MNsure
Health Industry
Advisory Committee (HIAC)

Financing Mechanism Policy Recommendation

The Health Insurance Advisory Committee (HIAC) was established by the MNsure Board under authority of Minn. Stat. § 62V.04, subd. 13(a).

The HIAC "will provide appropriate and relevant advice and counsel on MNsure's duties and operations and other related issues for the benefit of the Board."

July 28, 2016

Table of Contents

HIAC Members

Jonathan Watson is the committee chair. He resides in the Twin Cities and is public policy director at the Minnesota Association of Community Health Centers.
Ghita Worcester is the committee vice chair. She resides in the Twin Cities and is the senior vice president for public affairs and the chief marketing officer at UCare.
Kenneth Bence resides in the Twin Cities and is the director of public health at Medica.
Kyle Bozentko resides in the Twin Cities and is the executive director of the Jefferson Center.
David Dziuk resides in the Twin Cities and is senior vice president and chief financial officer at HealthPartners, Inc.
Forrest Flint resides in the Twin Cities and is vice president of strategy and innovation at Delta Dental of Minnesota.
Carl Floren resides in the Twin Cities and is a retired software professional.
Matthew Flory resides in the Twin Cities and is a state health systems manager with the American Cancer Society.
Christopher Johnson resides in the Twin Cities and is a physician with Emergency Physicians Professional Association.
Harlan Johnson resides in Greater Minnesota and is an insurance broker at Harlan V. Johnson Agency, Inc., a small business owner and an employer. He also serves on the board of directors for the Minnesota Association of Health Underwriters.
Andy McCoy resides in the Twin Cities and is the vice president of revenue management for Fairview Health Services.
Heidi Michaels Mathson resides in the Twin Cities and is a health insurance broker at Dyste Williams.
Reuben Moore resides in the Twin Cities and is a wellness strategy and innovation leader at Humana, a health and well-being company.
Chris Rofidal resides in the Twin Cities and is a regional sales director with Health Information Designs.
Charles Sawyer resides in the Twin Cities and is a chiropractor as well as senior vice president at Northwestern Health Sciences University.

Executive Summary

The HIAC recommends Minnesota maintain the current 3.5% assessment on health products sold through MNsure. This financing mechanism has been in place since the inception of MNsure.

The HIAC originally considered five options to fund a portion of MNsure operations. Subsequently, the HIAC narrowed the final options to the following two:

1. Maintain the current 3.5% assessment on products sold through MNsure; and

2. Reduce the assessment to approximately 1.75% and apply to individual market products sold on and off MNsure.

The HIAC recognizes that financing of MNsure is a complex topic with many known and unknown consequences. Nonetheless, the HIAC worked in a collaborative manner to develop this recommendation for the MNsure Board.

After five HIAC meetings to develop, discuss and refine the research and options, the final occurred on July 28, 2016. The vote attests to the complexity of the financing issue: Six (6) members voted to maintain the current financing mechanism; five (5) members voted for the reduced assessment applied on and off the exchange; one (1) member voted in abstention; and three (3) members were not present to vote.

Issue Statement

The MNsure Board of Directors charged the Health Industry Advisory Committee (HIAC) to develop a recommendation regarding the financing of MNsure.

Specifically, the **HIAC is to make recommendations related to the current withhold mechanism that collects 3.5% of premium revenue from Qualified Health Plans (QHPs) sold on MNsure**.

Background

Minnesota is one of seventeen (17) states that operate a state-based exchange. (27 states use a federally-facilitated exchange and 7 states use a state-partnership exchange.)

Federal grants support establishing state-based exchanges through the Center for Consumer Information and Insurance Oversight (CCIIO) for the initial years of Exchange operation. In addition to federal grants, states supplement exchange operations through three main vehicles:

1. Assessments only on health plan products sold through the state exchange;

2. Assessments on health plan products sold both on and off of the state exchange; and

3. State funding.

Some states use a combination of the above as well.

Table 1 | Financing Approach of State-Based Exchanges[1]

Assessment on Plans Offered Through Exchange Only	Broad-based Assessment (On and Off the Exchange)	State Appropriation	TBD
1. California 2. Hawaii* 3. Idaho 4. Massachusetts 5. Minnesota 6. Nevada* 7. Oregon* 8. Washington	1. Colorado 2. Connecticut 3. DC 4. Kentucky 5. Maryland 6. New Mexico*	1. New York 2. Vermont	1. Rhode Island

* States that use a "federally supported exchange."

Financing of state-based exchanges rely on a variety of funding sources and mechanisms, sometimes in conjunction with one another. For example, Colorado and Washington use federal grants, a percentage withhold on plans and a PMPM assessment for plans sold on the exchange. Overall, the percent withhold is lower in states that apply it to products sold on and off the exchange.

In Minnesota, state statute dictates one of the MNsure revenue sources – namely the percent of premium assessment. Specifically, under Minn. Stat. § 62V.05, Subd. 2(c), MNsure:

> "shall retain or collect up to 3.5% of total premiums for individual and small group market health plans and dental plans sold through MNsure to fund operations of MNsure…"

The total amount collected under the above shall not exceed 100% of the funds collected under the now-defunct Minnesota Comprehensive Health Association (MCHA) funds collected in 2012.

For federally-operated exchanges, the Affordable Care Act (ACA) law provides CMS with the authority to assess an "exchange user fee" to cover the administrative costs of operating an exchange.[2] CMS publishes the fee – expressed as a percent of premiums – on an annual basis in the Benefit and

[1] http://www.commonwealthfund.org/publications/blog/2015/may/state-marketplaces-and-financing-stability
[2] 45 CFR 156.50

Payment Parameters final regulations.[3] For 2017, the rate is 3.5% - similar to the rate in 2014, 2015 and 2016.

Table 2 | State Based Marketplaces, Funding Mechanisms[4]

State	Percent of Premium		Per Member Per Month (PMPM) On Exchange	Other	Federal Funds, 2010-14 ($s in Mil)
	Inside Only	Inside & Outside			
FEDERALLY FACILITATED MARKETPLACES	***3.5%***				
California			$13.95		$1,065.7
Colorado		1.4%	$1.25 (on & off)		178.9
Connecticut		1.35%			200.1
DC		1.00%			
Hawaii	2.00%				205.3
Idaho	1.99[5]%				69.4
Kentucky		1.00%			253.7
Maryland		2.00%			171.1
Massachusetts	2.50%				193.0
Minnesota	3.50%				155.0
Nevada			$13.00		90.8
New Mexico		% based on mkt. share			123.3
New York				State Funds[6]	451.2
Oregon			$9.66		305.2
Rhode Island				TBD	139.1
Vermont				State Funds	168.1
Washington	2.00%		$4.19		266.0

[3] Federal Register, Vol. 81, No. 45, Tuesday, March 8, 2016, page 12293 – sets the 2017 percent withhold at 3.5%

[4] Commonwealth Fund, May 2015: http://www.commonwealthfund.org/publications/blog/2015/may/state-marketplaces-and-financing-stability

[5] 2016 assessment. 2015 assessment was 1.5%

[6] Revenue generated from "covered lives assessment" – a tax on private insurance.

Currently, MNsure operations are funded from **three primary revenue sources**:

1. 3.5% assessment on products sold through MNsure ("premium withhold");

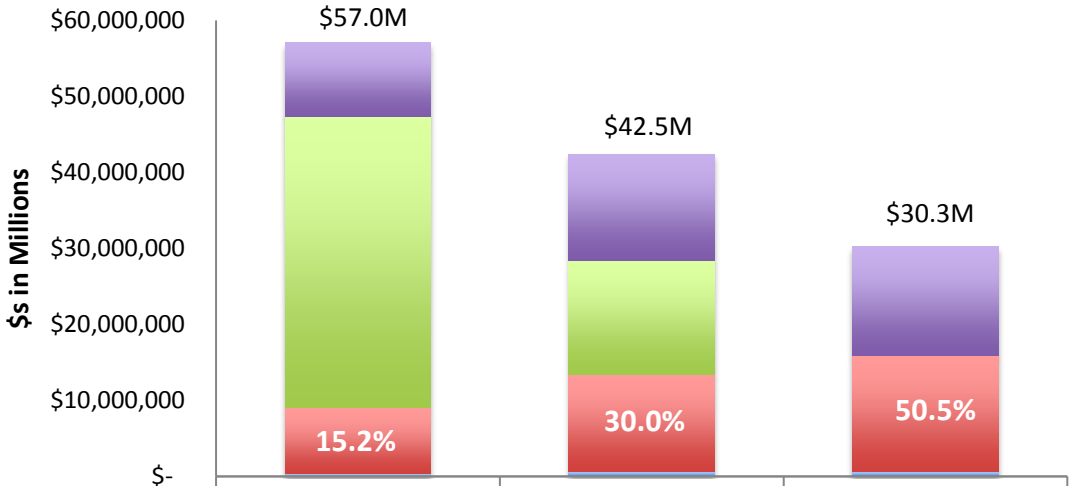
2. Federal grants (namely through the Affordable Care Act and the Center for Consumer Information & Insurance Oversight – "CCIIO grants");

3. Minnesota Department of Human Services (DHS) funds to support Minnesota Health Care Program (MHCP) enrollment through MNsure (i.e., Medical Assistance and MinnesotaCare programs).

In FY16, the 3.5% premium withhold contributes $8.7 million to MNsure's operating budget – or 15%. With the reduction of CCIIO grants, by FY18, the premium withhold is projected to contribute roughly 50% of MNsure's operating budget. Based on current projections, the premium withhold will generate $15.3 million in FY18 – a 76% increase.[7]

[7] Budget information is based on the March 9, 2016 and July 20, 2016 MNsure Board Meetings. Materials can be found at: https://www.mnsure.org/assets/bd-2016-03-09-premium-withhold-revenue-projections_tcm34-194421.pdf and https://www.mnsure.org/assets/bd-2016-07-20-DRAFT-FY17-budget_tcm34-249915.pdf

Chart 1 | MNsure Preliminary Three Year Plan
(March 9 & July 20, 2016 MNsure Board Meetings)



	FY16	FY17	FY18
DHS Reimb.	$9,608,860	$13,979,900	$14,351,000
CCIIO Grants	$38,391,615	$15,037,368	$-
Withhold Rev.	$8,682,297	$12,779,459	$15,284,000
Forward Balance	$345,965	$618,933	$617,458

Key Assumptions

- Assumption #1 | MNsure Enrollment Projections

  The MNsure budget assumes a 21% average annual growth in member months from FY16 to FY18. In addition, the budget assumes a 10% annual growth rate in the average premium from FY16 to FY18.[8]

Table 3 | MNsure Enrollment and Premium Projections

	Enrollment		Premium		Withhold Revenue
	Member Months	% Growth	Average Premium	% Growth	
FY2016	717,310		$346.50[9]		$8.6M
FY2017	911,945	+27%	$399.75[10]	+15%	$12.8M
FY2018	1,038,981	+14%	$419.74[11]	+5%	$15.3M
AVERAGE		**+21%**		**+10%**	

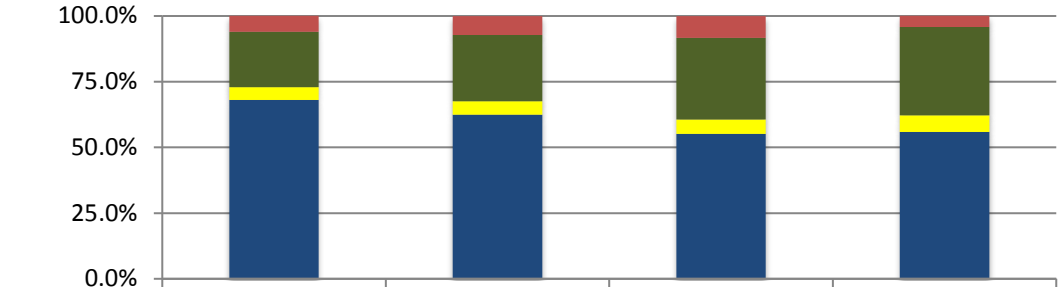
[8] Ibid
[9] Calculated by 6 months at $303.00 in EY15 and 6 months at $390.00 in EY16
[10] Calculated by 6 months at $390.00 in EY16 and 6 months at $409.50 in EY17
[11] Calculated by 6 months at $409.50 in EY17 and 6 months at $429.98 in EY18

For purposes of this analysis, the HIAC will use the assumptions regarding member months and premium levels from the March 9, 2016 MNsure Board meeting as outlined in Table 3.

- Assumption #2 | Size of Minnesota's Individual Health Insurance Market

According to the Minnesota Department of Health's (MDH) Health Economics Program, in 2015 roughly 6.3% of the state's population received health care coverage through the non-group market[12].

Chart 3 | Sources of Health Care Coverage, MN, Select Years



	2001	2007	2013	2015
Uninsured	6.1%	7.2%	8.2%	4.3%
Public	21.1%	25.2%	31.1%	33.6%
Non-Group	4.8%	5.1%	5.4%	6.3%
Group	68.1%	62.5%	55.2%	55.9%

[13]

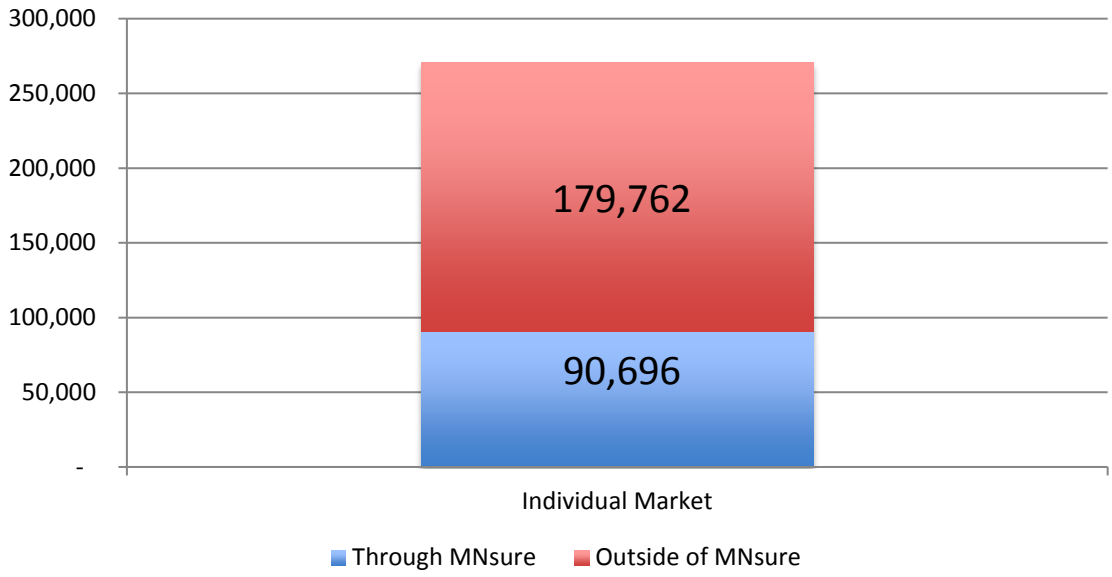
In addition, the Minnesota Council of Health Plans (MCHP) recently released a report[14] citing that the number of Minnesotans buying insurance on their own is nearly half of what was originally predicted in 2013. According to the report, the number of Minnesotans buying health insurance on their own was 270,458 – 90,696 through MNsure and 179,762 outside of MNsure.

[12] "Health Insurance Coverage in Minnesota: Results from 2015 Minnesota Health Access Survey," MDH, Health Economics Program, February 29, 2016. http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf

[13] Ibid.

[14] http://mnhealthplans.org/nearly-260000-fewer-buy-health-insurance-on-their-own-than-expected-council-to-study-effect-of-fewer-people-buying-individual-and-family-policies/

Chart 4 | Estimate of Minnesota's Individual Market, 2015



Based on the above, the size of Minnesota's individual market, expressed in member months, is roughly 3.2 million. Using MNsure's assumption for the average premium, the total individual market place premium amount is $1.12 billion.[15]

- Assumption #3 | Impact of MinnesotaCare expansion

Currently, MinnesotaCare eligibility for non-pregnant adults is between 138% and 200% of poverty. As permitted under the Affordable Care Act (ACA) law, Minnesota re-purposed MinnesotaCare as the state's Basic Health Program (BHP). Prior to the ACA law, MinnesotaCare eligibility for specific populations was up to 275% of poverty.

The 2016 Minnesota Legislature proposed expanding MinnesotaCare back to 275% of poverty. While no proposal was enacted into law in 2016, an expansion back to 275% of poverty will impact the number of individuals in the individual market place in Minnesota.

According to estimates provided during the 2016 Minnesota Legislative session, 41,300 individuals with incomes between 200% and 275% of poverty would enroll in MinnesotaCare if eligibility were expanded. Furthermore, HIAC assumes that roughly half of these newly MinnesotaCare eligible are currently uninsured. Consequently, the member months "removed" from the individual market place in Minnesota

[15] Roughly 3.2 member months on the individual market and the FY16 average premium (per MNsure budget assumptions) is $346.50.

through an expansion of MinnesotaCare would be roughly 247,800. This translates to roughly $85 million in premiums removed from the individual market.[16]

The HIAC assumes that MinnesotaCare eligibility will remain at the current eligibility levels.

Issues For Further Analysis

"Grandfathered" Health Plans & Premium Assessment

Under the Affordable Care Act (ACA) law, health plans offering coverage on the employer group market and individual market can be "grandfathered" so long as the plan was purchased on or before March 23, 2010.

According to Medical Mutual (an Ohio insurance company), the exchange user fee (3.5%) is only applied to non-grandfathered health plans.[17]

However, in the preamble to the 2012 Exchange and QHP Filing Rule grants flexibility to Exchanges in developing their financing structure. The preamble notes:

> The Exchange should identify the issuers that are subject to any user fees or other assessments, if applicable. This could include all participating issuers, as defined in § 156.50 of this final rule, or a subset of issuers identified by the Exchange. Similarly, an Exchange could exempt certain issuers from assessments. We believe that Exchange discretion is important with respect to issuer participation so that Exchanges can consider a broad range of user fee and assessment alternatives."[18]

Consequently, an argument could be made that premium withhold could be applied to "grandfathered" health plans.

Lastly, the number of "grandfathered" health plans in Minnesota is very small and assessing a premium withhold on these plans is inconsequential from a financial perspective.

Per Member Per Month versus Percent Assessment

[16] Per 2016 legislative fiscal note on SF2541-2A, roughly 41,300 individuals would enroll in MinnesotaCare through expansion from 200% to 275% of poverty. Roughly 50% are currently uninsured. Consequently, 20,650 would be transferred from the individual market – 247,800 member months. Using the MNsure assumption of $346.50 monthly premium, this translates to $85.9 million in premium revenue.
[17] https://www.medmutual.com/Healthcare-Reform/Reform-for-Individuals/Healthcare-Reform-Fees-and-Costs.aspx
[18] 77 Federal Register 18323 (March 27, 2012).

States that opt to operate a state-based exchanges have broad discretion over mechanisms to achieve sustainability. According to a Commonwealth Fund issue brief:

> *States may fund their marketplaces through ordinary budget appropriations, for example, or even through sale of ancillary products or website advertising. At present, however, most are financed predominately through an assessment on health plans*[19]*.*

Further analysis is needed, however, it appears that states can set their per member per month (PMPM) rate at any level and that it is not "capped" by a federal rule or regulation. State statute, like Minnesota's, may cap the percent assessment or PMPM.

State Discretion on Setting Percent Assessment and/or PMPM

Outside of specific state statute "capping" the percent assessment and/or PMPM, there does not appear to be any federal regulation that "caps" the assessment/PMPM for state-based exchanges. While further research is needed, it appears that under current Minnesota Statute, the MNsure Board could set the percent assessment at any rate 3.5% or below. To increase the percent assessment above 3.5%, a change to Minnesota law is required, but no change to federal law/regulation.

Options

The HIAC considered the following **five options**:

1. Maintain status quo – 3.5% withhold on products sold through MNsure;

2. Reduce premium withhold to 1.75%[20] and apply to products sold through MNsure and individual plans sold "off MNsure;"

3. Replace current 3.5% withhold with a Per Member Per Month (PMPM) assessment on plans sold through MNsure.

[19] http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/state-run-marketplaces-use-healthcaregov#/#20

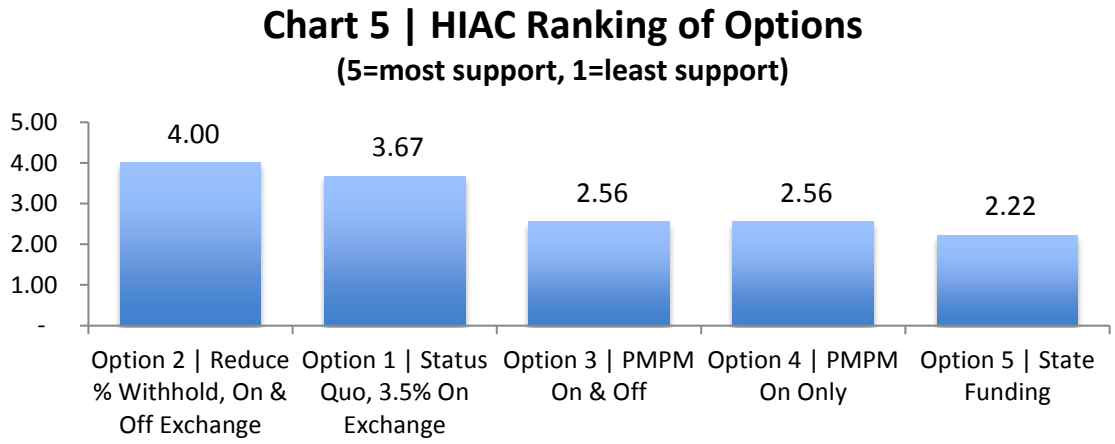
[20] Or a percentage that raises an equivalent amount of revenue currently collected under the 3.5%

4. Replace the current 3.5% withhold with a Per Member Per Month (PMPM) assessment on plans sold through MNsure and on individual plans sold "off MNsure;" and

5. Replace the current 3.5% withhold with state funding to support MNsure operations that are not supported with current DHS funds (i.e., operations related to Qualified Health Products – QHPs).

Preliminary Assessment

Through a "ranking process," HIAC members assessed the above options.



Based on those results, the HIAC identified **the following two options for further evaluation:**

1. Maintain status quo – 3.5% withhold on products sold through MNsure;

2. Reduce premium withhold to 1.75%[21] and apply to products sold through MNsure and individual plans sold "off MNsure;"

The HIAC identified the "advantages" and "disadvantages" of the two remaining proposals.

Option 1 | Status Quo – Maintain current 3.5% Withhold to Plans Sold On MNsure Only	
Advantages	**Disadvantages**
1. No legislative action required 2. Consistent with federal exchange percent assessment of 3.5% 3. Assessment (tax) applied to plans receiving the benefit of participating on MNsure.	1. Application of tax to plans in Minnesota is not transparent to consumers. 2. Consistent revenue for MNsure is dependent upon a stable/growing enrollment of Minnesotans through MNsure. 3. Perceived incentive that potential enrollees are "steered" away from MNsure in order to avoid tax (assessment).

Option 2 | Reducing Percent Withhold to 1.75% and Assessing to Plans sold on MNsure and Off MNsure in the Individual Market	
Advantages	**Disadvantages**
1. Provides MNsure with a reliable funding source that is relatively	1. Potential increase in rates for current plans sold only "off" the

[21] Or a percentage that raises an equivalent amount of revenue currently collected under the 3.5%

easier to project into the future. 2. Rates for plans sold on the exchange could decrease. 3. Easier for the participating stakeholders (e.g., health plans, brokers, navigators, consumers) to understand the revenue mechanism. 4. Dis-incents managed care organizations from selling plans off MNsure to avoid paying withhold.	exchange. 2. Unclear impact on "grand-fathered" plans that remain in Minnesota.[22] 3. Legislation is necessary to enact option.

Recommendation

- **The HIAC recommends Option 1 – Maintaining the current 3.5% withhold on plans sold only on MNsure.**

- The HIAC voted on this recommendation on July 28, 2016 as follows:

Option	Number of Votes
1| Maintain 3.5%	6
2| Reduce to 1.75% On and Off Exchange	5
Abstentions	1
Not Present to Vote	3
TOTAL	15

- Members voting for Option 1 (6 members): Kenneth Bence, David Dziuk, Forrest Flint, Heidi Mathson, Chris Rofidal and Ghita Worcester (Vice-Chair)

- Members voting for Option 2 (5 members): Kyle Bozentko, Carl Floren, Matt Flory, Charles Sawyer and Jonathan Watson (Chair)

- Members Voting in Abstention (1 member): Rueben Moore

[22] It is unclear if "grand-fathered" plans could be subject to an assessment (percent or PMPM).

- Members Not Present (3 members): Chris Johnson, Harlan Johnson and Andy McCoy

Policy Rationale

HIAC members had **robust, cooperative discussion** throughout the development of the policy recommendation. All participants recognized and emphasized that MNsure financing is a complex topic with many consequences for MNsure, consumers, navigators/brokers, health plans and providers.

Support for Option #1

- Predictable rate that organizations are accustomed to paying for three years.
- Consistent with federal rules regarding premium withhold.
- Places accountability on MNsure to improve consumer experience (e.g., call center, web interface).
- Consumers using MNsure to purchase coverage are paying for MNsure operations.
- Consumers not using MNsure should not be assessed a "tax/fee," to support operations that they are not using.

Support for Option #2

- MNsure is serving as a "public good" to reduce the number of uninsured Minnesotans.
- As part of their coverage evaluation, consumers use MNsure to evaluate coverage options, even though they may ultimately purchase coverage directly from a health carrier.
- Assessment across entire individual market is easier to administer.
- Because carriers must charge the same premiums for plans sold on- and off-exchange, the 3.5% premium withhold is amortized across plan premiums based on volume projected to be sold on- and off-exchange. Moving to an assessment across the entire individual market would more transparently demonstrate this effect while eliminating the need for carriers to estimate proportional sales on- and off-exchange.

Other Discussion

- One-time state funding should be considered to support the completion of MNsure's information technology activities.