2011 baseline, and establish a 2016 pre-ACA status quo baseline.

We augment these data with information from survey data received from insurers in each of the individual, small group, and larger group (51-100 employee size) market segments in Minnesota. This survey data included detailed benefit design information, demographic information, claims distributions, rating information and other financial information by insurer. This information was also collected from the Minnesota Comprehensive Health Association (MCHA), the state's high risk pool. Additional descriptions of this survey data can be found in the Gorman Actuarial overview below.

Lastly, we also received detailed data from the Minnesota Department of Human Services on public program enrollment by age and income and wage distribution data from the Minnesota Department of Employment and Economic Development.

These data are then used to implement a detailed microsimulation model of the impacts of ACA and an Exchange on the state. Appendix A of this report provides details on the underlying structure of this model. We consider the following aspects of the ACA, including:

- The expansion of Medicaid, where the ACA mandates coverage of all state residents (who are legal residents) up to 133% FPL. Existing state policy covers adults and children to higher levels of income. In this modeling, we assume that non-pregnant adults above 133% FPL would move from public health insurance to private subsidized coverage through the Exchange. We also assume that children retain their public insurance eligibility up to 150% of poverty and are eligible for private subsidized coverage through the Exchange. But we also consider a scenario where children retain their original eligibility for public health insurance, which extends to 275% FPL. These two income eligibility levels are considered lower and upper bounds of potential eligibility under maintenance of effort requirements under the ACA for existing public health insurance programs for children. As such, there are potential alternative income eligibility and benefit

structure scenarios for children between these lower and upper bounds that have yet to be explored under this model.

- Insurance market reform, whereby insurers face modified community rating (prices can differ by age, but not by health status), must guarantee issue insurance to all applicants and cannot exclude pre-existing conditions. There are also minimum standards put in place for insurance products in the individual and small group markets, most importantly a minimum actuarial value floor of 0.6. Individuals who held policies in the individual market as of March 23, 2010 can remain “grandfathered” into those products.
- An Exchange which provides a competitive shopping place for individual and small group insurance.
- An individual responsibility requirement to purchase health insurance, which applies to those with incomes above the tax filing threshold who can obtain insurance for no more than 8% of their income.
- Employer responsibility payments of \$2,000 to \$3,000 for those employers whose employees use tax credits in the Exchange.
- Tax credits of up to 50% for small and low wage firms.
- New payroll taxes on the highest income families.

Gorman Actuarial Overview

The actuarial modeling was performed by Gorman Actuarial (GA). GA utilized Minnesota insurer specific data collected from an insurer survey administered by the Minnesota Department of Health (MDH). The survey specifically requested information on the individual, small group, and large group 51 to 100 employee size markets. Data collected included detailed plan design information, claims distributions, distribution of health status surcharges and discounts for each market, and detailed demographic data. Claims, premium, membership and rating information was also utilized. GA aggregated the data across insurers where possible. This information was supplemented with publicly available information from the 2010 Supplemental Health Care Exhibits filed by each insurer. Finally, GA received enrollment, claims, benefit and demographic data for the Minnesota Comprehensive Health Association (MCHA), Minnesota’s high risk pool from MDH.

This data and information was used to estimate premium impacts as a result of rating limitations imposed by the ACA. For example, in calendar year 2014 insurers will no longer be allowed to use health status as a rating variable. GA assumes there will be “winners and losers” but the overall premium would remain revenue neutral. In addition, GA utilized the Minnesota specific data to estimate the premium impact of combining the high risk pool with the individual market and merging other market segments.

GA also estimated an actuarial value for each plan design offering. Actuarial value is defined in simple terms as the share of medical costs covered by the health plan. The higher the actuarial value, the more comprehensive, or the richer, the benefit plan design. The lower the actuarial value, the more the member pays for benefits and member cost sharing. For the same benefit plan design, there can be significant variation in estimated actuarial value due to a variation in the assumptions used to calculate them. Actuarial value models use data such as claims distributions and utilization data. The underlying data of a model may vary across geographies due to cost differences as well as different practice patterns. Actuarial value calculations may also vary from one insurer to another within the same state. The U. S. Department of Health and Human Services (HHS) has issued a bulletin that suggests that states will be required to use a federal calculator to calculate actuarial value.² In addition, the bulletin suggests that states may petition to use their own claims distribution data rather than the national data to support the calculations in the federal calculator. The federal calculator will focus on the primary cost sharing elements that impact actuarial value. For these reasons, the actuarial values we show in this report will most likely be different than what will eventually be used in determining the "metal tiers" (bronze, silver, gold or platinum). However, we believe the actuarial values that GA calculates can provide directional guidance. In addition, the analysis performed here may assist the state in determining whether they would like to use state specific data or national data once the federal calculator is developed and released. The actuarial value model developed by GA uses inputs on key cost sharing elements for each product offering, including the deductible, coinsurance, out-of-pocket maximum, copays, and pharmacy benefits. Using the actuarial values, GA estimated the premium impact due to the essential benefit requirement.

Integration of the Approaches

The results of the actuarial modeling analysis are provided to Dr. Jon Gruber who then models the economic effect of the many provisions of the ACA that will impact population movements, including: the expansion of Medicaid to 133% FPL; tax credits for those from 133% to 400% FPL; small business tax credits; penalties on firms whose workers use tax credits in the Exchange; the individual responsibility requirement; and others. Key outputs of GMSIM are the characteristics of those who enroll in the newly formed Exchange. This output is provided back to GA, who models the premium impacts of the change in population mix in the new Exchange relative to the previous individual market. The change in population mix is due to the splitting of the existing individual market pool into grandfathered and non-grandfathered populations, the migration of employer sponsored insurance members, public program enrollees, and high risk pool participants into the Exchange, and the newly insured population. GA then provides these new premiums to Dr. Jon Gruber, who re-models population movements based on the new prices. Through this iterative process our joint team produces both the best estimates of population movements and prices in the new Exchange.

² <http://cciio.cms.gov/resources/files/Files2/02242012/Av-csr-bulletin.pdf>

A Word of Caution

The estimates that are presented here are based on a number of assumptions – and with such assumptions come uncertainty. These are our best projections of the impact of the ACA and the Exchange, but they should not be interpreted as precise point estimates. More useful would be to use the estimates to provide a guide as to the magnitude and direction of the impacts that the ACA and the Exchange will have on Minnesota.

3. Analysis of Impacts to Coverage: Child Public Health Insurance Eligibility at 150% FPL

The first step in our analysis is to model how the ACA will impact insurance coverage in Minnesota. To do so, we contrast two scenarios for the year 2016. We focus on 2016 to allow three years for the ACA to phase in; this follows Congressional Budget Office (CBO) assumptions on the amount of time it takes for the individual responsibility requirement to become fully effective.

The first scenario is a projection for the state of Minnesota without any effects of the ACA. This will reflect underlying trends that would impact insurance enrollment aside from the ACA, but no effects of the ACA itself. The second scenario is the projection for that same year for Minnesota with the ACA in place. The difference between these two scenarios is the projected impact of the ACA relative to the “counterfactual” results had the ACA not been implemented.

As noted above, we consider lower and upper bound income eligibility cases for the state: the first where public health insurance eligibility is set at 150% FPL for children, and the second where public health insurance eligibility levels for children is set at 275% FPL.

The results for overall insurance coverage for the non-elderly population in Minnesota are presented in Table 1. The first row shows that we project only a very small change in employer sponsored insurance (ESI) due to the ACA. We project that the unreformed or “grandfathered” individual market will decline precipitously as individuals move to the newly reformed market, including the Exchange. The net result of these movements is that total enrollment in the individual market roughly doubles. There is no net change in public health insurance in this scenario. The share of the population that is uninsured falls by almost 60%, with a net reduction in the uninsured of 290,000.

Table 1: Estimate of ACA Effect: 2016

	No Reform	With ACA	ACA Impact
ESI	3,130,000	3,120,000	-10,000
>Small Firm ESI (1-50 employees)	420,000	420,000	0
51 – 100 employees	120,000	120,000	0
Unreformed Individual Market	260,000	50,000	-210,000
Reformed Individual Market	0	510,000	510,000
Public Insurance	690,000	690,000	0
Uninsured	500,000	210,000	-290,000
Total	4,580,000	4,580,000	

Table 1 – Estimate of ACA Effect: Non-Elderly Population 2016

The lack of enrollment change in public health insurance is somewhat surprising, so we further decompose those results in Table 2. We see here that the net change of zero represents the offsetting effects of both additions and subtractions to enrollment in public health insurance programs including Medicaid and MinnesotaCare. There are about 110,000 individuals who leave public health insurance as the eligibility is set at lower income levels and these people move to private coverage with subsidies through the Exchange. At the same time, about 50,000 persons join public health insurance who are made newly eligible by the expansion of Medicaid to those below 133% of poverty. Another 60,000 individuals who were previously eligible for public health insurance now enroll due to the individual responsibility requirement. These inflows cancel the outflows due to public health insurance eligibility being set at 133% FPL for adults and 150% FPL for children.

These population flows reflect inflows and outflows between public health insurance and private coverage; they do not reflect changes in enrollment between different types of public health insurance programs. For example, this table does not reflect population flows from MinnesotaCare to Medicaid as a result of the expansion of Medicaid to 133% FPL for single adults as these adults are already counted in the public health insurance category.

Table 2: Changes in Public Enrollment Due to ACA: 2016

Leaving Public to Private Exchange Subsidies	110,000
Leaving Public Voluntarily	0
Joining Public, Newly Eligible due to Expansion up to 133% FPL	50,000
Joining Public, Previously Eligible	60,000
Net Change	0

Table 2 – Changes in Public Enrollment Due to ACA: 2016

3.1. The Uninsured

Figure 1 shows the sources of coverage for those gaining health insurance due to the ACA. About one-quarter of those gaining coverage are obtaining coverage from employers. As we will see shortly, these are largely individuals who were previously eligible for ESI who now take up that insurance offer due to the individual responsibility requirement. A roughly equal share obtain coverage through public health insurance. The largest source of new coverage is subsidized coverage through the reformed individual insurance market, including the Exchange, while fewer than 10% of individuals obtain coverage through the reformed market without subsidies.

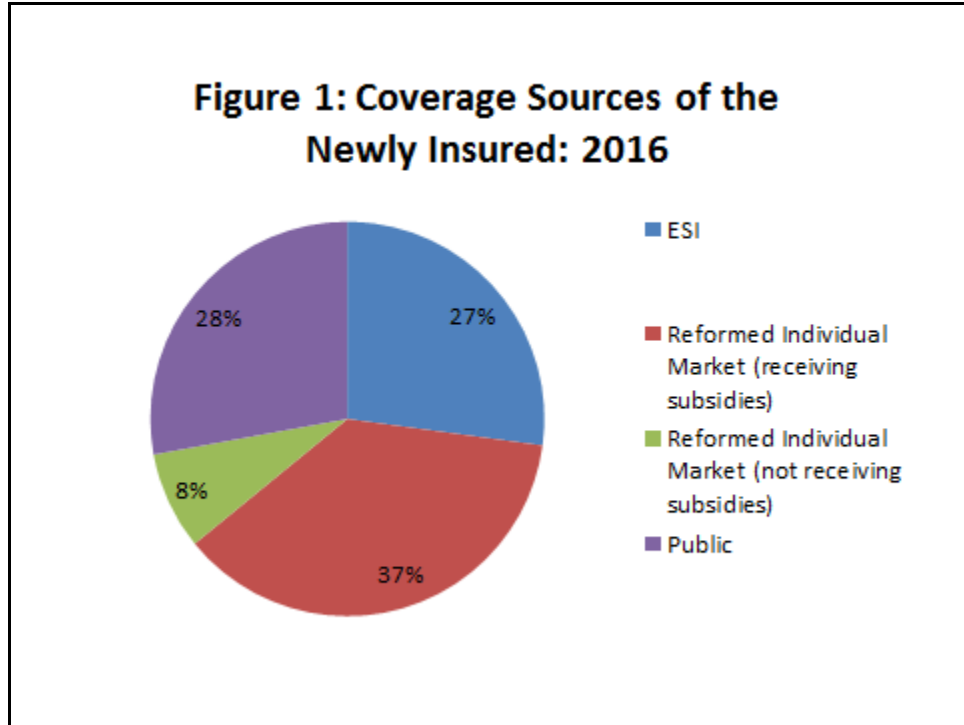


Figure 1 – Coverage Sources of the Newly Insured: 2016

The income distribution of those gaining insurance coverage is shown in Figure 2. The largest group gaining coverage is those between two and four times the poverty line, with somewhat smaller but equivalent shares gaining coverage below 133% of poverty and from 133-200% of poverty, respectively. Only 8% of those who gain coverage have incomes above four times the poverty line.

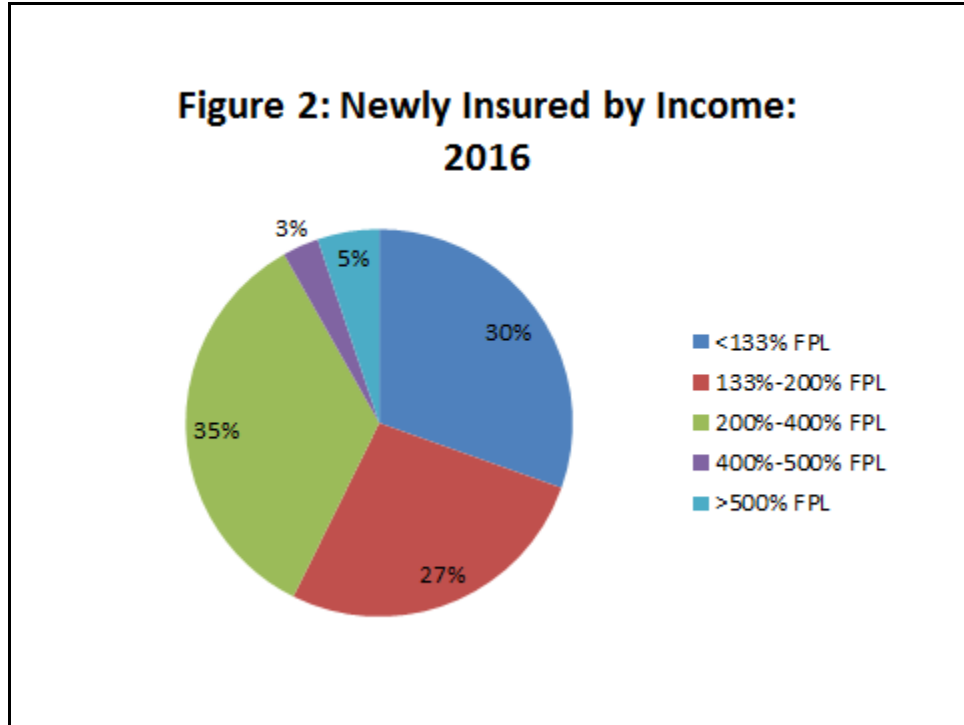


Figure 2 – Newly Insured by Income: 2016

Despite the decrease in the number of uninsured, under the ACA there will still be around 210,000 uninsured individuals in 2016. Figure 3 shows the breakdown of those remaining uninsured.

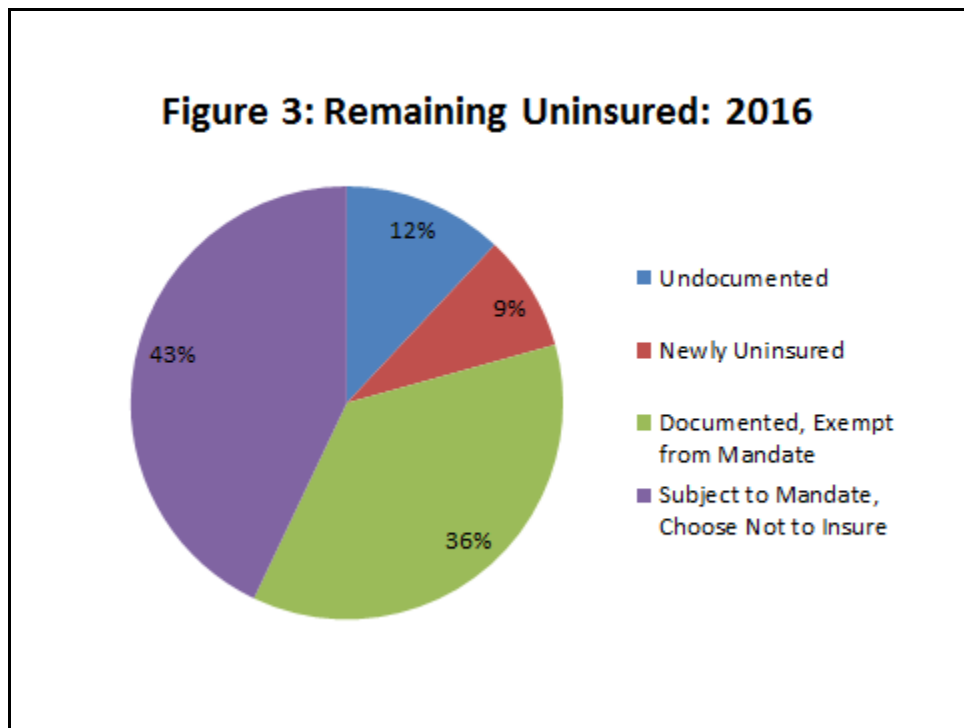


Figure 3 – Remaining Uninsured: 2016

About 9% of those who remain uninsured after the ACA are individuals who were actually insured absent the ACA, but who lose insurance, largely due to reductions in employer sponsored insurance. The remainder of this chart represents individuals who were uninsured absent the ACA and remain so even with the ACA. About one-eighth of those who are uninsured after the ACA are undocumented immigrants. The coverage provisions of the ACA are explicitly denied to undocumented immigrants, so there is little reason to believe that the ACA will improve insurance coverage in this population. The remaining 79% of individuals uninsured even after the implementation of the ACA can be split into two categories, those who are exempt from the individual responsibility requirement/coverage mandate (because their income is below the individual tax filing threshold or because insurance costs more than 8% of their income) and those that are subject to the individual responsibility requirement and still choose to remain uninsured. Thirty-six percent of the remaining uninsured are in the exempt group and 43% are in the group choosing to ignore the individual responsibility requirement. In total, the 210,000 remaining uninsured represent less than 5% of the non-elderly population. Please see Appendix B for a detailed distribution of coverage sources, the newly uninsured, and the remaining uninsured by race and ethnicity.

3.2. Employer Sponsored Insurance

As previously mentioned, ESI will experience only a small net decline in enrollment, although there will be larger gross flows within the employer sponsored insurance population. There are a few reasons for this lack of effect. The first is that the full effects of the ACA will take a few years to manifest themselves. Exchange enrollment is expected to phase-in over the first 3 to 4 years of the ACA, so 2016 impacts on ESI enrollment will be somewhat muted. The second major reason is that firms will not generally take up some of the incentives provided by the ACA to drop coverage. This is due to the employer responsibility requirement codified in the ACA. Firms with 50 or more employees will face fines if they do not offer adequate, affordable policies to their employees and those employees as a result become eligible for and utilize premium tax credits through the Exchange to purchase coverage. These fines partially offset the financial incentives to drop coverage and shift employees to the Exchange. In addition, the presence of the individual responsibility requirement provides an incentive for individuals to pressure employers to maintain ESI coverage. Since insurance coverage is mandatory at the individual level, employees will desire the security provided by the ESI plans they are already enrolled in. Furthermore, evidence from the recent health insurance reform in Massachusetts suggests that most firms will not drop coverage, even with the presence of a viable alternative like the Exchange. It is not clear how relevant this experience is for Massachusetts given the differences in the two states, but it further confirms the conclusions from our analysis (and CBO's) that show small effects on employers.

Figure 4 summarizes the flow in and out of ESI in 2016. In this figure we divide the ESI movements into three categories: those dropped by their firm; those who voluntarily leave employer sponsored insurance to move to the Exchange, Medicaid, or even to become uninsured; and those who join employer sponsored insurance either due to

changing prices, the individual responsibility requirement, or the expansion of dependent coverage to young adults. The last set of bars shows the very small overall net effects.

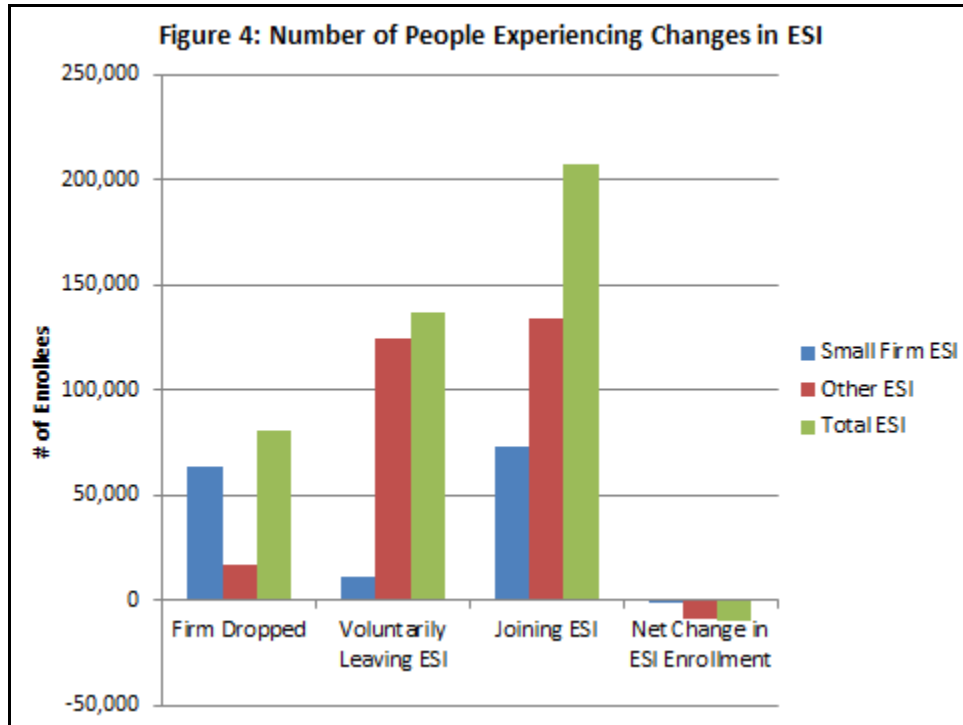


Figure 4 – Number of People Experiencing Changes in ESI

We estimate that roughly 75,000 individuals are dropped from ESI, mostly by small firms. Another 140,000 individuals voluntarily leave ESI for other forms of insurance. But at the same time about 210,000 persons join ESI. Thus, we get only a small net effect on ESI coverage.

3.3. Individual Insurance Market and the Exchange

By 2016, individuals desiring non-group insurance can participate in one of three different markets. The first is to stay in the traditional individual market by maintaining their “grandfathered” plan (which was held in 2010). Individuals in this market will be able to retain non-community rated insurance policies, but they will not be eligible for the new tax credits. This market will decline substantially by 2016, however, as very few individuals maintain consistent individual market coverage for that long a period. The second is to move to the new Exchanges, which are adjusted community rated and provide federal subsidies for those who are eligible. The third is to move to the newly reformed market, but to purchase a policy outside of the Exchange. This may be attractive for non-subsidized individuals if there are a wider variety of health plan choices available outside the Exchange.

The Exchange will also garner enrollment from employees in small firms. This will include any enrollees in small group insurance who wish to take advantage of the small

business tax credit, which must be claimed through the Exchange, as well as other firms with fewer than 100 employees who find it attractive to purchase through the Exchange. Finally, the Exchange will be the source of eligibility determination and enrollment for (non-disabled, non-elderly, and non-waivered) children and adults signing up for Medicaid.

Table 3 forecasts the size of the Exchange in Minnesota. The first column shows the number of persons projected to be in each category that might use the Exchange, while the second column shows the projected Exchange enrollment from that group. For tax credit recipients in both the individual and small group markets, 100% of those in the group are enrolled in the Exchange, since tax credit receipt requires Exchange enrollment. For individuals and small firms that do not receive tax credits, there will only be partial enrollment, as the Exchange competes with outside markets; we assume that half of such individuals, and one-quarter of small firms, will choose to enroll in the Exchange, but the outcome here will very much depend on future decisions that impact the attractiveness of the Exchange as a source of insurance purchase. Finally, we add publicly insured individuals who will now be enrolling through the Exchange; this number is smaller than the number with public health insurance presented in Table 1 due to the fact that non-elderly disabled individuals have a different basis of eligibility and are not required to determine eligibility or enroll in coverage through the Exchange.

Table 3: Predicting the Size of the Exchange, 2016

	No BHP		With BHP	
	# of individuals	Enrollment in the Exchange	# of individuals	Enrollment in the Exchange
Tax credit Recipients	390,000	390,000	190,000	190,000
Enrollees in Firms <50 Receiving Tax Credit	70,000	70,000	70,000	70,000
Non-tax Credit Recipients in Reformed Market	Up to 120,000	60,000	Up to 140,000	70,000
Enrollees in Firms <50 Not Receiving Tax Credit	Up to 350,000	90,000	Up to 350,000	90,000
Enrollees in firms 50-99	Up to 120,000	30,000	Up to 120,000	30,000
Public Insurance Enrollees	590,000	590,000	780,000	780,000
Total Exchange Enrollment		1,230,000		1,230,000

Table 3 – Predicting the Size of the Exchange: 2016

In total, we estimate that over 1.2 million individuals will pass through the Exchange. About half will be purchasing insurance on the Exchange, and about half will be the publicly insured determining eligibility and enrolling through the Exchange.

Later in the report we will discuss the state’s choice about whether to offer a Basic Health Plan (BHP) option. If the state does so, it will greatly reduce the number of tax credit recipients purchasing through the Exchange, and raise the number of publicly insured enrolling through the Exchange, but the total number of individuals passing through the Exchange remains unchanged.

4. Analysis of Impacts to Coverage: Child Public Health Insurance Eligibility at 275% FPL

In this section we turn to the upper bound scenario where the state continues to move adults from public health insurance above 133% of poverty to private subsidies through the Exchange, but maintains public health insurance eligibility for children up to 275% FPL.

The results for overall insurance coverage are presented in Table 4. The results for ESI and the unreformed individual market are identical to those in Table 1. The major difference in this table is that the reformed individual market grows only to 400,000 persons, while public health insurance rises by 120,000 (rather than remaining unchanged).

Table 4: Estimate of ACA Effect: 2016

	No Reform	With ACA	ACA Impact
ESI	3,130,000	3,120,000	-10,000
>Small Firm ESI (1-50 employees)	420,000	420,000	0
>51 – 100 employees	120,000	120,000	0
Unreformed Individual Market	260,000	40,000	-220,000
Reformed Individual Market	0	400,000	400,000
Public Insurance	690,000	810,000	120,000
Uninsured	500,000	210,000	-290,000
Total	4,580,000	4,580,000	

Table 4 – Estimate of ACA Effect: Non-Elderly Population 2016

Table 5 once again shows the sources of change in public health insurance. There are two noticeable differences from Table 2. First, 60,000 fewer children leave public health insurance because they are not moved to the Exchange. Second, 60,000 more children

join public health insurance because eligibility for public health insurance coverage is maintained at 275% FPL. Therefore, on net, 120,000 more children are on public health insurance coverage in this case relative to the case where eligibility for children is set at 150% FPL. As in Table 2, these population flows reflect inflows and outflows between public health insurance and private coverage; they do not reflect changes in enrollment between different types of public health insurance programs.

Table 5: Changes in Public Enrollment Due to ACA: 2016

Leaving Public to Private Exchange Subsidies	50,000
Leaving Public Voluntarily	0
Joining Public, Newly Eligible due to Expansion up to 133% FPL	50,000
Joining Public, Previously Eligible	120,000
Net Change	120,000

Table 5 – Changes in Public Enrollment Due to ACA: 2016

Table 6 forecasts the size of the Exchange in Minnesota, using the same format as Table 3. The only difference here is that there are fewer tax credit recipients, and an equal rise in the number enrolling in public health insurance through the Exchange. So the total use of the Exchange remains constant, although in these cases (both with and without BHP) more use of the Exchange comes through public health insurance eligibility determination and enrollment.

Table 6: Predicting the Size of the Exchange, 2016

	No BHP		With BHP	
	# of individuals	Enrollment in the Exchange	# of individuals	Enrollment in the Exchange
Tax credit Recipients	280,000	280,000	160,000	160,000
Enrollees in Firms <50 Receiving Tax Credit	70,000	70,000	70,000	70,000
Non-tax Credit Recipients in Reformed Market	Up to 120,000	60,000	Up to 130,000	65,000
Enrollees in Firms <50 Not Receiving Tax Credit	Up to 350,000	90,000	Up to 350,000	90,000
Enrollees in firms 50-99 Public Insurance	Up to 120,000	30,000	Up to 120,000	30,000
Enrollees	700,000	700,000	820,000	820,000
Total Exchange Enrollment		1,230,000		1,235,000

Table 6 – Predicting the Size of the Exchange: 2016

5. Impacts on Individual Market Premiums

There are many changes that will take place starting in 2014 that will affect premiums within the individual market. Some changes will affect just portions of the individual market and others will affect the market as a whole. We have focused our modeling and assumptions on the five categories of change listed below. Note that these estimates do not reflect the impact of the risk adjustment, reinsurance, and risk corridor programs that are mandated by the ACA, which may mitigate premium changes due to the law. Since it is still unknown as to how these programs will be designed, we have not shown their potential impact in the numbers below. However, we do provide some analysis around the federal Individual Market Reinsurance Program further in the report. In addition, these premium impacts do not reflect the impact of annual medical trends. These premium impacts are shown prior to the implementation of the federal tax subsidy. There will be a portion of the individual market that will be eligible for these subsidies. We show premium impacts after the subsidies later in the report.

- (1) **The impact of product limitations:** While the essential benefits coverage has yet to be determined in Minnesota, we assumed that benefits such as pharmacy and physician visits will be included as specified in the ACA. In addition, we assumed that the minimum actuarial value allowed in 2014 will be 0.60 as specified in the ACA. The exception to this is the catastrophic plan for the 18 to

30 year olds. We have assumed a minimum actuarial value of 0.45 for this plan.³ This will require the majority of the market to “buy up” and will therefore result in premium increases. However, along with premium increases will be more comprehensive health insurance coverage. We have estimated the premium impact due to product limitations to the entire individual market to be **8% to 11%**.

- (2) **The impact of rating limitations:** Insurers are currently allowed to adjust premium rates for health status in the Minnesota individual market. These health status adjustments must be within a +25%/-25% band around an index rate. This translates into a 1.667 to 1 band (1.25/.75). In 2014 and beyond, the ACA will no longer allow health underwriting as a rating variable. Insurers who currently adjust premiums for health status will no longer be able to do this. However, insurers will still be allowed to adjust premiums up to 50% for smoking status. In addition to the elimination of health underwriting, the ACA also imposes other rating limitations such as the elimination of gender rating and the limiting of age rating for adults to a 3 to 1 band. In Minnesota today, insurers are not allowed to gender rate and are required to adjust premiums for age as long as the adjustments are within a 3 to 1 rating band. It appears there may be some differences in how the age rating limitations in the current Minnesota market compare to the age rating limits in the ACA, but is unclear if Minnesota will need to make any changes to their age rating limits as a result of these differences. We have identified that the most significant change to the Minnesota individual market will be the elimination of health status as a rating variable. This will increase premiums for a healthier demographic and decrease premiums for the less healthy. However, we believe the rating limitations alone will not affect overall average premiums.
- (3) **The impact of merging Minnesota Comprehensive Health Association (MCHA) with the individual market:** In 2014, we have assumed that MCHA would begin migrating into the individual market rating pool as guarantee issue becomes a requirement in 2014. We estimate that by 2016 merging MCHA with the existing individual market will increase overall premiums for the individual market by **10% to 15%**.
- (4) **The impact of the new Exchange market:** In 2014, with the introduction of the individual responsibility requirement, the tax subsidies provided within the Exchange, and a move of some individuals from public health insurance coverage to the private coverage tax subsidies through the Exchange, there will also be new individual market entrants. These new individual market members will come primarily from the uninsured and public health insurance and to a lesser extent from employer sponsored insurance. These new members will have an impact on the existing individual market premiums and the magnitude of the impact will depend on how their risk profile compares to the risk profile of the individual

³ Gorman Actuarial is unaware of any regulation or guidance pertaining to the Catastrophic Plan as allowed within the ACA. The 0.45 Actuarial value limit is an assumption.

market. This last modeling exercise was performed by Dr. Gruber using his microsimulation model (GMSIM). Neither we nor Dr. Gruber have incorporated in our modeling the impact of the risk adjustment, reinsurance, and risk corridor programs that are mandated by the ACA, which may mitigate premium changes due to the law. In the absence of these programs, we find that premiums for the entire individual market as a result of these new entrants may increase an additional **15% to 20%**.

- (5) **Managed Competition Effect:** The introduction of transparency and easy comparison through an Exchange and corresponding tax subsidies provides insurers with a membership growth opportunity and incentive to be more competitive. Insurers may strive to achieve efficiencies which may lead to lower premiums within the Exchange. Dr. Gruber has assumed a **7.5%** reduction in premiums due to this effect, which follows the efficiencies assumed by the CBO in their analysis.

Table 7 below illustrates the estimated premium impact to the individual market, prior to the application of premium tax subsidies. The overall expected premium impact is 26% to 42%, with a best estimate of 29%. Note that these results are assuming that public health insurance eligibility is set at 150% FPL for children and that there is no Basic Health Plan in Minnesota. Additional information pertaining to the 275% case and the Basic Health Plan are presented in Section 9 related to the merged market analysis. These premium changes do not include the 2010 ACA changes related to preventive services, annual limits and lifetime limits, which are estimated to increase premiums from 1% to 3%. As detailed above, the overall impact of the elimination of health status rating is 0%, but note that each individual may be impacted differently.

	Minimum	Maximum
Minimum Essential Benefit Requirement	8%	11%
MCHA	10%	15%
New Risk Mix of Individual Market Pool	15%	20%
Managed Competition Effect	-7.5%	
Premium Change	26%	42%
Best Estimate	29%	

Table 7 – MN Individual Market Summary of Premium Change

5.1. Impact of Product Limitations

The benefit plans of members in the current individual market and small group market differ greatly. In general, plans in the individual market are much less rich than plans in the small group market. For example, less than 0.1% of members in the individual market have a plan with a zero dollar deductible, whereas 22% of members in the small group market have such a benefit plan.

Distribution of single policy in-network deductible also varies significantly between the two markets. As shown in Table 8, nearly all small group market members have deductibles less than \$3,000. In the individual market, only two-thirds have a deductible less than \$3,000, with more than 9% having deductibles greater than \$5,000.

Single Policy In-Network Deductible	% Individual Market	% Small Group Market
\$0	0.1%	21.7%
<= \$1,000	13.1%	34.1%
\$1,150 - \$2000	33.9%	17.9%
\$2,100 - \$3,000	18.2%	26.2%
\$3,100 - \$5,000	25.5%	0.1%
\$5,100 - \$9,300	3.6%	0.1%
\$10,000	4.6%	0.0%
\$15,000	0.9%	0.0%

Table 8 – 2009 Market Share by Deductible

GA estimated the actuarial value for the most popular benefit plans in each of the individual and small group markets. At a high level, the actuarial value represents the average percent of medical expenses that would be paid by an insurer. The higher the actuarial value, the more comprehensive or the richer the plan design. The lower the actuarial value, the more the member pays in member cost sharing. For this analysis GA used data provided as part of the insurer survey. This information included the number of covered lives for each benefit plan and several plan attributes, including annual deductible, out of pocket maximum, coinsurance, copayments, benefit limits and prescription drug benefits. GA calculated high-level actuarial values using GA pricing models that take into account varying cost sharing by major service categories including inpatient, outpatient hospital, primary care visits, specialist visits, emergency room visits and pharmacy.

Beginning in 2014, the ACA will require that all individual and small group benefit plans cover a set of “essential benefits”. The specifics of the essential health benefits have not

yet been determined for Minnesota, but the framework defined in the ACA includes maternity care, behavioral health treatment, and prescription drugs.

The ACA will also require that all plan designs (excluding catastrophic plans⁴) provide benefits at a minimum actuarial value of 0.60 (“Bronze” level). Member cost sharing will be limited to \$5,950 per individual policy or \$11,900 per family policy. Many individuals will be required to “buy up” to more comprehensive plan designs that meet at least the Bronze standard.

Approximately 44% of Minnesotans in the individual market are currently enrolled in benefit plans that have an actuarial value below the ACA minimum of 0.60. Figure 5 5 shows that benefit plans in the individual market vary widely. There are many people with “bare bones” plans that have high deductibles, copays and out of pocket expenses, and there are others with more rich benefit plans. About 13% of individuals in the individual market are in plans with an AV greater than 0.8.

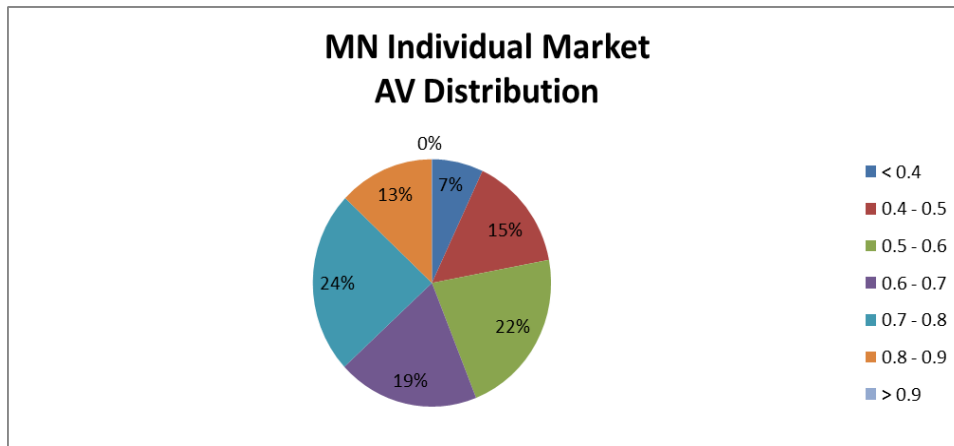


Figure 5 – 2009 Individual Market Actuarial Value Distribution

We have estimated the overall premium impact due to the ACA’s product requirements will increase premiums 8% to 11%. Our modeling assumes that individuals must be enrolled in a minimum actuarial value plan of 0.60 for non-catastrophic plans and 0.45 for catastrophic plans. Note that these increases do not take into account other aspects of the ACA, such as premium tax subsidies or cost sharing subsidies.

5.2. Impact of Rating Limitations – Elimination of Health Underwriting

Health underwriting today is variable across insurers. Insurers who aggressively underwrite today will experience greater premium disruption while those insurers that

⁴ Individuals under 30 years of age or those exempt from the individual responsibility requirement because no affordable plan is available to them may purchase a catastrophic plan providing the essential benefits package with a deductible of \$5,950 for a single policy (\$11,900 for a family policy) and first dollar coverage for at least three primary care visits. These plans will not be required to meet the 0.60 minimum actuarial value standard.

moderately underwrite will experience lesser premium shocks. In addition, some insurers only use a smoking surcharge, other insurers only use a health status adjustment, and others use a combination of the two. Approximately 6.0% to 6.5% of the market is estimated as smokers with an average surcharge of 23%.⁵

We also calculated the average surcharges and discounts to premiums due to health status adjustment in the individual market. These surcharges/discounts were normalized so that the overall surcharge/discount by insurer averages to 1.0 when weighted by member months. Note that these surcharges and discounts will also include smoking adjustments as some insurers were unable to disaggregate these rating adjustments. As shown in Table 9, in 2009, 85% of the market received a slight discount (-2%) and 7.2% of the market either received no surcharge or a minimal surcharge (1%). The remaining 8.3% of the market received an average surcharge of 25%. Approximately three quarters of the 8.3% are smokers (~6% of the market). Based on our analysis of current rating practices in the market, it appears that there is more emphasis placed on the smoking adjustment than the health status adjustment.

Health Status/Smoking Surcharges & Discounts	% Distribution	Average Surcharge/Discount
-10% to 0%	84.6%	-2%
0 to 10%	7.2%	1%
10% to 20%	1.5%	14%
20% to 30%	5.3%	24%
30% to 40%	1.2%	33%
40% to 50%	0.2%	46%
50% to 60%	0.2%	53%
60%+	0.1%	62%
Grand Total	100.0%	0.0%

Table 9 – MN Individual Market Distribution of Premium Surcharges and Discounts

The elimination of health status as a rating variable has minimal impact on the market as a whole. However, it does vary by insurance insurer depending on the insurer’s current rating and underwriting practices. Insurers that use health underwriting will experience more premium disruption, especially those that aggressively health underwrite. The guaranteed issue provisions within the ACA will no longer allow insurers to deny coverage due to member health status. In order to understand the impact of guaranteed issue, we compared data from insurers that use health status as a rating variable to those that do not.⁶ We analyzed claims PMPMs and adjusted for benefits so that we were analyzing claims experience on a more consistent basis. Our findings show that medical costs for a health plan that does not health underwrite can be approximately 100% higher

⁵ Smoking analysis based on those insurers that were able to report smoking status.

⁶ One insurer was excluded from this analysis due to lack of claims data.

than a health plan that does. Note that our analysis did not reflect the provider reimbursement differences among insurers. While this is an interesting finding, these results are absent an individual responsibility requirement which we anticipate will limit this selection issue. However, we can conclusively say that in 2014 those insurers that currently health underwrite in the market will experience higher premium increases than those that do not when guaranteed issue is required and health underwriting is prohibited. Portions of the market that do experience significant premium increases will be more apt to “shop around” for new insurance. Due to this, these same insurers may experience greater membership migration as well. While the overall change to the market is expected to be revenue neutral prior to any member migration, it is expected that premium changes as a result of the elimination of health underwriting will range from a 7% decrease to an 18% increase.

5.3. Impact of Minnesota Comprehensive Health Association

Due to changes in the market rules under the ACA, including guarantee issue and the elimination of health underwriting, it is expected that some portion of the current Minnesota high risk pool, known as the Minnesota Comprehensive Health Association (MCHA), will become part of the individual market in 2014. The premiums for MCHA are currently set at up to 125% of the standard rate in the individual market. In addition to member premiums, MCHA is also funded through state assessments.

We have made the assumption that between 2014 and 2016 an increasing number of members from the high risk pool will migrate to the individual market:

- 40% in CY 2014 (11,000 members)
- 60% by CY 2015 (16,500 members)
- 80% by CY 2016 (22,000 members)

GA reviewed the distribution of claims for MCHA members and compared their claims to the current individual market. We assumed that the healthier of the high risk pool members would migrate to the individual market. GA estimated that the members who migrate to the individual market from MCHA will have, on average, claim costs that are 70% lower than members who remain in MCHA. As a result of these assumptions, we have estimated that the overall impact to the individual market as a result of the migration of MCHA members in 2016 will be an increase in the individual market premiums of **10% to 15%.**

The MCHA assessment in 2010 was approximately \$143 million, which is estimated to represent a 2.4% increase in the commercial rates. MCHA funding may still be required in 2014. The state may continue to use the MCHA assessment for funding purposes, recognizing that the assessment could be reduced each year as the membership in MCHA declines. The state may also be able to use funds from the Transitional Individual Market Reinsurance fund. Note that this is for the entire individual market and it is unclear how much would be allocated to MCHA, especially given the fact that the individual market will experience a large increase in membership by 2016, as detailed above. In addition, the HHS regulations specify that the reinsurance program will most likely be a corridor

type program with a threshold, coinsurance and a reinsurance cap. MCHA would still need to fund the claims up to the threshold level, the coinsurance difference and any claims above the reinsurance cap.

5.4. Individual Market Premium Impacts After Implementation of Tax Subsidy

Many changes will take place in 2014 that will impact what a consumer will pay in the individual market. Federal premium tax subsidies will be offered through the Exchange, based on income. After receiving premium changes from Gorman Actuarial, Dr. Gruber modeled the effect of the tax subsidy on the individual market. Note that, once again, our results do not account for any further reduction in premiums from state risk adjustment/reinsurance or from redirecting the high risk pool assessment. As shown in Figure 6, half the individual market will experience premium decreases while 32% of the market will experience premium increases.

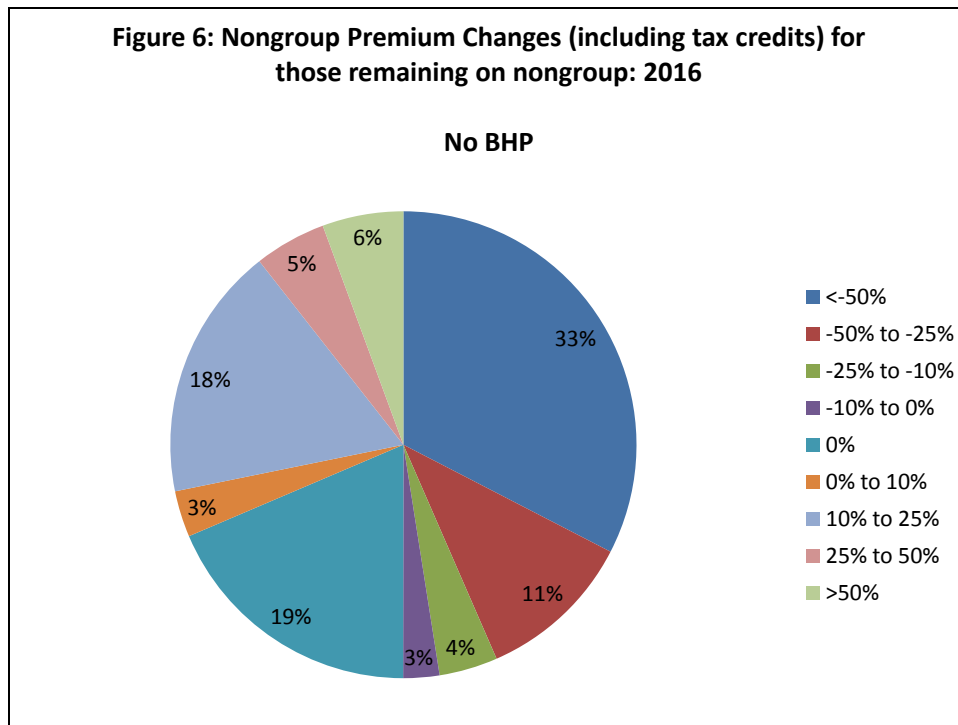


Figure 6 – Nongroup Premium Changes (including tax credits) for those remaining on nongroup: 2016, 150% FPL Case and No BHP

5.5. Individual Market Annual Fees

The ACA imposes an annual fee on health insurers that is equal to \$8 billion in 2014, \$11.3 billion in 2015 and 2016, \$13.9 billion in 2017 and \$14.3 billion in 2018. The fee will be based on the market share by premium for all commercial, Medicare, and Medicaid health plans. Non-profits with greater than 80% of gross revenues from

government programs and those plans with less than \$50 million in premiums are exempt from this fee. It is assumed that insurers will build this fee into their premiums. GA estimated the 2016 fee based on 2016 expected enrollment and the percentage of premiums reported in the 2010 Supplemental Health Care Exhibit for Minnesota. It is estimated the annual fees for Minnesota insurance insurers for 2016 will be \$175 million, which will increase premiums approximately 1%.

5.6. Transitional Reinsurance Program

The ACA establishes a transitional reinsurance program from 2014 to 2016 for the individual market. This program is designed to mitigate some of the cost uncertainty in the individual market that will have many new entrants during this time. The program is temporary (three years) in order to stabilize premiums while insurers develop a better understanding of the costs of the expanded individual market.

Both the fully-insured and self-insured markets will be assessed to fund a new not-for-profit reinsurance entity that will help pay benefits for higher cost members in non-grandfathered individual market plans. HHS will develop the baseline assessment as a percentage of premiums for fully-insured insurers, and a percentage of medical claims for self-insured plans. The assessment percentages will decline each successive year of the reinsurance program. The initial 2014 federal baseline will target assessments of \$10 billion nationally with targets declining to \$6 billion in 2015, and \$4 billion in 2016. Minnesota's share will be in proportion to its share of premiums and self-insured medical costs nationally.

HHS will also establish the baseline attachment point (the threshold of benefit costs above which a member qualifies for reinsurance), reinsurance cap (the maximum benefit costs covered by reinsurance) and the coinsurance rate (the percentage of costs between the attachment point and cap to be covered by reinsurance). States will have flexibility to modify many of these provisions including higher assessments than the federal baseline.

Assessments will need to cover reinsurance payments plus administrative costs at the state and federal level. If assessments are not enough to cover payments, payments will be reduced pro-rata. States will be required to collect significant data from all payers in the market in order to administer the reinsurance program.

Note that as the funding decreases each year and individual market enrollment increases each year, the effect of the reinsurance program gets smaller. HHS had indicated a 15% premium reduction in 2014, however this is when the individual market is the smallest and funding is the greatest. GA estimates the premium reduction for the Minnesota individual market in 2016 to be approximately 2.5%. However the rest of the market's premiums will increase up to approximately 0.5% due to the reinsurance program assessment.

5.7. Caveats

In our analysis, we do not incorporate either the effect of the annual fees on insurance or the effect of the temporary reinsurance pool in 2016; as noted above, the net of these two would likely be minimal reduction in insurance costs. If the reinsurance program is eliminated in 2017, there may be a slight increase in insurance costs. In addition, we do not account for the fact that the existing subsidized funding for MCHA will fade over time, potentially freeing up those dollars to use to reduce premiums in the reformed insurance market.

6. Impacts on Small Group Market Premiums

Like the individual market, there are many changes that will take place starting in 2014 that will affect small group premiums. We have focused our modeling on two categories of change which are listed below. Please note that this modeling exercise is performed on the total small group premium which includes the employer and employee portions of the premium.

- (1) **The impact of product limitations:** While the essential benefits coverage has yet to be determined for Minnesota, we assumed benefits such as pharmacy and physician visits will be included as specified in the ACA. In addition, we assumed that the minimum actuarial value allowed in 2014 will be 0.60 as specified in the ACA. The exception to this is the catastrophic plan for the 18 to 30 year olds. We have assumed a minimum actuarial value of 0.45 for this plan.⁷ This will require the majority of the market to “buy up” and will therefore result in premium increases. However, along with premium increases will be more comprehensive health insurance coverage. We have estimated the premium impact due to product limitations to the entire small group market to be **minimal**. **We have performed additional sensitivity analysis on this assumption in Section 6.1.**
- (2) **The impact of rating limitations:** Insurers are currently allowed to adjust premium rates for health status in the Minnesota small group market. These health status adjustments must be within a +25%/-25% band around an index rate. This translates into a 1.667 to 1 band (1.25/.75). In 2014 and beyond, the ACA will no longer allow health underwriting as a rating variable. Insurers who currently adjust premiums for health status will no longer be able to do this. However, insurers will still be allowed to adjust premiums up to 50% for smoking status. In addition to the elimination of health underwriting, the ACA also imposes other rating limitations such as the elimination of gender rating, the elimination of group size adjustments and the limiting of age rating for adults to a 3-to-1 band. In Minnesota today, insurers are not allowed to gender rate and are

⁷ Gorman Actuarial is unaware of any regulation or guidance pertaining to the Catastrophic Plan as allowed within the ACA. The 0.45 Actuarial value limit is an assumption.

required to adjust premiums for age as long as the adjustments are within a 3 to 1 rating band. It appears there may be some differences in how the age rating limitations in the current Minnesota market compare to the age rating limits in the ACA, but it is unclear if Minnesota will need to make any changes to their age rating limits as a result of these differences. We have also observed that insurers currently do not apply group size adjustments in the small group market. Therefore, we have identified that the most significant change to the Minnesota small group market will be the elimination of health status as a rating variable. This will increase premiums for a healthier demographic and decrease premiums for the less healthy. However, we believe the rating limitations alone will not affect overall average premiums. However, note that while the overall impact of the elimination of health status rating is zero, each group may be impacted differently.

Given the minimal impact of the benefit requirements in the small group market along with minimal member migration assumed in the employer sponsored insurance segment, there is expected to be minimal overall premium impact to the small group market in 2016 as a result of the ACA.

While the managed competition effect has been modeled in the individual market, we have not explicitly modeled it for the small group market. There has been some evidence that due to increased transparency and the greater membership potential in the individual market, there may be some downward pressure on price. Similar pressures may occur in the small group market, especially within a defined contribution model within an Exchange. It is difficult to quantify the premium reduction for the small group market, but it is likely to be less than the 7.5% savings used in the individual market.

6.1. Impact of Product Limitations

The small group market is enrolled in benefit plans that are in general much richer than the individual market. As shown in Figure 7, less than 1% of the market is enrolled in plans that are below the ACA minimum actuarial value of 0.60 compared to 44% in the individual market. Also note that nearly 54% of the small group market is in plans with an AV greater than 0.80, compared to only 13% in the individual market. There will be a minimal overall premium impact due to the minimum actuarial value requirement in the small group market.

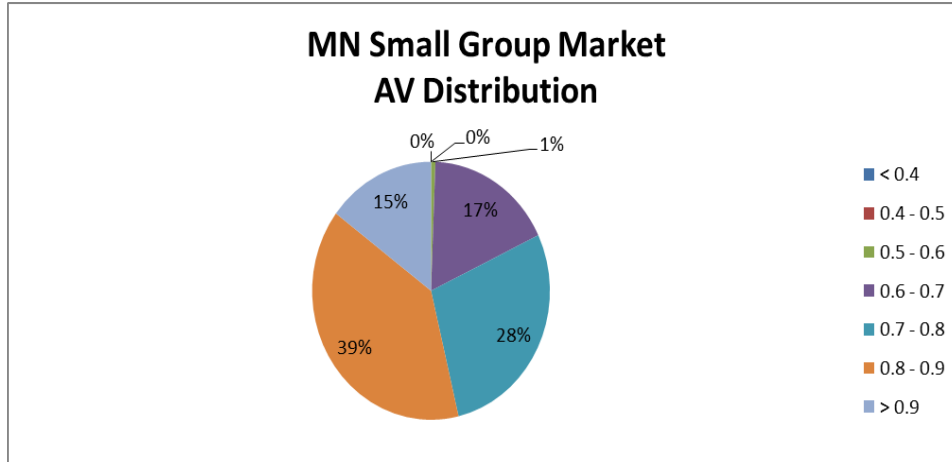


Figure 7 – 2009 Small Group Market Actuarial Value Distribution

Sensitivity Analysis on Small Group Actuarial Value

After discussions with insurers in the Minnesota market, it was felt that there has been significant benefit buy down since 2009. Gorman Actuarial performed a sensitivity analysis to understand the impact of benefit buy down on premiums in 2014. If we assumed that everyone in the market enrolled in benefits that decreased their actuarial value by 10 points, the average actuarial value of the small group market would decrease 10 points from 0.79 to 0.69. However, only 18% of the market would have an actuarial value that is below 0.60 and would be impacted by the minimum actuarial value requirement in 2014. Using this sensitivity analysis on benefit buy down, we estimate that small group premiums could increase 1% to 2% due to the actuarial value requirement.

6.2. Impact of Rating Limitations – Elimination of Health Underwriting

Similar to the individual market, insurers in the Minnesota small group market are also currently allowed to adjust premium rates for health status. These health status adjustments must be within a +25%/-25% band around an index rate. This translates into a 1.667 to 1 band (1.25/.75). Insurers who currently adjust premiums for health status will no longer be able to do this beginning in 2014.

We calculated the average surcharges and discounts to premiums due to health status adjustment based on 2009 data. These surcharges/discounts were normalized so that the overall surcharge/discount by insurer averages to 1.0 when weighted by member months. As shown in Table 10, 56% of the small group market is currently receiving a discount based on health status and their average discount is 13.0%, while the remaining 44% of the market is currently receiving a surcharge based on health status and their average surcharge is 16.4%. The average premium PMPM increases steadily as the health status adjustment increases, but note that these premiums reflect other rating variables in addition to health status adjustments, such as age and benefit plan design.

The Impact of the ACA and the Exchange on Minnesota

Health Status Surcharges/Discounts	Distribution of Members	Distribution of Groups	Average Premium PMPM	Average Surcharge/Discount
less than -20.0%	12.6%	16.1%	\$255.59	-22.0%
-20.0% to -10.1%	21.8%	21.1%	\$273.63	-15.2%
-10.0% to -0.1%	21.5%	18.2%	\$308.96	-5.5%
0.0% to 9.9%	17.0%	15.1%	\$343.64	5.0%
10.0% to 19.9%	10.2%	10.0%	\$387.91	15.5%
greater than or equal to 20.0%	16.9%	19.5%	\$454.19	28.5%
Grand Total	100.0%	100.0%	\$333.09	0.0%

Table 10 – MN Small Group Market Distribution of Premium Health Status Surcharges and Discounts

Starting in 2014, when insurers are no longer able to adjust premiums due to health status, those groups who had favorable health status adjustments will experience premium increases and those groups who had unfavorable health status adjustments will experience premium decreases. Table 11 shows the results of modeling the impact of eliminating health status as a rating adjustment. These results tie directly to Table 10 in that 56% of the small group market will receive a premium increase (those who currently have a discount) and 44% of the market will receive a premium decrease (those who currently have a surcharge). Roughly 20% of the market will receive an increase greater than 20%. Note that while the impact of health status underwriting impacts each group very differently, the overall impact to the rating pool prior to any member migration is expected to be zero.

Premium Change	Distribution of Members	Distribution of Groups	Average Premium PMPM Pre-ACA	Average Premium Change
less than -20.0%	13.5%	16.0%	\$464.95	-22.9%
-20.0% to -10.1%	13.6%	13.5%	\$394.01	-14.9%
-10.0% to -0.1%	16.9%	15.0%	\$344.18	-4.8%
0.0% to 9.9%	14.3%	12.2%	\$322.22	3.8%
10.0% to 19.9%	22.1%	20.8%	\$285.63	14.3%
greater than or equal to 20.0%	19.6%	22.6%	\$251.78	25.5%
Grand Total	100.0%	100.0%	\$333.09	0.0%

Table 11 – MN Small Group Market Premium Changes due to Elimination of Health Status

Employer groups that receive significant premium increases will be provided additional incentive to drop coverage. This may impact the overall small group risk pool since these groups are the healthier groups. For example, if we assume that 10% of the membership that received rate increases greater than 20% dropped coverage, the overall medical costs of the small group market would increase approximately 1%. However, this is absent the effect of the individual responsibility requirement which could slow down the rate of small group terminations.

7. Impacts on State Public Insurance Spending

7.1. Baseline Impacts of the ACA on State Spending

The ACA will have impacts on Minnesota state public health insurance spending. These impacts will depend on various issues, such as the level of income eligibility for children between 150% FPL and 275% FPL, whether to have a Basic Health Plan (BHP) option, and how to structure the BHP. In this section we explore those scenarios to show the potential financial impacts on state government.

There are three major effects of the ACA on state public health insurance spending in 2016; note that this does not include any costs or savings from newly eligible individuals (including single adults for whom Minnesota expanded Medicaid eligibility to 75% FPL in 2011 under the state early expansion option in the ACA), which are 100% financed by the federal government in that year. The first is increased spending on those who were previously eligible for public health insurance, but who now newly enroll in the program; the state bears one-half of the cost of such new enrollment. The second is savings from children or parents who were previously enrolled in public health insurance and now leave the program for other coverage primarily under Exchange tax credits; the state receives one-half of the savings from those exits. The third is savings from childless adults who were previously enrolled in public health insurance and now leave the program for other coverage primarily under Exchange tax credits; this population was roughly 100% financed by the state, so that the state gets the savings from reduced public health insurance spending.

Of course, the net impacts of these financial flows will depend on the income eligibility level for children. Table 12 shows the net impact of these spending changes in 2016 for both the 150% FPL and 275% FPL public health insurance lower and upper bound eligibility cases for children.

Table 12: State Spending Effects, 2016
(in millions of dollars)

	150 no BHP	275 no BHP
Extra spending on existing eligibles who newly take up public ex-post	\$140	\$280
Savings from moving from public to private Exchange subsidies (excluding childless adults)	-\$270	-\$130
Savings from moving from public to private Exchange subsidies (childless adults)	-\$120	-\$120
Net State Spending Effect	-\$250	\$30

Table 12 – State Spending Effects: 2016 (in millions of dollars)

The state spends \$140 million dollars on those enrolling in public health insurance who were previously eligible for the program in the 150% FPL case, but the figure doubles when eligibility for children is extend to 275% FPL, as many of those children were not enrolled and will now sign up. The state saves \$270 million on those children and parents leaving public health insurance in the 150% FPL case, but that figure is only half as large in the 275% FPL case as fewer children leave public health insurance. Finally, in both cases the state saves about \$120 million on childless adults who leave public health insurance for the private Exchange subsidies. On net, the financial impact on the state ranges from a reduction in spending of \$250 million to a slight increase of \$30 million.

7.2. The Basic Health Plan (BHP) Option

One of the policy decisions facing Minnesota under the ACA is whether to use the Basic Health Plan (BHP) to provide public health insurance coverage up to 200% FPL, rather than ending it at 133% FPL for adults and 150% FPL to 275% FPL for children. There are numerous arguments for and against a BHP program, and we will not present them here. Rather, in this section we will simply evaluate the effect of a BHP option on state finances.

The cost of a BHP option is the extra state spending on public health insurance. This extra spending will be for adults from 133% FPL to 200% FPL, who will now be financed by the state, as well as for children 150% FPL to 200% FPL in the 150% FPL case described above; in the 275% FPL case, obviously, there are no children in the BHP range. Offsetting revenues come from the federal government, who will provide 95% of

the tax credit spending it would have done on behalf of individuals in the BHP who would otherwise receive private Exchange subsidies. It should be noted that these financial impacts do not incorporate existing state and federal spending on the MinnesotaCare program, but instead reflect a pure comparison of total spending for the population assumed to enroll in this program compared to estimates of the 95% federal funding.

A key issue in computing the federal 95% amount is risk adjustment. In principle, the state of Minnesota should be reimbursed for 95% of the amount that those in the BHP would cost if they were receiving tax credits. The problem is that when the BHP individuals are removed from the Exchange, premiums in the reformed individual market are lower (since the BHP population is sicker than average). The BHP population represents individuals between 133% FPL and 200% FPL that previously were uninsured, covered by a public health insurance program, covered by Minnesota's high risk pool MCHA or covered by a policy in the individual market. As we show in Table 13, reformed non-group premiums are roughly 12% lower (before the application of tax credits) with the BHP than without the BHP. So if the federal government reimburses 95% of the amount that the BHP individuals would cost at that lower level of premiums, it will understate the true cost to Minnesota of covering those higher cost individuals in the BHP. In principle, then, the federal government should *risk adjust* the premiums that are used to compute its reimbursement. That is, the federal government should take 95% of what the BHP individuals would have cost - the (higher) premium that would prevail in the individual market had they still been enrolled in that market. In practice, it is unclear if the federal government will undertake such risk adjustment.

Table 13: Premiums and Actuarial Values for those Remaining on Nongroup: 2016

No BHP	No Reform	With Reform (No Subsidies)	With Reform (With Subsidies)
Average Nongroup Premium	\$4,375	\$5,687	\$3,487
Average Nongroup Actuarial Value	0.641	0.702	0.702
With BHP	No Reform	With Reform (No Subsidies)	With Reform (With Subsidies)
Average Nongroup Premium	\$4,448	\$5,061	\$3,606
Average Nongroup Actuarial Value	0.641	0.678	0.678

Note: Includes 150% FPL case

Table 13 – Premiums and Actuarial Values for those Remaining on Nongroup: 2016

Therefore, in Table 14, we consider four scenarios: both the 150% FPL and 275% FPL cases, for both risk adjusted and non-risk adjusted federal payments. We focus on the second column to describe the format of the table, and then discuss differences across the columns.

Under the scenario where public health insurance eligibility is set at 150% FPL for children, there are 190,000 persons in the 133% FPL to 200% FPL range who were previously uninsured, enrolled in a public health insurance program, enrolled in MCHA, or purchasing coverage in the individual market that are now enrolled in the BHP. The average cost of public health insurance for these individuals based on their risk mix is \$6,320. The risk adjusted average Exchange premium and cost-sharing for these individuals is \$5,960, which is already lower than their public cost. In addition, individuals in the Exchange pay a share of their premium and cost-sharing, which amounts to \$660 on average, so that average Exchange subsidies paid by the federal government are only \$5,300. The sum total of 95% of these subsidies is \$980 million, which is well below the \$1.19 billion cost of providing public health insurance to this population. Therefore, on net, the state faces additional net spending of \$210 million if they implement the BHP. As stated previously, these estimates do not incorporate existing state and federal spending on the MinnesotaCare program.

The first column shows that this net financial impact is much larger if the federal payments are not risk adjusted, rising to \$340 million. The second set of columns consider the scenario where public health insurance eligibility for children is set at 275% FPL. In this case, there are fewer individuals enrolled in BHP, since many of those enrolled in the first scenario are children from 150% FPL to 200% FPL who are covered by public health insurance in this scenario. The public health insurance cost for BHP enrollees is now higher, since children are not included in this population, but at the same time the Exchange premium and cost-sharing is also higher, for the same reason. The result is a net financial impact due to the BHP which is smaller than the 150% FPL case.

Table 14: BHP Financing

BHP Statistics	Case I: 150%		Case II: 275%	
	Non Adjusted	Risk Adjusted	Non Adjusted	Risk Adjusted
BHP enrollment	190,000	190,000	120,000	120,000
Average public cost for BHP enrollees:	\$6,320	\$6,320	\$6,980	\$6,980
Average Exchange premium/cost-sharing for BHP enrollees (before subsidies):	\$5,270	\$5,960	\$5,450	\$6,730
Average Exchange premium/cost-sharing for BHP enrollees (after subsidies):	\$660	\$660	\$740	\$740
Average exchange subsidies for BHP enrollees:	\$4,610	\$5,300	\$4,710	\$5,990
Total BHP funding (millions)	\$850	\$980	\$560	\$700
Total BHP costs (millions)	\$1,190	\$1,190	\$820	\$820
Financial Impact of BHP	(\$340)	(\$210)	(\$260)	(\$120)

Note: Calculations assume Medicaid provider rates (with 5% fee for service reduction and 15% managed care reduction) and benefits

Note: Funding includes 95% of both premium subsidies and cost sharing subsidies

Note: Estimates do not include existing state and federal spending on MinnesotaCare

Table 14 – BHP Financing: 2016

7.3. Financial Implications of Alternative BHP Structures

In addition to the decision on whether to offer a BHP, the state faces a variety of decisions on how to structure the BHP. In this section, we consider the financial implications of those decisions. We focus on the case of child eligibility at 150% FPL, and assume that the federal government risk adjusts state reimbursements.

The results for these alternatives are presented in Table 15. The first row presents the results from the second column of Table 14, showing a state cost of \$210 million in 2016. As noted above, these results reflect the reductions in Medicaid reimbursement put in place by recent legislation, which impose by 2016 a 15% cut in managed care capitation rates and a 5% net change in fee for service (FFS) reimbursement. We consider in the next three rows three alternative changes in provider rates: no change in either capitation or FFS rates (e.g. a full repeal of the legislative changes); a 10% capitation reduction paired with a 5% reduction in FFS rates; and a 20% capitation reduction paired with a 5% reduction in FFS rates. In the fifth row, we then consider moving all public program provider payment rates to private sector provider payment rates.

The next two rows consider alternative approaches to making the BHP less generous. The BHP may protect low income families in two ways relative to the ACA: it could lower their premium payments and their out of pocket costs. We consider in the next two rows the impacts of varying these two aspects: first charging BHP enrollees the same amount as they would pay with tax credits; then, alternatively, applying to them the lower

actuarial values that apply to Exchange enrollees. In both cases, we cut the BHP financial impact.

**Table 15: Alternative BHP Scenarios
150% Case
(millions of dollars)**

	BHP Funding	BHP Costs	BHP Financial Impact
Baseline Results	\$980	\$1,190	-\$210
Zero Capitation Change	\$980	\$1,340	-\$360
10/5% Capitation Change	\$980	\$1,240	-\$260
20/5% Capitation Change	\$980	\$1,170	-\$190
Private Rates	\$980	\$1,390	-\$410
Apply Exchange Enrollee Premiums	\$980	\$1,080	-\$100
Apply Exchange AVs	\$980	\$1,070	-\$90

Note: Estimates do not include existing state and federal spending on MinnesotaCare

Table 15 – Alternative BHP Scenarios 150% Case: 2016 (millions of dollars)

The changes in rates have sizeable impacts on BHP costs. Removing recently enacted rate cuts, or moving to private sector provider payment rates, greatly increases the financial impact associated with the BHP. There are smaller effects of the alternative 10% and 20% capitation changes and applying Exchange premium levels and actuarial values.

Table 16 shows the same alternative scenarios for the case where public health insurance eligibility for children is set at 275% FPL. In this case, the cost to the state of the BHP program is smaller, and the impacts of the policy changes are likewise smaller. Again, these estimates do not incorporate existing state and federal total spending on the MinnesotaCare program, but instead reflect a pure comparison of total spending for the population assumed to enroll in this program compared to risk adjusted estimates of the 95% federal funding.

**Table 16: Alternative BHP Scenarios
275% Case
(millions of dollars)**

	BHP Funding	BHP Costs	BHP Financial Impact
Baseline Results	\$700	\$820	-\$120
Zero Capitation Change	\$700	\$920	-\$220
10/5% Capitation Change	\$700	\$850	-\$150
20/5% Capitation Change	\$700	\$800	-\$100
Private Rates	\$700	\$1,020	-\$320
Apply Exchange Enrollee Premiums	\$700	\$740	-\$40
Apply Exchange AVs	\$700	\$730	-\$30

Note: Estimates do not include existing state and federal spending on MinnesotaCare

Table 16 – Alternative BHP Scenarios 275% Case: 2016 (millions of dollars)

8. Impacts on Household Budgets

We use a budget-based approach to evaluate the effects of the ACA on household spending. We compare the additional household benefits produced by the ACA with the additional household costs due to the ACA to determine the net impact on household budgets.

Seven aspects of the ACA have household budgetary effects.

- The first is the higher wages that arise from reduced employer spending, through firm dropping and lower employer contributions towards health insurance (although this is partially offset by higher ESI enrollment among those previously eligible). This reduced employer spending is passed through in the form of higher wages to employees.
- The second is Exchange tax credits; for this analysis, we consider only the tax credits received by those who would be uninsured absent the ACA. Those who are insured either with or without the law will already see the benefits of the tax credits as a decrease in premium spending, and thus it would be double-counting to consider them here.
- The third component is Medicaid expenditure on those gaining Medicaid coverage; once again, benefit is also only considered for those who would otherwise be uninsured to eliminate concerns of double-counting for the previously insured.

- Fourth is ESI premiums paid by employees, which will go down as employers drop insurance, but may rise as the remaining employers shift the cost of insurance to their employees.
- Fifth is spending on individual market premiums. The Exchanges created by the ACA dramatically increase individual market enrollment, which will increase individual market spending; but tax credits to those who were already holding individual market insurance will reduce spending.
- Sixth is out of pocket spending, which is health care spending that is paid directly by the household, through cost sharing like deductibles, copayments and coinsurance for the insured or for care received by the uninsured; this will fall for the previously uninsured, but may rise for the previously insured if they buy less generous insurance (or rise if they buy more generous insurance)
- Seventh is the change in taxes, which is the result of higher wages as firms that drop insurance raise their employees' compensation through direct pay.

Table 17 shows these impacts for Minnesota households. There are sizeable positive benefits from Exchange tax credits and public health insurance, and more modest benefits from reduced employee contributions towards employer sponsored insurance. On net, households budget rise by \$1.1 billion from the ACA, which amounts to benefits of \$500 per household for the 150% FPL case.

	Status Quo (in billions)	After ACA (in billions)	ACA Effect (in billions)	Per Household Effect
Wages	\$157.2	\$157.2	-\$0.0	-\$20
Exchange Credits	\$0.0	\$0.4	\$0.4	\$210
Public Insurance	\$0.0	\$0.4	\$0.4	\$200
ESI Contribution	\$4.0	\$3.7	\$0.3	\$120
Non-group Premium	\$1.1	\$1.1	\$0.0	\$0
OOP Spending	\$2.5	\$2.5	\$0.0	\$10
Taxes	-\$31.9	-\$31.9	-\$0.0	-\$20
Net Effects			\$1.1	\$500

Note: Represents results for 150% FPL case.

Table 17 – Household Budget Effects: 2016

While the aggregate budget effect is positive, there are some differences when the household effects are isolated for different income levels. Figure 8 details the budget effects by income level. Lower income households see the majority of the benefits of the

ACA. Households making less than 133% FPL receive over \$600 million in benefits, which equals a benefit of \$1,040 per household. Households from 133% FPL to 200% FPL receive a smaller aggregate benefit, but a larger per household benefit of \$1,760. Benefits are smaller but positive for households between 200% FPL to 400% FPL. Above 400% FPL, the benefits become negative, although fairly small. Even for the highest income groups, those with incomes more than ten times the poverty line, the loss per household is only \$340.

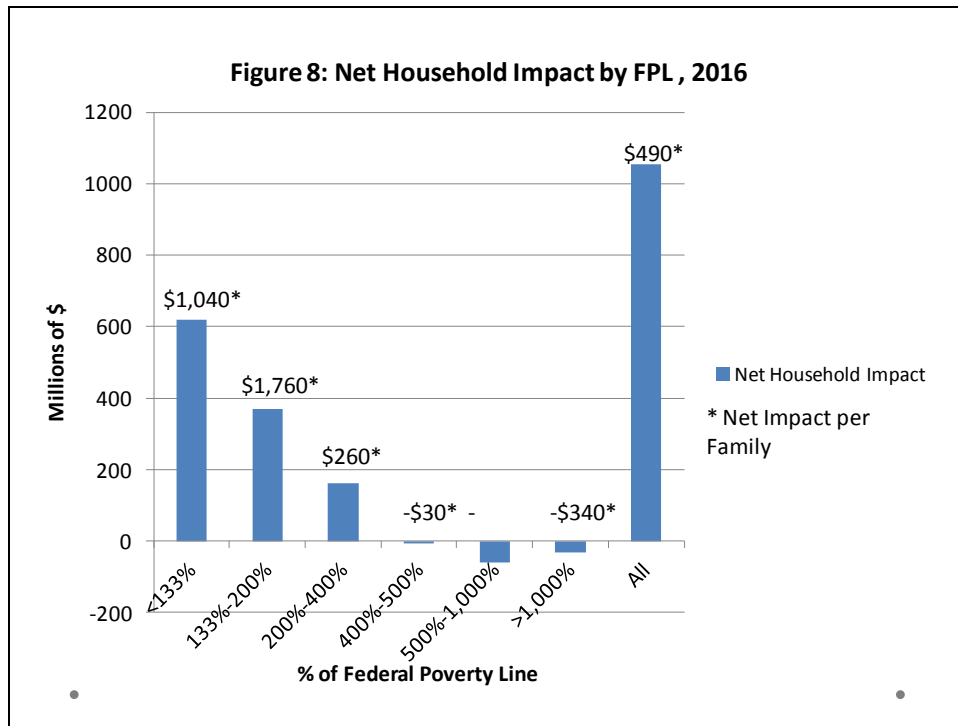


Figure 8 – Net Household Impact by FPL: 2016

Another way to examine these impacts is to consider how many households win, lose or are unaffected by the ACA. We see in Figure 9 that for lower income groups, there are a large number of winners as well as a large number of unaffected households, with very small numbers of losers. Between 133% FPL and 400% FPL, over three-fourths of the losers are individuals who have ESI, but whose wages go down or employee contributions for coverage increase. The number of losers rises as income rises, but always remains below the number of winners – even in the highest income group, where there are aggregate losses, the number of winners exceeds the number of losers.

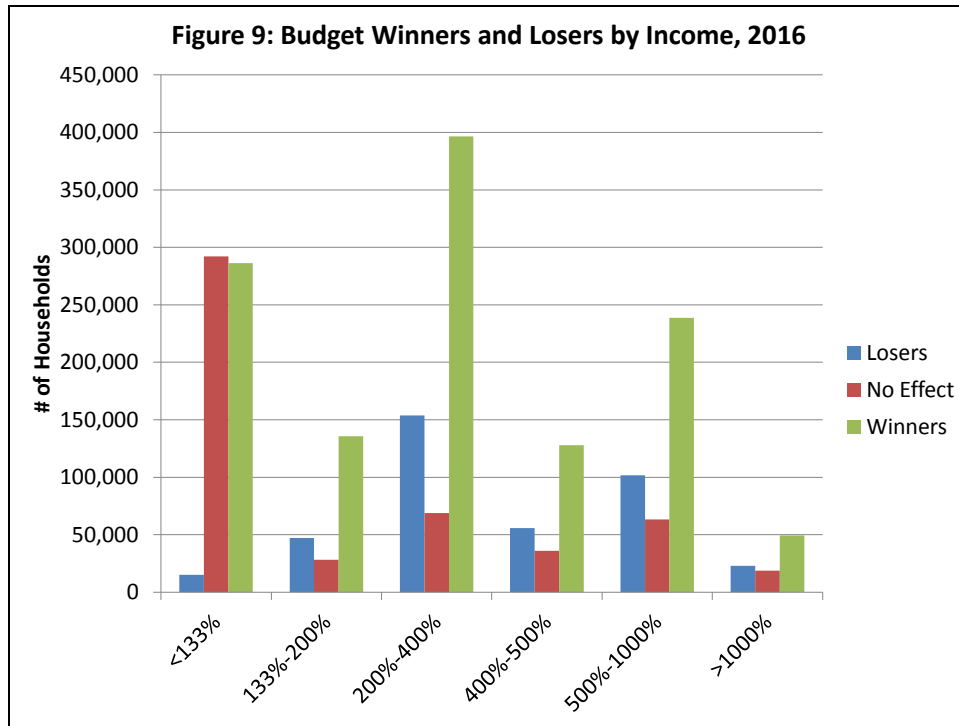


Figure 9 – Budget Winners and Losers by Income: 2016

Figure 10 extends this analysis to consider the four different scenarios that we study in this report. The case analyzed in detail, where child eligibility is set at 150% FPL and there is no BHP, is shown in the first bar, with the previously-reported net benefits per household of \$500. If there is a BHP in place, aggregate household benefits rise by more than \$100 million dollars, to \$600 per household. This largely offsets the extra state spending in this scenario, assuming federal risk adjustment; that is, undertaking the BHP option essentially amounts to transferring resources from state government to low income households. If child eligibility is set at 275% FPL without a BHP, then household benefits rise as well, although the increase in benefits in this case is much smaller than the incremental government spending of \$280 million shown in Table 12. Once again, introducing a BHP raises household benefits further.

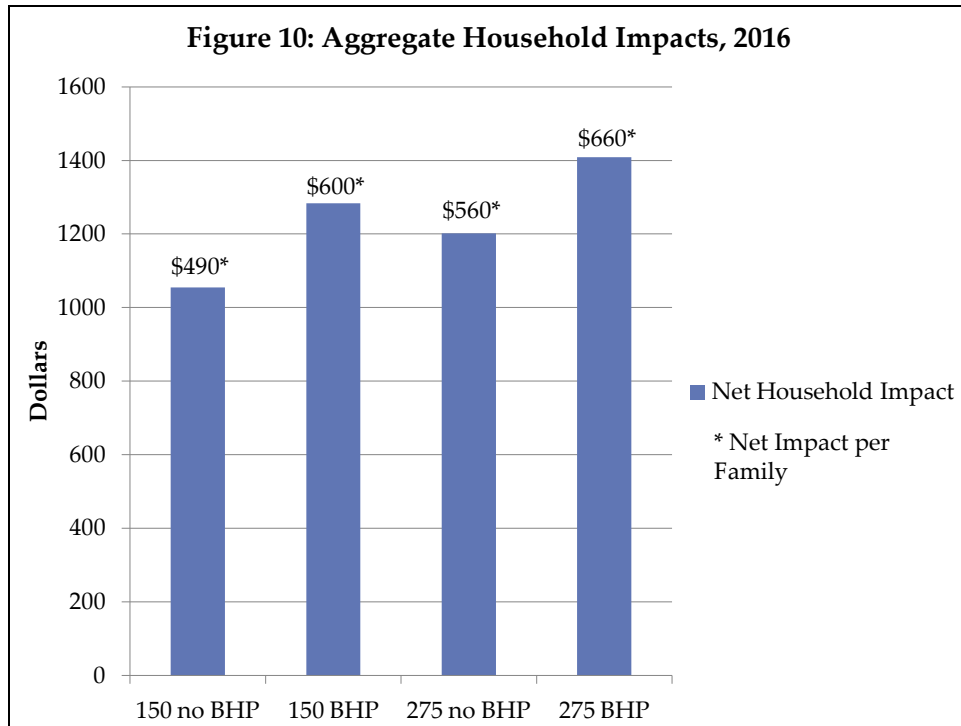


Figure 10 – Aggregate Household Impacts, 2016

9. Merged Market Analysis

States will be faced with several policy decisions related to merging markets under the ACA. States may at any time elect to merge the individual market and the small group market. Furthermore, in 2016 states will be required to expand the definition of small group to 100 employees, essentially merging the small group and large group 51-100 employee markets. States have the option of expanding the small group definition to 100 employees prior to 2016. Merging market segments requires insurers to pool the claims experience from each market when establishing premium rates for the merged market. When markets are merged, one market segment may end up subsidizing the other market segment based on their relative claims experience after adjusting for allowable rating adjustments.

9.1. Market Segment Comparisons

Our focus in this analysis includes the following Minnesota insured markets: high risk pool (MCHA), individual market, small group market and the large group 51-100 market. As discussed above, the premiums for MCHA are set at up to 125% of the standard rate in the individual market. In addition to member premiums, MCHA is also funded through state assessments. The current individual and small group markets are separate pools where premiums are calculated using the cost and utilization experience for each particular market. If these market segments are merged, the claims experience from both the individual and small group markets would be combined to develop premiums.

Currently, large group market premiums are established in a variety of ways since this market segment is not regulated similarly with rating restrictions. Merging the small group and large group 51-100 markets would require premiums to be based on the combined pool of the experience from these two markets and the large group 51-100 market would be subject to the same adjusted community-rating rules as the small group market in 2014.

Figure 11 shows the membership distribution in 2009: 51% of the membership is in the small group market, 32% in the individual market, 13% in the large group 51-100 market, and the remaining 4% is in MCHA. The small group market represents approximately half of this current pool with 400,000 members in 2009.

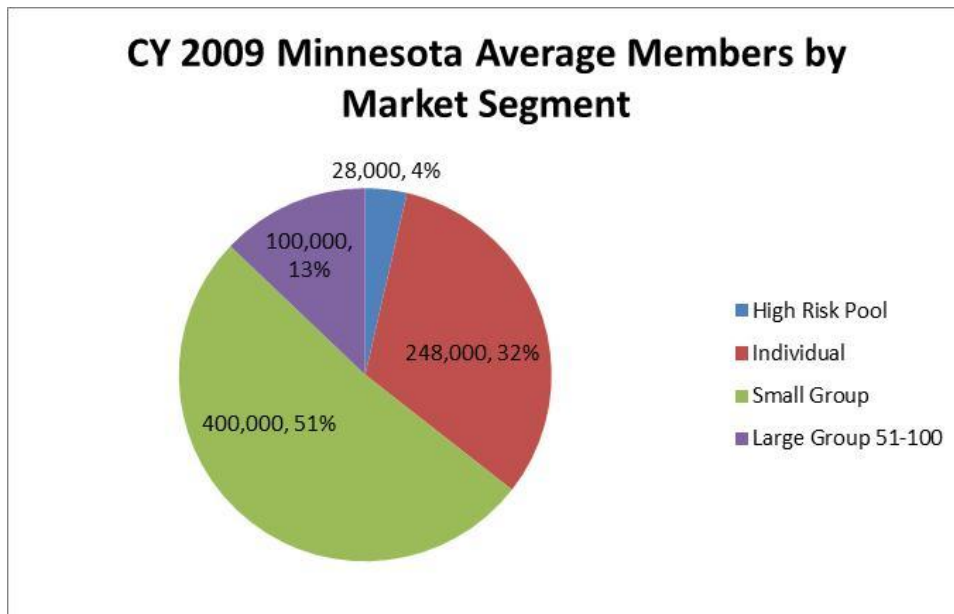


Figure 11 – 2009 Market Segment Distribution

Figure 12 shows the average age for each of the four market segments. MCHA has the highest average age at 47 years old, while the small group and large group 51-100 markets have the youngest average population at 33 years old.

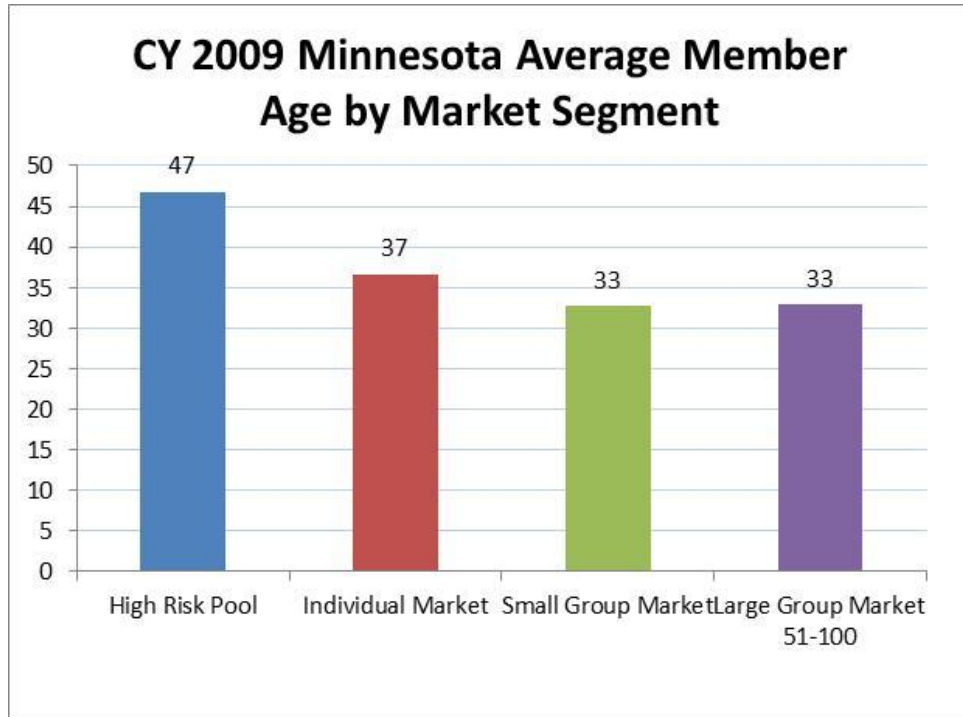


Figure 12 – 2009 Market Segment Average Age

We also compared the actuarial values for each market segment as shown in Figure 13. Actuarial value is a measure of the average proportion of medical expenses paid by a health plan for a given plan design. The average actuarial values are fairly close between MCHA and the individual market and also fairly close between the small group market and the large group 51-100 market. Note that given the amount of variation in plan designs in the large group 51-100 market and the manner in which the information was summarized, the precise calculation of an average actuarial value produced inconclusive results. We estimated that the actuarial value for the large group 51-100 market segment would equal the actuarial value in the small group market segment based on a comparison of the incurred claims PMPM and our experience in other states.

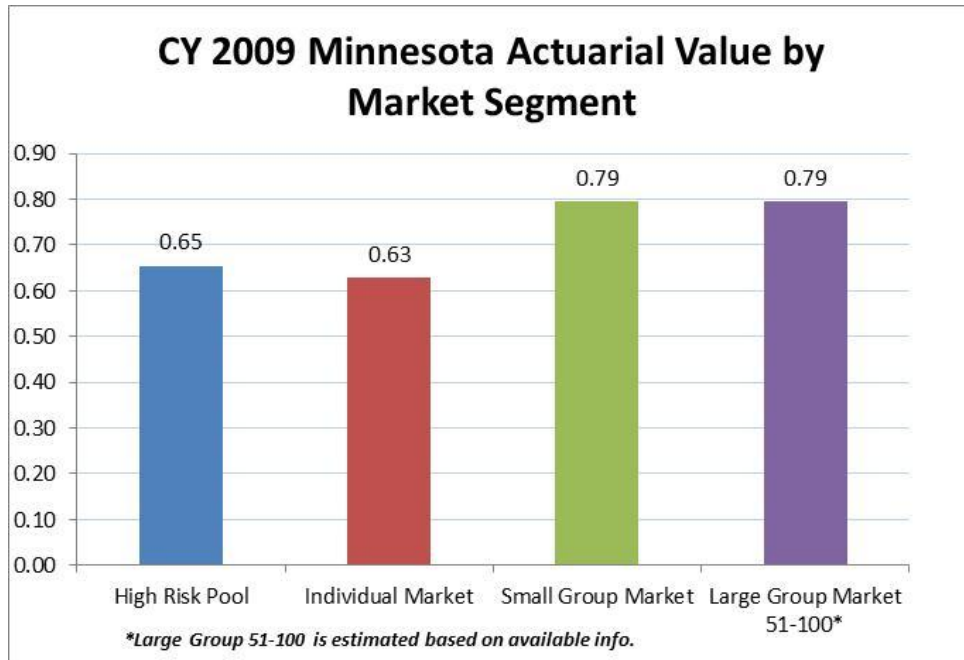


Figure 13 – 2009 Market Segment Actuarial Value

Error! Reference source not found. 14 compares the incurred claims PMPM and medical loss ratio in 2009 for the four market segments. Note that MCHA does not have a medical loss ratio as they do not have a comparable premium. The loss ratio (the ratio of incurred claims PMPM to premium PMPM) for 2009 was 0.89 in the individual market, 0.86 in the small group market and 0.85 in the large group 51-100 market. The incurred claims PMPM in the small group and large group 51-100 markets are higher than the individual market (by 58% and 54% respectively.) This is driven in part by the richer plan designs in the small group and large group 51-100 markets compared to the individual market. The incurred claims PMPM for MCHA is even higher with claims experience 2.5 times as great as the small group market. While the small group market has richer benefits than MCHA, the older demographics of the high risk pool are a significant driver of the large claims difference.

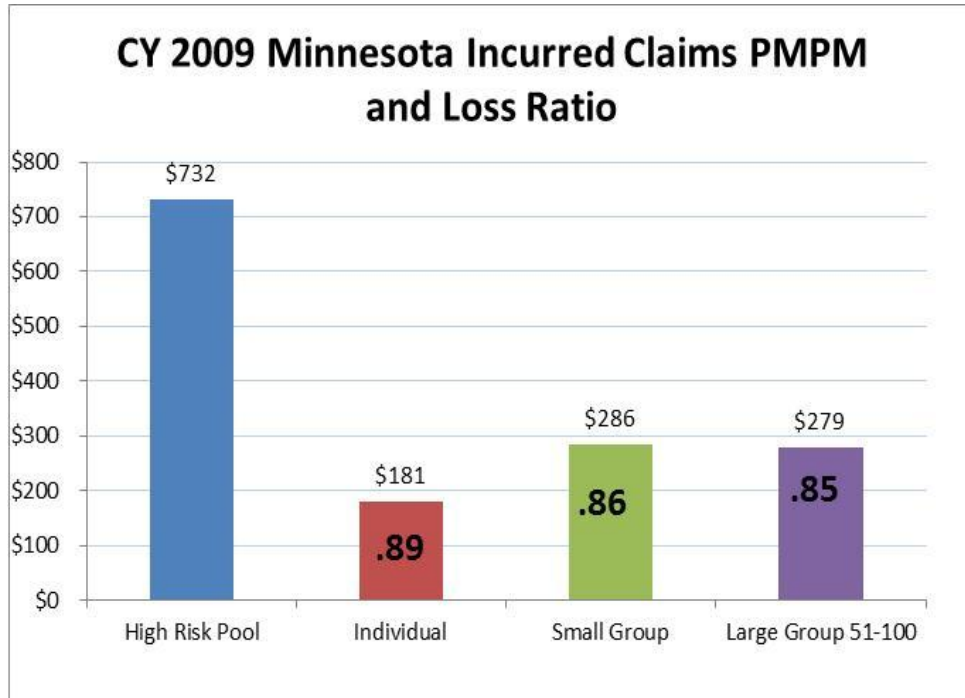


Figure 14 – 2009 Market Segment Incurred Claims PMPM

9.2. Impact from Merging Markets

The impact of merging markets can vary based on when the merger occurs. In 2014 and beyond, the composition of the individual market will most likely change. As shown previously, this market will experience significant membership growth. Along with this growth, there may be a change in this market's relative claims costs or relative risk. The small group and the large group 51-100 markets may also experience membership shifts as groups enter and exit the markets. We modeled the impact of merging various market segments by using claims, membership, benefit and demographic information primarily from the insurer survey data as well as outputs from Dr. Gruber's microsimulation model.

The Minnesota Department of Commerce requested a merged market analysis under four different scenarios:

- **Scenario 1:** Assume child eligibility at 150% FPL for a state public program and Minnesota does not offer a Basic Health Program (BHP)
- **Scenario 2:** Assume child eligibility at 150% FPL for a state public program and Minnesota does offer a Basic Health Program (BHP)
- **Scenario 3:** Assume child eligibility at 275% FPL for a state public program and Minnesota does not offer a Basic Health Program (BHP)
- **Scenario 4:** Assume child eligibility at 275% FPL for a state public program and Minnesota does offer a Basic Health Program (BHP)

Under scenario 1, the individual market membership is estimated to increase 100% to approximately 500,000 members and new entrants into this market will increase risk pool costs approximately 15% to 20%. It is also assumed that there is no significant change to the small group or large group 51-100 markets, but given the large growth in the individual market, the individual market represents half the combined market segments in 2016.

Under scenario 1, if the state were to merge the individual and small group markets, the individual market may experience a small premium increase of 1% to 5% and the small group market may experience a small premium decrease of 2% to 6%. These relatively small changes are due to diminishing differences between the relative risk of these populations as the individual market grows. If the state were to merge the small group and large group 51-100 markets, the small group market may experience minimal impact and the large group 51-100 market may experience a slight premium increase ranging from 0% to 4%. Since these market segments resemble each other today, the premium changes are relatively small. However, as the 51-100 market shifts to an adjusted community rating formula, there may be an incentive for the younger and healthier groups to seek coverage in the self insured market. This may have an adverse impact on the rating pool. If the state were to merge all three market segments, the individual market would experience a premium increase of 1% to 5%, the small group market would experience a premium decrease of 2% to 6% and there would be minimal impact to the large group 51-100 market. These results are all as of 2016.

Table 18 summarizes our results of merging various markets under each of the four scenarios described above. As shown in scenario 2, premiums increase significantly for the individual market when merged with the other market segments. This is primarily due to the state offering a BHP. By offering a BHP, the risk pool of the individual market improves significantly. When this market is merged with the group market, the individual market subsidizes the group markets. Under scenario 3, the individual market risk pool worsens as children up to 275% FPL are carved out. In this scenario, the group markets subsidize the individual market. Under scenario 4, premiums increase for the individual market when merged with the other markets due to the offering of a BHP as in scenario 2, but the increase is less under a merger as the premiums in this market start higher with children up to 275% FPL carved out.

The Impact of the ACA and the Exchange on Minnesota

	Individual + HRP Impact	Small Group Impact	Large Group 51-100 Impact	Merge IND + HRP and Small Group	Merge Small Group and Large Group 51-100	Merge IND + HRP and Small Group and Large Group 51-100
Scenario 1: no BHP and Children under 150% FPL in Public Program	↑ 1-5%	↓ 2-6%		Minimal Change	↑ 0-4%	↑ 1-5% Minimal Change ↓ 2-6%
Scenario 2: with BHP and Children under 150% FPL in Public Program	↑ 11-15%	↓ 8-12%		Minimal Change	↑ 0-4%	↑ 12-16% ↓ 5-9% ↓ 9-11%
Scenario 3: no BHP and Children under 275% FPL in Public Program	↓ 1-5%	↑ 1-5%		Minimal Change	↑ 0-4%	↓ 1-5% ↑ 3-7% ↑ 0-4%
Scenario 4: with BHP and Children under 275% FPL in Public Program	↑ 7-11%	↓ 4-8%		Minimal Change	↑ 0-4%	↑ 7-11% ↓ 1-5% ↓ 4-8%

Table 18 – 2016 Merged Market Results

9.3. Advantages and Disadvantages of Merging Individual and Small Group Markets

There are several advantages and disadvantages to merging the individual and small group markets in Minnesota:

Advantages:

- Creating a larger risk pool will help the spread the risk of high cost claims over a larger population and therefore potentially decrease the volatility in claims and premium of the combined pool.
- In Scenario 3, the individual market will experience slight premium decreases, which may increase enrollment.
- In Scenarios 1, 2 and 4 the small group market will experience minimal to modest premium decreases, therefore helping to encourage participation and possibly offsetting the likelihood of groups choosing to drop coverage or to self insure.
- If a defined contribution approach in the Exchange grows for small businesses, the rating approach in both the individual and small markets will become the same.

Disadvantages:

- In Scenarios 1, 2 and 4 the individual market will likely experience slight to moderate increases to their premiums which may discourage participation.

- There may be significant costs and other administrative challenges to both the state and insurers in combining the markets. For example, insurers may need to make updates to rating systems to support a merged market.
- Given the other market changes occurring in 2014 and that the individual and small group markets can be merged at any time during or after 2014, it may make sense to hold off on making a decision to merge markets until the post-ACA health care environment can be analyzed further.

9.4. Advantages and Disadvantages of Expanding Small Group Market Definition to 100 Employees Prior to CY 2016

There are several advantages and disadvantage to expanding the small group market definition from 50 to 100 employees prior to 2016 in Minnesota:

Advantages

- Creating a larger risk pool will help the spread the risk of high cost claims over a larger population and therefore potentially decrease the volatility in claims and premium of the combined pool.
- Since this has to be done by 2016, it may be better to implement sooner to have time to work out any unforeseen complications.
- Given the numerous market changes occurring in 2014, it may be better for ongoing market stability for this to happen simultaneously.

Disadvantages

- Since the small group and large group 51-100 markets appear to have similar morbidity, merging these markets may not have a significant impact on either market's premium and therefore there is no clear advantage to merging prior to 2016.
- The large group 51-100 market is partially experience rated. The rating methodology will change for the large group 51-100 market when it merges with the small group market and as a result there may be an additional impact on premiums that is difficult to quantify.
- There is the potential for increased administrative costs for the large group 51-100 segment when moving to the adjusted community-rated small group market rating regulations.
- Merging the small group and large group 51-100 markets prior to 2016 may encourage some of the 51-100 groups to self insure - particularly the young and healthy groups - and leave the pool with potentially sicker risk. Of course, this might just be a matter of timing since the markets will merge regardless in 2016.
- Since the definition of small group will be expanded in 2016, it may make sense to wait until it is a requirement rather than opting to introduce more change and complexity earlier than necessary given other market changes happening in 2014.

10. Conclusions

The Affordable Care Act (ACA) will have important implications for insurance markets in Minnesota. In this report we have endeavored to provide an overview of those implications.

We find that the ACA and the Exchange will both greatly increase insurance coverage in Minnesota and cause a large rise in individual market coverage through the newly reformed individual market. There will be little effect on employer sponsored coverage.

We find that the implications for public health insurance coverage and state costs are impacted by two issues: the income eligibility level for public health insurance for children between 150% FPL and 275% FPL; and whether to adopt a Basic Health Program (BHP). Depending on those issues, state public health insurance enrollment and expenditures could rise or fall in the coming years.

Regardless of those decisions, we find that the introduction of the ACA will lead to a rise in benefit coverage and individual market premiums. This premium increase, however, is more than offset by tax credits newly available to those purchasing individual insurance. We also find that the ACA provides a net benefit to households in Minnesota, amounting to roughly \$500 to \$700 per household per year by 2016.

There is more work to be done as the state of Minnesota considers its policy options under the ACA. We hope that this report can serve as a benchmark against which the state can compare its future policy decisions.

11. Appendix A

I. Overview of the Gruber Microsimulation Model (GMSIM)

The results presented in this report are based on modeling performed using the microsimulation model described in this appendix. There are two major components to the Gruber Microsimulation Model (GMSIM): the “premod” which is the baseline dataset, and the GMSIM model itself which produces the simulation results.

To improve the accuracy of our pre-reform estimations of the non-group and small group markets in Minnesota, we utilize data provided by Gorman Actuarial (GA). GA provided us with data on annual claims and plan premium and actuarial value that is based on data submitted by Minnesota insurers. We first use this data to adjust our estimated distribution of “true cost” or annual expected health spending to match the distribution of claims paid by Minnesota insurers. Next, we match the distribution of insurance products in these markets. We begin by grouping together plans with similar actuarial value, which we then refer to as a “product”. Then we group the enrollees into sub-population cells determined by the enrollee’s age, sex, and claims cost. We find the distribution of “product” market share and average premium and actuarial value for each “product” in

each age, sex, and claims population group. We then assign individuals from the Minnesota Health Access Survey (MHAS) dataset to products, matching the distribution of enrollment and premium spending that we observe in the GA data. At the end of this process, our estimation of the Minnesota non-group and small group markets reflects the actual Minnesota marketplace.

To model firm behavior, it is important to understand that firms make decisions based on the firm wide aggregate effects of a policy. To mimic this in GMSIM, we construct “synthetic firms” which are meant to reflect the demographics of actual firms. The core of this computation comes from the U.S. Bureau of Labor & Statistics (BLS) and Minnesota Department of Employment and Economic Development (DEED) data providing the earnings distribution of co-workers for individuals of any given earnings level, for various firm sizes and regions of the country. Using these data, we randomly select individuals in the same firm size/region/health insurance offering cell as a given worker in the survey data in order to statistically replicate the earnings distribution that the BLS and DEED data would predict for that worker. These 99 workers then become the co-workers in a worker’s synthetic firm.

To project our “premod” forward for future year analysis we use a variety of income and health cost inflation rates, as well as population projections from the Census Bureau, and insurance growth rates from the Congressional Budget Office (CBO). We use CBO’s projections for GDP growth to inflate income measures. We use a flat 6% growth rate to inflate health care costs following the CBO. We grow the overall population based on Census Bureau projections of population growth by age and sex. We also adjust the relative size of insurance categories using growth rates supplied by CBO.

To begin the policy simulation process, we first consider firm reactions to policy changes. We do this because 90% of private health insurance is provided by employers, giving them great influence in insurance markets. To model firm behavior, we assume that the firm’s decision-making reflects the aggregation of worker characteristics and preferences. To model these preferences we compute “pseudo-takeups”, which are the firm’s prediction of worker reactions to policy changes. We then average these reactions across the firm. There are three ways that we allow firms to react to policy changes and their predictions of worker behavior: change in employer sponsored insurance (ESI) offering, change in the premium contribution split, and change in the spending on the total ESI premium. We also consider the size of the firm, as small firm behavior is more sensitive to policy changes. We assume that total worker compensation remains constant, so firm increases in ESI spending are offset with wage reductions and decreases in spending are offset with increases in wages.

We model changes in ESI offering by considering the incentives to offer insurance provided by the policy. We consider each policy component separately and compute an “offer pressure” that reflects the influence of the policy component on the firm’s decision to offer or not offer insurance. Therefore policies that provide viable alternatives to ESI coverage reduce the likelihood that the firm offers ESI. For example, the introduction of individual Exchanges or expansion of Medicaid would reduce the likelihood that a firm

offers insurance. Additionally, policies that subsidize alternative sources of insurance reduce the likelihood that a firm will offer insurance. Subsidies or penalties for not offering insurance raise the probability of offering insurance. If there is a mandate policy, it will result in a positive offer pressure. Since individuals will be required to take up a form of insurance if they are uninsured and many will prefer ESI over other insurance types, this will reduce the likelihood that the firm drops coverage. The decision to offer insurance is the most direct method by which firms react to policy changes.

We utilize a similar framework to firm offering when considering contribution shift and spending decisions. In this process, we consider each policy component's impact of the contribution decision and spending decision, and then aggregate the individual components to get the final contribution and spending change. The contribution and spending decisions are more subtle methods for firms to influence worker behavior. Policies that provide or subsidize alternative forms of insurance will cause firms to reduce their contribution to the ESI premium and reduce spending on the premium. This works as an indirect influence on workers to move to these alternatives. Conversely, when ESI is subsidized or firms are penalized for not providing coverage, firms will increase their contribution or spend more on the policy. All of these reactions will increase with the size of the subsidy or penalty. When firms change the total spending on the ESI premium, half of the spending increase goes to purchasing a higher actuarial value product, and half goes to buying unobservably better coverage (i.e. purchasing from a more reliable or higher reputation insurer).

After determining the firm response, we move on to estimate the reactions of individuals to the policy changes. When considering individual reactions, we use a hierarchy of insurance desirability. ESI is most desirable, followed by individual Exchanges, then traditional non-group insurance, and last is public health insurance. To decide between the insurance options we use "takeup" equations to determine the probability that an individual will move to a certain insurance type. Generally speaking, these equations are of the form:

$$\text{Takeup} = (\text{Constant} + \text{Elasticity} \times \% \text{ Price Change} \times \text{Income Effect}) \times \text{Income Adjustment}$$

The constant is a term that reflects the individual's health and the desirability of the insurance option. The elasticity determines the responsiveness of individuals to price changes. These are determined, to the greatest extent possible, by a survey of the health economics literature. The price change measures the change in price from the pre-reform state to the post-reform state, and is adjusted for changes in the actuarial value of the plan. The income effect measures the level of the price change relative to income. This is important because price changes have diminishing returns to movement. That is to say that as the price change becomes large in dollar terms its impact on movement gets progressively weaker. The income effect also picks up the assumption that price changes are less important as income rises. Finally, the income adjustment reflects the assumption that takeup of insurance will fall as the final cost of insurance rises relative to income. After we compute the takeup probabilities for all the possible insurance

movements, we apply any regulatory apparatus. For example, individuals with an ESI offer may be barred from moving to the individual Exchange. After making the regulatory changes, we adjust the probabilities for overlap such that the sum of the movement probabilities and the probability of remaining on the pre-reform insurance category equals 100%.

By this point we have predicted the probability of the individual making all possible insurance choices. We now relax the assumption that each individual observation can only be on one insurance type. We use the movement probabilities as the share of the individual's weight that is moved to the relevant insurance category. For example, an observation might have a total weight of 1,000 and in the pre-reform state is uninsured. Pre-reform, we say this observation represents 1,000 uninsured individuals. Now in the post-reform world, we have concluded there is a 50% probability that this observation will continue to be uninsured, and a 50% probability that this observation will be covered by public health insurance. We now say that this observation represents 500 uninsured individuals and 500 individuals covered by public health insurance.

At this point we have computed what we call the voluntary movement: the movement that occurs as a result of individual and firm decisions. The next step is to apply any additional regulatory apparatus that affects movement such as an individual responsibility requirement or an auto-enrollment process. To make these adjustments, we move a portion of the observation's post-reform uninsured weight to a pre-determined insurance destination. The insurance destination represents the most likely source of insurance coverage for the person. The portion of the post-reform uninsured weight that is shifted depends on the insurance destination, and is calibrated to produce results in line with CBO estimates. We also have the capability to restrict the movement of undocumented immigrants. Utilizing data provided by Dr. Jeffery Passel of the Pew Hispanic Center, we are able to identify likely undocumented immigrants in the data, and to adjust or restrict their movement.

After considering the regulatory apparatus, we have finished the movement section of the model. To conclude the modeling process we finalize cost changes for individuals, firms, and governments. The first step in this process is to reset premiums in any Exchanges that have been created. Exchanges will charge premiums that reflect the underlying risk of the overall pool, instead of the individual as in traditional non-group markets. To model the premiums that will be charged in the new Exchanges we collaborate with Gorman Actuarial (GA) to determine the effect of ACA regulations and Exchange population characteristics on premiums. This is an iterative process where we complete a model run and then GA provides premium effects, which we feed back into the model until the premiums and populations stabilize. For the initial run, we estimate Exchange premiums by using the existing non-group and half of the existing uninsured population (selected randomly). In the subsequent iterations, we use data from GA to predict an Exchange premium that is either higher or lower than the pre-reform premium based on the regulatory impacts of the ACA and the underlying cost of the Exchange population. We then calculate changes in the following measures for individuals: premiums, out of pocket spending, regulatory penalties, wages, and taxes. For firms we calculate changes

in: ESI spending, payroll taxes, and regulatory penalties. For governments, both state and federal, we calculate changes in: public health insurance spending, subsidies (both for individuals and firms), tax revenues, and revenues from regulatory penalties.

II. Actuarial Modeling

A. Actuarial Value

Gorman Actuarial (GA) used plan design information for the most popular plan designs in both the individual and small group markets collected from Minnesota insurers. Plan design information for the MCHA population was also collected. Information collected included 2009 deductible levels, coinsurance charge, copayments, and out of pocket maximums along with details about pharmacy coverage and pharmacy cost sharing. High level actuarial values were calculated using GA pricing models and the cost sharing elements listed above. The pricing model accounts for varying cost sharing by major service categories including inpatient, outpatient hospital, primary care visits, specialty visits, emergency room, and pharmacy. Summary information on plan designs in the large group 51-100 market was also collected from Minnesota insurers, but given the breadth of plan designs in the large group 51-100 market and the level of information provided, it was difficult to use the information directly to calculate actuarial values for this market segment. GA estimated that the actuarial value for the large group 51-100 market would equal the actuarial value for the small group market based on a comparison of adjusted incurred claims and GA's experience in other states. Claims distributions were also provided by each insurer in each market segment. This information was used to calibrate the data used in the pricing model.

B. Rating Practices

GA collected rating information along with rate filings for the largest insurers in the individual market and in the small group market in Minnesota. The key pieces of rating information focused on the health status adjustments in each market segment. For each insurer, these rating factors were normalized using the insurer's member month distribution and then aggregated across insurers. The normalized factors were used to estimate discounts and surcharges off the base rate. Information was also collected on the distribution of members who receive a surcharge for tobacco use for insurers in the individual market who apply a tobacco surcharge and were able to disaggregate the information from their health status adjustments.

C. Premium Impacts due to the ACA – Individual Market

The analysis of the rating, premium and economic impacts of ACA involves an integrated approach using both actuarial modeling and economic microsimulation modeling. The actuarial modeling was performed by GA. This modeling utilizes claims, premium, membership, rating and plan design data collected from the largest insurance insurers that participate in the Minnesota insured markets. Using the insurer survey data described above, GA developed actuarial models

that analyzed the change in premium in the individual market due to the following changes:

1. Product Limitations
2. Rating Limitations
3. Impact of Minnesota Comprehensive Health Association (MCHA) – high risk pool
4. Impact of the new Exchange market on the individual market

Note these premium impacts do not reflect the impact of annual medical trends.

1. Product Limitations

In 2014, we have assumed the minimum actuarial value allowed will be 0.60 which would equate to a Bronze product offering. We have also assumed a 0.45 actuarial value for the catastrophic plan for the individuals that are ages 18 to 30. Approximately 35% of the individual market is enrolled in plans that have greater than a \$3,000 deductible. Overall we estimate the premium impact due to this requirement is 8% to 11%. Also note that these increases do not take into account other aspects of the ACA, such as premium tax subsidies or cost sharing subsidies.

2. Rating Limitations

As described in the report, we have identified that the most significant rating change to the Minnesota individual market will be the elimination of health status as a rating variable. This will increase premiums for a healthier demographic and decrease premiums for the less healthy. However, we believe the rating limitations alone will not affect overall average premiums.

There is variation across the insurers on how they adjust premiums for health status. Some insurers only use a smoking surcharge, other insurers only use a health status adjustment, and others use a combination of the two. As shown below, 66% of the market is rated using a smoking adjustment only whereas 21% of the market is rated using both variables. Approximately 6.0% to 6.5% of the market is estimated as smokers with an average surcharge of 23%.⁸

⁸ Smoking analysis based on those insurers that were able to report smoking status.

	Smoking Adjustment Only	Health Status Adjustment Only	Combined Smoking and Health Status Adjustment
Rating Method 1	X		
Rating Method 2			X
Rating Method 3		X	
% of Market	66%	13%	21%

Table 19 – Minnesota Individual Market Rating Adjustments

Insurers provided distributions of their individual market health status adjustments. For each insurer, GA normalized these adjustments using each insurer’s membership distributions. Premium surcharges and discounts were then calculated for each insurer. Finally distributions of premium changes were calculated for each insurer and then aggregated across the market.

3. Impact of Minnesota Comprehensive Health Association

Since premiums are based on estimated medical costs for a population, the impact of merging various risk pools would increase average medical costs for one segment and decrease medical costs for another segment. This leads to one market segment subsidizing the other. To estimate the impact of merging the MCHA population with the individual market, GA analyzed paid claims costs, plan design distributions, age/gender distributions and claims distributions of each market respectively. In addition, GA analyzed respective market share. GA adjusted the claims costs for the corresponding benefits and age demographics within each market. Note that while there may be differences due to distribution of members by geography, we were not able to model this given the data provided and therefore have essentially assumed that there are no significant differences due to geography for these various market segments. We then compared these adjusted claims to understand relative morbidity. This analysis shows that the high risk pool morbidity is approximately three times the morbidity of the individual market. These relative claims adjustments are based on 2009 data and prior to any assumptions around market shift as a result of ACA. GA has also assumed that between 2014 and 2016 an increasing number of members from the high risk pool will migrate to the individual market:

- 40% in CY 2014 (11,000 members)
- 60% by CY 2015 (16,500 members)
- 80% by CY 2016 (22,000 members)

We assumed that the healthier of the high risk pool members would migrate to the individual market. GA estimated that the members who migrate to the individual market from MCHA will have, on average, claim costs that are 70% lower than members who remain in MCHA. As a result of all of these assumptions, we have estimated that the overall impact to the individual market as a result of the migration of MCHA members in 2016 will be an increase in individual market premiums of 10% to 15%.

4. Impact of the New Exchange Market on the Individual Market

For the individual market, Gorman Actuarial relied on Dr. Gruber and his microsimulation model to understand the impact of the new Exchange pool on the individual market. GA provided Dr. Gruber data for the Minnesota individual market. Data included claims costs, premiums, actuarial value and demographic information. GA also provided estimated premium impacts due to the changes described above. Dr. Gruber calibrated his models to this data and then provided GA with relative costs and demographic information for the new Exchange pool as compared to the existing individual market. Based on this data, GA estimated that the premium impact of the new Exchange pool on the individual market is approximately 15% to 20%.

D. Premium Impacts due to the ACA – Small Group Market

GA estimated both the impact of the product limitations and the rating limitations on the small group market.

1. Product Limitations

Starting in 2014, we have assumed the minimum actuarial value allowed will be 0.60 which would equate to a Bronze product offering. We have also assumed a 0.45 actuarial value for the catastrophic plan for individuals that are ages 18 to 30. As shown in Figure 7, less than 1% of the market is enrolled in plans that are below the ACA minimum actuarial value of .60 therefore the overall premium impact due to this requirement is minimal.

2. Rating Limitations

The most significant rating change to the Minnesota small group market will be the elimination of health status as a rating variable. This will increase premiums for a healthier demographic and decrease premiums for the less healthy. However, we believe the rating limitations alone will not affect overall average premiums.

Insurers provided distributions of their small group market health status adjustments. For each insurer, GA normalized these adjustments using

each insurer’s membership distributions. Premium surcharges and discounts were then calculated for each insurer. Finally distributions of premium changes were calculated for each insurer and then aggregated across the market.

GA used data from Minnesota insurers to understand the distribution of group size in the small group market. Table 20 shows the distribution by group size in the small group market as of 2009.⁹ The small group market is dominated by the smaller groups with 44% of members and 80% of groups in the small group market having 10 or less employees. This table also shows an estimated average premium impact due to the elimination of health underwriting. We did not notice a considerable difference in premium change among group sizes. However, the larger groups on average have higher surcharges due to health status and will experience larger premium decreases when health underwriting is eliminated.

Group Size Range	Distribution of Members	Distribution of Groups	Average Premium PMPM Pre-ACA	Average Incurred PMPM Pre-ACA	MLR	Average Premium Change due to Elimination of Health UW
less than 10	43.6%	80.3%	\$345.66	\$295.90	85.6%	0.3%
11-20	25.7%	12.6%	\$328.32	\$277.74	84.6%	0.3%
21-30	16.3%	4.5%	\$324.59	\$289.41	89.2%	0.2%
31-40	9.8%	1.9%	\$328.88	\$269.87	82.1%	-1.6%
41-45	2.7%	0.4%	\$325.77	\$290.48	89.2%	-3.7%
46+	2.0%	0.3%	\$305.91	\$361.76	118.3%	0.0%
Grand Total	100.0%	100.0%	\$334.82	\$288.78	86.2%	0.0%

Table 20 – Minnesota Small Group Market Distribution by Group Size

Given the minimal impact of the benefit requirements in the small group market along with minimal member migration assumed in the employer sponsored insurance segment, there is expected to be minimal overall premium impact to the small group market in 2016 as a result of the ACA.

E. Merged Markets

GA modeled the impact of merging various market segments by using claims, membership, benefit and demographic information primarily from the insurer survey data as well as outputs from Dr. Gruber’s microsimulation model.

- **Scenario 1:** Assume child eligibility at 150% FPL for a state public program and Minnesota does not offer a Basic Health Program (BHP)
- **Scenario 2:** Assume child eligibility at 150% FPL for a state public program and Minnesota does offer a Basic Health Program (BHP)

⁹ Note that this data only includes some of the insurers in the small group market since one insurer reported group size differently and therefore was not consistent.

- **Scenario 3:** Assume child eligibility at 275% FPL for a state public program and Minnesota does not offer a Basic Health Program (BHP)
- **Scenario 4:** Assume child eligibility at 275% FPL for a state public program and Minnesota does offer a Basic Health Program (BHP)

We calculated an adjusted claims base for each of the market segments (individual market, small group market, and large group 51 to 100 market) using the following methodology. GA analyzed paid claims costs, plan design distributions, age/gender distributions and claims distributions of each market respectively. In addition, GA analyzed respective market share as of 2016, after the change in membership due to the individual responsibility requirement and federal subsidies. GA adjusted the claims costs for the corresponding benefits and age demographics within each market. Note that while there may be differences due to distribution of members by geography, we were not able to model this given the data provided and therefore have essentially assumed that there are no significant differences due to geography for these various market segments. We then compared these adjusted claims to understand relative morbidity. These results were analyzed under each of the four scenarios listed above. The results are presented in Table 18.

In addition to analyzing actuarial values, demographics and financial information by market segment, the next three tables show distribution of claimants and dollars by different annual spend categories, also known as claims continuance tables. Tables 21 through 23 are continuance tables for the individual, small group and large group 51-100 markets, respectively. These tables are based on allowed annual spend (i.e., payments to providers, including the members' cost sharing.) In the individual market, 26% of members have \$0 in annual allowed spend, while in the small group market 19% have \$0 in annual allowed spend and in the large group 51-100 market 21% have \$0 in annual allowed spend. The average allowed spend per claimant also varies by market segment. In each of the small group and large group 51-100 markets, the average allowed spend per claimant is over \$3,000 per year, while in the individual market this amount is \$2,300 per year.

CY 2009 Minnesota Individual			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
\$0	26.3%	0.0%	\$0
\$1 - \$999	70.3%	7.2%	\$377
\$1,000 - \$4,999	91.3%	27.2%	\$2,202
\$5,000 - \$9,999	95.4%	40.0%	\$7,055
\$10,000 - \$24,999	98.6%	60.9%	\$15,308
\$25,000 - \$49,999	99.5%	74.1%	\$34,035
\$50,000 +	<u>100.0%</u>	<u>100.0%</u>	<u>\$112,645</u>
Total	100.0%	100.0%	\$2,306

Table 21 – 2009 MN Individual Allowable Claims Distribution

CY 2009 Minnesota Small Group			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
\$0	18.8%	0.0%	\$0
\$1 - \$999	60.3%	5.1%	\$396
\$1,000 - \$4,999	87.1%	24.3%	\$2,306
\$5,000 - \$9,999	93.4%	38.2%	\$7,087
\$10,000 - \$24,999	98.0%	60.0%	\$15,260
\$25,000 - \$49,999	99.3%	73.9%	\$34,270
\$50,000 +	<u>100.0%</u>	<u>100.0%</u>	<u>\$117,474</u>
Total	100.0%	100.0%	\$3,219

Table 22 – 2009 MN Small Group Allowable Claims Distribution

CY 2009 Minnesota Large Group 51-100			
Annual Allowed Dollars	Cumulative % of Claimants	Cumulative % of Dollars	Average Allowed Claims per Claimant
\$0	21.1%	0.0%	\$0
\$1 - \$999	63.8%	5.3%	\$378
\$1,000 - \$4,999	88.1%	23.7%	\$2,292
\$5,000 - \$9,999	93.8%	37.0%	\$7,084
\$10,000 - \$24,999	98.0%	58.3%	\$15,360
\$25,000 - \$49,999	99.3%	72.7%	\$34,226
\$50,000 +	<u>100.0%</u>	<u>100.0%</u>	<u>\$113,008</u>
Total	100.0%	100.0%	\$3,031

Table 23 – 2009 MN Large Group 51-100 Allowable Claims Distribution

F. Limitations and Data Reliance

Gorman Actuarial prepared this report solely for the use of the state of Minnesota Department of Commerce. While we understand that this report may be distributed to third parties, Gorman Actuarial assumes no duty or liability to any third parties who receive this information herein. This report should only be distributed in its entirety.

Any user of this report must possess a reasonable level of expertise and understanding of healthcare, health insurance markets and financial modeling so as not to misinterpret the information presented. The report addresses certain provisions of The Patient Protection and Affordable Care Act, but is not intended to act as an official or comprehensive interpretation of the legislation itself.

Analysis in this report was based on data provided by federal and state government authorities as well insurers in the Minnesota health insurance markets. Gorman Actuarial has not audited this information for accuracy. We have performed a limited review of the data for reasonableness and consistency. If the underlying data is inaccurate or incomplete, the results of this analysis may likewise be inaccurate or incomplete.

The assumptions and projections included in this report are based on our understanding of the ACA and the associated regulations as of the report date. Future regulatory and legislative actions may materially change the impact of the ACA and invalidate certain assumptions or projections presented in this report. Therefore this report should be considered time-sensitive and results may change as new information becomes available.

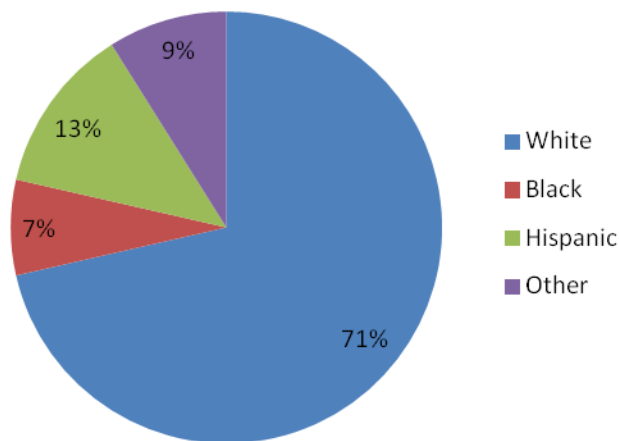
12. Appendix B

Breakdown of MN Population by Race/Ethnicity and Insurance Type, 2016

Before ACA	White	Black	Hispanic	Other
ESI	74%	38%	31%	55%
Traditional Nongroup	6%	4%	4%	5%
Public	11%	42%	36%	24%
Uninsured	9%	17%	29%	16%
	100%	100%	100%	100%

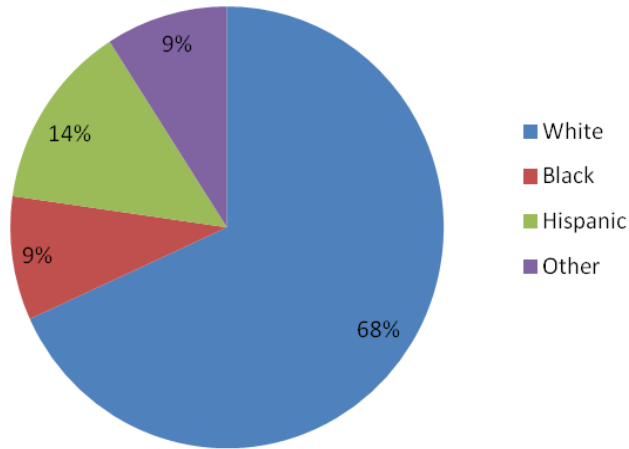
After ACA (150% FPL case and no BHP)	White	Black	Hispanic	Other
ESI	73%	40%	33%	55%
Traditional Nongroup	1%	2%	2%	0%
Reformed Nongroup / Exchange	11%	13%	11%	12%
Public	11%	38%	41%	26%
Uninsured	4%	8%	13%	7%
	100%	100%	100%	100%

Newly Insured by Race/Ethnicity, 2016



Coverage Sources of the Newly Insured by Race/Ethnicity: 150% FPL case and no BHP, 2016

Remaining Uninsured by Race/Ethnicity, 2016



The Remaining Uninsured by Race/Ethnicity: 150% FPL case and no BHP, 2016