

Health Care Financing Task Force Final Report

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Prepared by Manatt Health

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

Health Care Financing Task Force

Information: www.mn.gov/dhs/hcftf

Contact: dhs.hcfinancingtaskforce@state.mn.us

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I. Introduction

Throughout its 2015 session, the Minnesota State Legislature grappled with complex questions related to financing and reforming Minnesota’s health coverage continuum to ensure long-term sustainability. Legislators vigorously debated changes to several major components of Minnesota’s health care programs, most notably MNSure, the State’s health insurance Marketplace, and MinnesotaCare, the State’s health insurance program for low-income families. They also discussed whether a new opportunity—namely, State Innovation Waivers under Section 1332 of the Affordable Care Act (1332 waivers)—could afford the State more flexibility to provide coverage better tailored to Minnesota’s needs.

Acknowledging the complexity of the issues before them, the Legislature and Governor agreed to convene the Health Care Financing Task Force (the Task Force) to advise them on sustainable strategies that will increase access to and improve the quality of health care for Minnesotans (see [Appendix A – Task Force Statute](#)). The Governor and Legislature formed the Task Force to allow for a deeper discussion outside of the legislative session on critical policy questions with input from a broad range of perspectives—including providers, insurers, brokers, consumer representatives, and agency leadership.

MINNESOTA’S FOUNDATION FOR REFORM

The Task Force is the most recent in a series of State task forces and commissions, including the Minnesota Health Reform Task Force established under Executive Order 11-30, the Health Care Access Commission of 2008, and the Health Care Transformation Task Force of 2007, demonstrating Minnesota’s longstanding commitment to transparent, regular examination of the direction of health and health care in Minnesota.

Additionally, the Task Force’s work is informed by and dovetails with Minnesota’s ongoing State Innovation Model initiative through which the State is using federal grant money to test new ways of delivering and paying for health care by promoting networks of accountable providers.

Convened in August 2015, the Task Force was given a sweeping charge to consider alternatives to MNSure and options under 1332 or 1115 waivers, including: (1) options for providing and financing seamless coverage for populations eligible for insurance affordability programs;¹ (2) options for transforming health care purchasing and delivery; and, (3) options for alignment, consolidation, and governance of certain operational components of Minnesota’s coverage programs. The Task Force was directed to consider the impact of these options on the health care workforce and delivery system for hospitals, clinics, and rural and safety net providers.

The Task Force was also tasked with evaluating various reform options in light of seven distinct, but related, goals:

- Encouraging seamless consumer experience across all benefit programs;
- Reducing barriers to accessibility and affordability of coverage;
- Improving sustainable financing of health programs, including impact on the state budget;

¹ Insurance affordability programs are a range of programs that provide free or subsidized coverage to low-income individuals. Insurance Affordability Programs are defined in federal regulations as (1) a state Medicaid program, (2) a state Children’s Health Insurance Program, (3) a state Basic Health Program, (4) advance premium tax credits, and (5) cost-sharing reductions. See 42 C.F.R. § 435.4.

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- Assessing the impact of options for innovation on their potential to reduce health disparities;
- Expanding innovative health care purchasing and delivery systems strategies that reduce cost and improve health;
- Promoting effective and efficient alignment of program resources and operations; and
- Increasing transparency and accountability of program operations.

Weaving these seven goals together, an overarching vision for the work of the Task Force comes into focus: to provide sustainable, quality health care for all Minnesotans (see Appendix C – Task Force Vision). Achieving this ambitious vision, adopted by the Task Force at its August 26, 2015 meeting, required Task Force members to consider strategies that cut across multiple sources of coverage in the State, including: Medical Assistance, MinnesotaCare, MNsure, and the broader private health insurance market. It also required the Task Force to balance bold, forward-looking thinking with generating concrete, actionable recommendations, all while focusing on the key issues most likely to advance the State’s goals of increasing access, improving quality of care, and reining in growth in health care costs.

The Task Force convened from August 2015 through January 2016, through meetings of its full membership and three workgroups (described in Section IV below). Staff from State agencies including the Department of Human Services (DHS), the Department of Commerce, the Department of Health, MNsure, MN.IT, and Minnesota Management and Budget, as well as consultants from Manatt Health and actuaries from Milliman, supported the Task Force in its work.

This final report of the Task Force (Report) represents the culmination of the Task Force's work, and presents final recommendations intended to inform the Governor and Legislature on potential opportunities to reform Minnesota’s health coverage programs to ensure long-term sustainability.

II. Minnesota’s Coverage Continuum

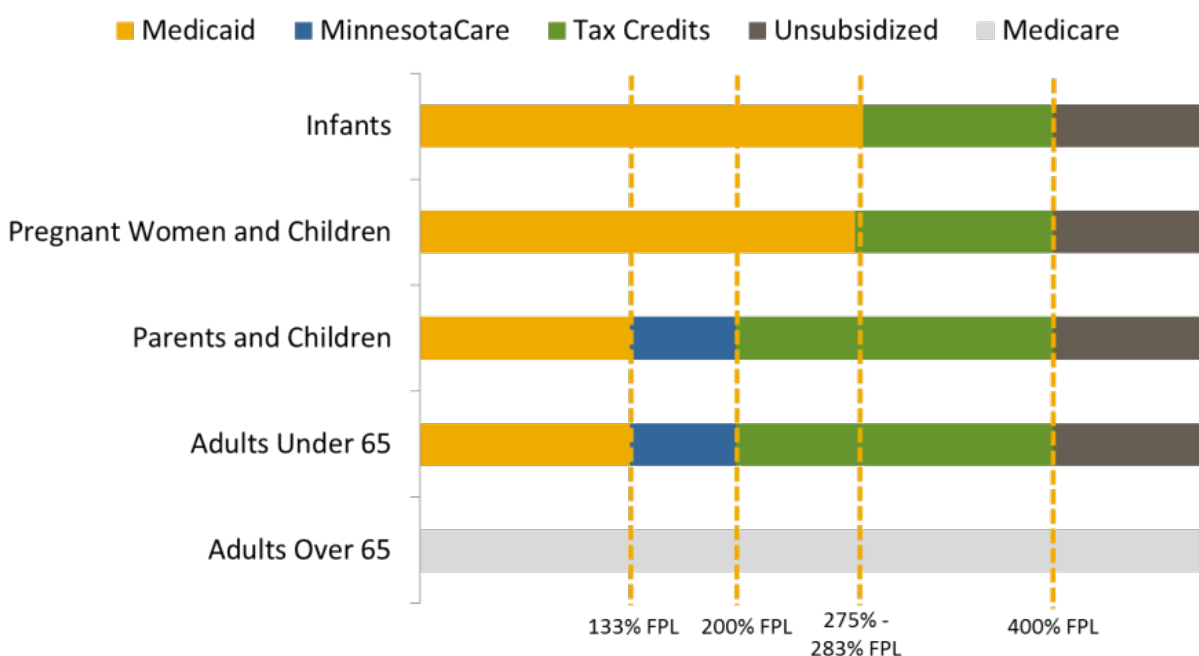
Minnesotans are among the healthiest Americans—consistently ranking sixth or better in the United Health Foundation’s rankings of state health — thanks in large part to the State’s long-standing commitment to providing access to comprehensive and affordable coverage to its residents. Minnesota is also among the “leader states” in the nation in terms of health coverage – ranking in the top five states in rates of insurance coverage, with only 5.9% of Minnesotans lacking health insurance in 2014.²

Minnesotans obtain health coverage through one of several pathways: employer-sponsored insurance, commercial insurance, and publicly funded health coverage programs. Currently, roughly two-thirds of Minnesotans receive health insurance through their employers. Another 239,000 purchase coverage in the commercial market outside of MNsure, without federal subsidies.³ The remaining Minnesotans access coverage through one of several publically funded insurance affordability programs.

² Minnesota Department of Health. *Coverage, Insurance Market Statistics and Barriers to Care in Minnesota*. September 2015. Available at: http://www.mn.gov/dhs/images/HCF-TF-Coverage-Demog-Barriers-9-17-15_FINAL.pdf

³ Minnesota Department of Health. *Coverage, Insurance Market Statistics and Barriers to Care in Minnesota*. September 2015. Available at: http://www.mn.gov/dhs/images/HCF-TF-Coverage-Demog-Barriers-9-17-15_FINAL.pdf

Figure 1 Minnesota's Coverage Continuum⁴



Minnesota's insurance affordability programs include:

- MEDICAL ASSISTANCE (OR MEDICAID).** As part of the Affordable Care Act's (ACA) coverage reforms, Minnesota was one of the first states to authorize the "early expansion" of Medicaid in 2011 and then in 2014 fully expanded the program for eligible low-income Minnesotans up to 138% FPL and children and pregnant women at higher income levels. Since expansion, Medical Assistance, the State's Medicaid program, has grown to over one million enrollees with total expenditures of over \$11 billion expected in fiscal year 2016 (\$4.9 billion of state share).⁵ Approximately, 70% of the state Medical Assistance spending is on health care and long term care for the elderly and individuals with disabilities.
- MINNESOTACARE.** For the past twenty-five years, MinnesotaCare has provided subsidized coverage for low-income Minnesotans whose income exceeds eligibility levels for Medical Assistance. In 2015, the State transitioned MinnesotaCare to become the nation's first Basic Health Program (BHP), accessing federal tax credit and cost sharing subsidy dollars to fund the program. To comply with federal BHP requirements, the State reduced eligibility for MinnesotaCare from 275% FPL to 200% FPL, allowing individuals with incomes from 200% to 275% FPL to purchase subsidized coverage through MNsure. Today, MinnesotaCare covers over 110,000 individuals with incomes up to 200% FPL at a projected cost of \$530 million (of which \$162 million is the State's share) for state fiscal year 2016.⁶

⁴ Note: Figure does not reflect 5% income disregard for determining Medical Assistance eligibility.

⁵ Minnesota Department of Human Services; *Background Data Tables for November 2015 Forecast*. November 2015. Available at: <http://www.mn.gov/dhs/images/background-tables-forecast-1115.xlsx>.

⁶ Minnesota Management & Budget; *Health Care Access Fund: November 2015 Forecast Update*. November 2015. Available at: <http://www.mn.gov/mmb/images/nov-2015-hcaf.pdf>

- **SUBSIDIZED QUALIFIED HEALTH PLANS SOLD THROUGH MNSURE.** Minnesota elected to establish MNSure, a state-based Marketplace (SBM), in part to accommodate the unique features of the State's coverage continuum, like MinnesotaCare. The Marketplaces were established by the ACA to provide a means for consumers to be determined eligible for insurance affordability programs, including Advance Payments of the Premium Tax Credit (APTC), Cost-Sharing Reductions (CSR), the BHP and Medicaid, and to compare and buy individual market Qualified Health Plans (QHPs). For 2014, only a small portion of the individual market—roughly 19% of 300,000 people—purchased individual market coverage through MNSure.⁷
- **MEDICARE.** Medicare is a federally administered program that provides low-cost health insurance to people age 65 and older, people with certain disabilities, and people of any age with End-Stage Renal Disease. Today, roughly 891,000 Minnesotans receive coverage through Medicare.⁸

Taken together, the State's insurance affordability programs establish a comprehensive—albeit complex—coverage continuum. The coverage programs are siloed: each has a unique benefit design, different (though in some cases overlapping) health plans, and distinct provider networks. For consumers, this program complexity can be confusing, impeding care on occasion, and can be particularly challenging for those with cultural and language barriers to accessing care. Providers can also be impacted by program complexities as they navigate varying benefits and administrative rules, especially when their patients transition between programs.

Finally, as over one million, or 1 in 5 Minnesotans, rely on Medical Assistance and MinnesotaCare for access to health coverage and care, the long-term sustainability of these programs is of paramount concern. Projected State spending for Medical Assistance and MinnesotaCare is approximately \$5.0 billion for 2016 (approximately \$4.9 billion projected spending for Medical Assistance and \$162 million for MinnesotaCare), with Medical Assistance making up approximately 21%⁹ of the State general fund budget in 2016, with annual cost growth of approximately 6%.¹⁰ In sum, there are significant opportunities, and a public health imperative, to continue to improve Minnesota's coverage continuum to advance the Triple Aim and ensure its long-term sustainability.

III. Innovation in Minnesota's Health Care Delivery and Payment

In addition to its status as a "leader state" in terms of coverage, Minnesota is among those states leading the nation in the development of innovative health care payment and delivery models to

⁷ Minnesota Department of Health; *Coverage, Insurance Market Statistics and Barriers to Care in Minnesota*. September 2015. Available at: http://www.mn.gov/dhs/images/HCF-TF-Coverage-Demog-Barriers-9-17-15_FINAL.pdf

⁸ Minnesota Department of Health; *Coverage, Insurance Market Statistics and Barriers to Care in Minnesota*. September 2015. Available at: http://www.mn.gov/dhs/images/HCF-TF-Coverage-Demog-Barriers-9-17-15_FINAL.pdf

⁹ Minnesota Management & Budget; *Budget & Economic Forecast*. November 2015. Available at: <http://www.mn.gov/mmb/images/nov-2015-fba-detail.pdf>

¹⁰ Minnesota Department of Human Services; *Family Self-Sufficiency and Health Care Program Statistics*. November 2015. Available at: <http://www.mn.gov/dhs/images/statistics-1115.pdf>

improve health outcomes and bend the health care cost curve. In 2010, the Legislature directed DHS to develop and implement a demonstration to test alternative and innovative health care delivery systems. This work built on 2008 health reform legislation,¹¹ which established foundational elements of delivery and payment models, such as statewide quality measurement reporting, administrative efficiency through enhancements to the use of electronic health records and health information exchange, and enhancements to care delivery.

To improve care coordination at the primary care level, and to hold providers accountable for quality and cost of care, Minnesota established a medical home model, as well as several Integrated Care Models (ICMs), including:

- **INTEGRATED HEALTH PARTNERSHIPS (IHPs).** This three-year Medicaid Accountable Care Organization (ACO) model demonstration launched with six delivery systems on January 1, 2013. Providers participating in IHPs must do the following for their attributed Medicaid patients: 1) provide the full scope of primary care services; 2) coordinate with specialty providers and hospitals to manage care; and 3) demonstrate how they will partner with community organizations and social service agencies and integrate their services into care delivery. IHPs contract with DHS either in an “integrated arrangement,” in which they assume both upside and downside risk, or a “virtual arrangement” in which they assume upside risk only. As of 2015, 16 provider organizations with approximately 225,000 attributed lives are covered through the IHP demonstration. Through its first two years, the total cost of care savings from the demonstration were estimated to be \$75 million.¹²
- **INTEGRATED CARE SYSTEM PARTNERSHIPS (ICSPs).** ICSPs is Minnesota’s demonstration project for dual eligible individuals—people who are eligible for both Medicaid and Medicare coverage. Minnesota’s “Duals Demonstration” is designed to improve health care access, coordination and outcomes through payment reform by establishing partnerships among managed care organizations, and primary, acute, long-term care and mental health providers that serve dually eligible seniors and people with disabilities. Though the ICSPs models vary, each is tied to a range of quality metrics designed to promote: outcomes improvement; care delivery in the right setting; involvement of long-term care providers; and increased coordination of physical and behavioral health. As of 2015, there are 54 ICSPs.
- **BEHAVIORAL HEALTH HOMES (BHHs).** Established under the ACA, this model will begin in July 2016. BHHs will serve Medicaid-enrolled adults with serious or persistent mental illness and children and youth with emotional disturbances by expanding the traditional medical home model to build linkages to other community and social supports and enhance coordination of medical and behavioral health care. Participating providers, who will receive a monthly payment for each of their enrolled patients, will provide: 1) comprehensive care management; 2) care coordination and health promotion; 3) comprehensive transitional care; 4) patient and family support; 5) referral to community and social support services; and 6) improved exchange of health information.

¹¹ Minnesota Department of Health; *2008 Health Care Reform Summary*. June 2008. Available at <http://www.health.state.mn.us/divs/opa/08reformsummary.html>

¹² Minnesota Health Care Financing Task Force, October 2, 2015.

- **HEALTH CARE HOMES (HCHs).** HCHs is Minnesota's medical home model, established in Minnesota's 2008 health care reform legislation. Within this model, primary care providers, families and patients work together to improve health outcomes and quality of life for people with chronic or complex health conditions. To achieve certification, which is overseen by the Department of Health, HCHs must meet five major standards, each with measurable criteria: 1) access/communication; 2) patient tracking and registry functions; 3) care coordination; 4) care plans; and 5) performance reporting and Quality Improvement. Certified HCHs receive a per-person care coordination payment (both fee-for-service and managed care), with fees varying by patient complexity.¹³

Additionally, in February 2013, Minnesota was awarded a \$45 million State Innovation Model grant to test an accountable care model that is integrated across payers, a broad range of health and social service providers, and provides support to providers across the continuum of health care. One goal of this model is to ensure that every Minnesotan has the option to receive team-based, coordinated, patient-centered care that improves access to medical care, behavioral health care, long term care, and other services.

IV. Overview of the Health Care Financing Task Force (HCFTF) & Workgroups

A. Task Force

The Task Force was composed of 29 members, appointed by the Senate, House of Representatives, and Governor (see Appendix B – Task Force and Workgroup Membership for a full list of Task Force members). As directed by the Legislature, Task Force members represented diverse interests, including, among others, majority and minority legislators, health plans, brokers, small business owners, consumers, the Executive Director of MNsure, and the Commissioners of Human Services, Commerce, and Health. As established by the authorizing legislation, Emily Johnson Piper, Commissioner of Human Services, served as co-chair of the Task Force (assuming the role after being appointed Commissioner effective December 14, 2015 upon Commissioner Lucinda Jesson's judicial appointment). Sahra Noor, CEO of People's Center Health Services, was elected by the Task Force at its August 7, 2015 meeting to serve as co-chair of the Task Force.

B. Workgroups

To advance its mandate, the Task Force established three Workgroups charged with developing specific recommendations. The Task Force established a charter for each Workgroup to define its charge and areas of focus (see Appendix K – Workgroup Charters). Task Force members, excluding the Co-Chairs, were asked to indicate their interest in a particular Workgroup and then assigned accordingly, ensuring that all Task Force members participated in a Workgroup. The Co-Chairs attended and participated in meetings of the Workgroups on an ad hoc basis, but were not voting members of any Workgroup.

- **WORKGROUP 1: HEALTH CARE DELIVERY DESIGN & SUSTAINABILITY** (Led by Dr. Penny Wheeler, President & CEO, Allina Health): Workgroup 1 was charged with identifying innovative health

¹³ Minnesota Department of Health; *Health Care Homes*. Retrieved January 2016. Available at: <http://www.health.state.mn.us/healthreform/homes/index.html>

care delivery system strategies to reduce costs and improve health outcomes. Specifically, the Workgroup assessed Minnesota's experiences to date with current delivery and payment reforms, heard provider (particularly safety net provider) and patient perspectives on these reforms, and identified ways to strengthen delivery and payment reform programs so that they can be more effective in achieving Triple Aim goals, while reducing provider administrative burden.

- **WORKGROUP 2: SEAMLESS COVERAGE CONTINUUM & MARKET STABILITY** (Led by Dr. Lynn Blewett, Director, State Health Access Data Assistance Center at the University of Minnesota): Workgroup 2 was charged with examining opportunities for providing and financing a seamless, affordable and financially stable coverage continuum in Minnesota. Specifically, the Workgroup assessed options for: smoothing consumer premiums and cost-sharing across programs; enhancing the Marketplace as a platform for coverage; promoting market stability; financing the coverage continuum; consolidating and aligning programs within the coverage continuum; and providing alternatives to the individual and employer mandates, Advanced Premium Tax Credits, and Qualified Health Plans. Additionally, this Workgroup considered the impact of recommendations on families' ability to maintain adequate and affordable coverage, as well as on program transparency and accountability.
- **WORKGROUP 3: BARRIERS TO ACCESS** (Led by Dr. Marilyn Peitso, Pediatrician, CentraCare Health): Workgroup 3 was charged with evaluating opportunities to reduce barriers to accessing quality care in order to improve health outcomes in Minnesota. Specifically, the Workgroup developed options to address existing financial and structural barriers to care for hard to reach populations. The Workgroup used the "Five A's"—availability, accessibility, accommodation, affordability and acceptability—as a framework for determining the degree of "fit" between Minnesotans' priorities and the health care system in terms of access (See [Appendix I – Barriers to Access Framework](#) for framework details).

Though each Workgroup had a distinct charge, their goals were interrelated and overlapping. Each Workgroup considered how its recommendations would impact health disparities in Minnesota—including disparities related to geographic location, socioeconomic status, race/ethnicity, and/or disability—as well as Minnesota's efforts to meet the goals of the Triple Aim (improving patient experience and health outcomes, while addressing health care cost growth). Additionally, the Workgroups considered recommendations in the context of improving availability of affordable and accessible health coverage; improving continuity in coverage and care; improving consumer health literacy; reducing health disparities and improving equity; promoting responsible consumer behavior; promoting financial sustainability; promoting administrative efficiency; and maximizing federal funding.

C. Overview of the Recommendation Development Process

The full Task Force met nine times to hear from state officials, providers, Navigators, data analysts, and the public. At these meetings, members discussed issues relevant to the mission of the Task Force and reviewed, deliberated and advanced the Workgroups' preliminary recommendations. The Task Force determined that recommendations would first be developed by individual Workgroups and then brought to the full Task Force for consideration and adoption. The Workgroups developed preliminary recommendations during 37 meetings between September 2015 and January 2016.

To promote transparency and encourage broad, public participation, Task Force and Workgroup public meetings were held in Rochester, the Twin Cities metro area, and St. Cloud. Conference call and webinar

capabilities were provided for meetings to enable virtual participation. Meetings allocated time for public comment and in addition to verbal testimony, individuals and organizations also influenced the deliberations of the Workgroups and Task Force through public comment letters. To maximize transparency, the State maintained a [website](http://www.mn.gov/dhs/hcftf/) (<http://www.mn.gov/dhs/hcftf/>), where the public could learn about upcoming meetings, access background resources, and review meeting materials.

State agency staff and consultants from Manatt Health provided support to Workgroup leads and members including: developing meeting agendas and materials, providing subject matter expert presentations on issues related to preliminary recommendation development, and facilitating Task Force and Workgroup meetings. Consulting actuaries from Milliman worked with staff from multiple state agencies, including the Departments of Health, Human Services, and Commerce, as well as the Office of Management & Budget and MN.IT, to produce cost/savings estimates for many of the Workgroups' preliminary recommendations. The Department of Human Services and Department of Health collaborated to provide Milliman with the majority of the data sources used to model the financial impact of program changes.

The Task Force developed a voting process (see [Appendix H – Voting Process and Structure](#)) to ensure all final recommendations reflected the work of the Task Force and the Workgroups. The process allowed time for discussion and consensus-building around the final set of recommendations. Critically, the goal of the recommendation scoring process was to allow consideration of diverse opinions to ensure all Workgroup members had a voice in decision-making. In voting to approve the final recommendations, Task Force members were asked to support the recommendations package as a whole. Thus, members' approval reflects support for the overall direction and a majority of the content of the Report, but not necessarily support by every member for every recommendation. The Task Force voted on the final set of recommendations on January 15, 2016.

V. Recommendations

A. *Removing Barriers to Access to Coverage and Care and Addressing Disparities*

Minnesota leads the nation in providing health coverage for its residents, offering a robust continuum of programs through Medical Assistance, MinnesotaCare, subsidized Qualified Health Plan coverage offered through MNsure, and coverage offered through Minnesota's individual and small group market more broadly. However, Minnesotans still experience barriers to accessing and using their coverage related to disparities in geography, language, culture, and health and financial literacy. Differences in coverage program rules and features of Minnesota's multiple vehicles for health insurance coverage programs also impede consumer understanding of and access to coverage.

Recommendation 1:

Improve and enhance community based consumer assistance resources, including Navigators, consumer assisters and agents/brokers:

- Develop expanded community based, consumer assistance capacity to support consumers in accessing health coverage, understanding how to use their health coverage, and addressing social determinants of health (e.g., food and nutrition, housing);

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- Provide adequate and timely payment to, and appropriate training for, community based consumer assisters;
- Utilize currently available race/ethnicity/data to identify type and level of consumer needs and target deployment of consumer assistance resources; and
- Ensure that the State's selection of Navigators prioritizes entities able to provide linguistically and culturally appropriate assistance and that new state-developed consumer assistance tools are culturally and linguistically appropriate.

JUSTIFICATION: Consumer assistance programs provide critical outreach, education, and support to Minnesotans related to the importance of health coverage, coverage options, and enrollment and renewal into coverage. Minnesota's population is becoming more diverse each year – the State's foreign born population is increasing faster than the national average and Minnesotans now hail from countries including Mexico, India, Somalia, Laos, Vietnam, Thailand (including Hmong), China, Korea, Ethiopia, and Canada. The Task Force concluded that to serve all Minnesotans, the State must make linguistic and cultural competency and health literacy throughout the coverage continuum a high priority. Testimony from providers and other stakeholders specifically highlighted: the vital role of community-based consumer assistance resources in reaching racial and ethnic minorities, who are also typically underserved populations; the need to build capacity among consumer assisters that have relationships with and successfully support culturally diverse communities; and opportunities to address current barriers to adequate capacity, such as inadequate training and delays in payments for assisters. Overall, the Task Force agreed that Minnesota needs additional investment in and development of community-based consumer assistance capacity, with a focus on linguistic and cultural competency and integration of services impacting social determinants of health.

COSTS/SAVINGS: Cost estimates were not evaluated for this recommendation, although additional costs to the State and Marketplace are anticipated with respect to expanding the scope of services provided by consumer assisters and enhancing assister training programs.

STATE/FEDERAL AUTHORITY: Minnesota would be able to implement these recommendations through changes and enhancements to some or all of its current assister programs. The Portico Healthnet model, which features robust training for its care coordinators in health literacy and navigation of the health care system, was raised as one potential best practice model. This Report also provides specific recommendations for Minnesota to improve race/ethnicity/data collection (see Recommendation 5) which can be utilized for targeting the deployment of consumer assistance resources.

OTHER OPTIONS CONSIDERED: None.

Recommendation 2:

Create benefit alignment across the coverage continuum and provide access to high value benefits:

Transportation

- Provide non-emergency medical transportation (NEMT) as a covered benefit in MinnesotaCare.
- Build volunteer transportation provider capacity through a grant program.

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- Assess the impact of enacted NEMT legislation on improving access to care and provider capacity.¹⁴

Dental

- Require that QHP issuers make available dental benefits on par with coverage in Medical Assistance and MinnesotaCare.
- Seek 1332 waiver to allow QHP enrollees to apply Advance Premium Tax Credits/Cost Sharing Reductions to available dental coverage.
- Raise Medical Assistance dental reimbursement rates.

JUSTIFICATION: While the benefits in Medical Assistance, MinnesotaCare, and QHPs through MNsure significantly overlap, there are some key differences in covered benefits across the continuum – mostly due to underlying federal requirements. The Barriers Workgroup of the Task Force engaged in robust discussion on whether the State should provide identical benefits across its coverage continuum – allowing for continuity in access to benefits when Minnesotans transition across programs as well as ease of consumer understanding their benefits—or to provide broader access to certain critical benefits (i.e., NEMT, dental coverage for adults). Public testimony reinforced the value of covering key benefits such as transportation and dental services, as essential to access, and the Workgroup ultimately concluded that its higher priority was to ensure access to these benefits rather than aligning benefits overall.

- **Transportation:** The Task Force heard presentations and testimony regarding access issues in rural areas of the State, where consumers face significant challenges related to provider shortages and travel to available providers. Low-income individuals are likely to experience these challenges most acutely, resulting in barriers to obtaining medical care and adhering to treatment protocols. To mitigate these challenges, the Task Force recommends adding NEMT to the MinnesotaCare benefit package. Task Force members raised concerns about NEMT provider capacity and urge that as part of deliberating this recommendation during the legislative process, the State evaluate the impact on NEMT access for Medical Assistance beneficiaries. Because the Task Force believes that expanding coverage of and reimbursement for NEMT will likely only partially address underlying NEMT provider capacity issues, it also recommends that the State explore creating a grant program to support the development of volunteer NEMT capacity. Finally, the Task Force recommends that the State evaluate the impact of legislation enacted last session to increase NEMT reimbursement rates in Medical Assistance.¹⁵
- **Dental:** Today, QHP issuers have the option of including coverage of dental benefits as part of their plan designs or offering stand-alone dental plans (or not offering dental benefits through the Marketplace). Sixteen qualified dental plans (QDPs) on MNsure offer standalone adult dental coverage and 9,578 policies were purchased in 2015. Individuals who qualify for APTC/CSR are not permitted to apply their subsidies to dental coverage and thus are responsible for the full cost of the premiums for dental insurance coverage. The Barriers Workgroup of the Task Force discussed at length the policy and premium implications of adding adult dental coverage to Minnesota's essential health benefit (EHB). Several members expressed concerns about requiring

¹⁴ Minnesota Laws 2015, Chapter 71

¹⁵ Minnesota Laws 2015, Chapter 71

all individual and small group market buyers to pay for dental benefits. As a result, the Task Force recommends that the State require QHP issuers to make available dental benefits to Minnesota consumers, either embedded in QHPs or as a stand-alone QDP, but does not recommend that the State amend the EHB to include dental services. The Task Force also recommends that the State pursue federal authority through a 1332 waiver to permit low-income consumers who are eligible for APTC/CSRs to apply their subsidies to dental coverage. Absent such federal permission, the Task Force recommends that the State subsidize the cost of dental benefits for low-income consumers using State-only dollars. Finally, to address dental provider shortages, the Task Force recommends that the State raise Medical Assistance rates for dental services.

COSTS/SAVINGS: Milliman modeled the annual cost of adding NEMT to MinnesotaCare at \$6.6 million. The estimate assumes that: (1) the vast majority of trips would occur through volunteer providers or personal mileage and (2) Medical Assistance level reimbursement rates.

DHS modeled the addition of adult dental benefits to QHPs at an estimated \$22.55 PMPM for QHPs sold both on and off-Marketplace. For products purchased on Marketplace, the estimate is based on a dental benefit cost of \$16.24 (\$22.55 PMPM less the enrollee's cost sharing of \$6.31 PMPM), which if subsidized by the State, would be a cost of \$11.3 million. This cost may be offset if the State is successful in obtaining 1332 waiver authority for consumers to apply APTC/CSR to the cost of dental benefits. Additionally, to the extent that the State implements Recommendation 10 to expand MinnesotaCare to cover individuals with incomes up to 275% FPL who are currently covered through the Marketplace, these individuals will automatically gain access to dental benefits, dramatically reducing the federal and state costs of subsidizing dental benefits for low-income Minnesotans.

DHS did not estimate the cost of increasing Medical Assistance rates for dental services since this recommendation was advanced after modeling was completed.

STATE/FEDERAL AUTHORITY: Adding NEMT to MinnesotaCare would require State legislation and, if the State continues to administer MinnesotaCare as a BHP, an amendment to the State's BHP Blueprint. The State would also require statutory and appropriations authority to implement a grant program for volunteer transportation provider capacity. The State would evaluate the effectiveness of enacted legislation to increase NEMT provider rates on provider capacity on or after July 2017 to allow sufficient experience with the new legislation to support robust evaluation.

Adding adult dental benefits to QHP coverage through MNsure would require two levels of State action. The State would require QHPs make available dental coverage either embedded in QHP benefits or as standalone products. To permit consumers to apply APTCs to the adult dental benefit, the State would need to seek a 1332 waiver. As noted above, the State's decision with regard to expanding MinnesotaCare to individuals with incomes up to 275% FPL would impact its approach to subsidizing dental services for low-income individuals in the Marketplace. Finally, raising Medical Assistance reimbursement rates for dental would require State legislation as well as an amendment to the State Plan.

OTHER OPTIONS CONSIDERED: The Workgroup considered a range of options related to aligning benefits across the coverage continuum including eliminating certain Medical Assistance benefits to align with MinnesotaCare and QHPs through MNsure (i.e., eliminating non-emergency medical transportation for the new adult group). This idea was ultimately rejected as not meeting the charge of the Task Force to make recommendations that would improve access to coverage and care.

With respect to adding NEMT to the MinnesotaCare benefit package, the Task Force considered narrowing the provider network for NEMT to personal and volunteer mileage providers to avoid overtaxing the capacity of the broader NEMT provider network. The Workgroup also consider conditioning the addition of the NEMT benefit on successful efforts to expand NEMT provider capacity. The Workgroup ultimately determined not to include these conditions on its recommendation to include NEMT coverage in the MinnesotaCare benefit package.

Recommendation 3:

Evaluate the impact of 2015 telemedicine (health) legislation on payment for and access to broad based telehealth/telemedicine (including mobile applications) services and effectiveness in addressing geographic barriers and health disparities.

JUSTIFICATION: Using telemedicine/telehealth (including smart phone mobile applications) to furnish care – through two-way, interactive video, or store-and-forward technology – is one way to address access barriers related to provider shortages and long travel times in rural areas of the State. During its last Legislative session, the Minnesota Legislature enacted law that prohibits carriers from excluding coverage of services provided by certain provider types solely because the service is delivered via telemedicine rather than in-person, and requires that carriers reimburse for services delivered via telemedicine on the same basis and at the same rate as services delivered in-person.¹⁶ The Task Force recommends evaluating the impact of the legislation, which became effective on January 1, 2016, and whether telehealth capacity is addressing workforce shortages and disparities in geography, culture and ethnicity effectively. The Task Force also acknowledges that while telemedicine is a tool to increase access, more thinking needs to be done to leverage telemedicine to reach and build trust with individuals from varying cultural backgrounds, including how to more effectively leverage the most accessible forms of technology: smart phone mobile applications.

COSTS/SAVINGS: Cost estimates were not evaluated with respect to this recommendation.

STATE/FEDERAL AUTHORITY: Sufficient experience with the new legislation – which became effective January 1, 2016 – would be needed before a robust evaluation can be conducted. Therefore, the evaluation would be targeted for 2017 or after.

OTHER OPTIONS CONSIDERED: None.

Recommendation 4:

Improve demographic data collection and reporting to inform development of solutions to address disparities in health access and care:

- Ensure all Minnesota health data collection and reporting systems including state agencies, providers, payers, and systems that collect health data comply with the State Quality Reporting and Measurement System's (SQRMS') standardized best practices (i.e., allowing patients to identify themselves, allowing a multi-racial category) for collection and reporting of race, ethnicity, language and country of origin data and data elements.
- Charge MDH with development of a standardized set of additional socio-economic measures affecting health and health disparities.

¹⁶ Minnesota Laws 2014, Section 62A.672 and Section 256B.0625, sub. 3b

- Develop mechanism for continuous improvement of health data collection and reporting in partnership with racial and ethnic communities disproportionately affected by disparities.

JUSTIFICATION: Detailed race, ethnicity, and language (REL) data by population group are critical to identifying disparities in access to health coverage and care, targeting interventions, and evaluating progress in reducing disparities.¹⁷ Race, ethnicity, preferred language, and country of origin data are requested in the application for Medical Assistance, MinnesotaCare, and MNsure. In 2014, the Legislature directed MDH to develop a plan for collecting, analyzing and reporting measures based on disability, race, ethnicity, language, and other socio-demographic factors through the SQRMS.¹⁸ While Minnesota has made some advances in the collection and analysis of REL data, the Task Force concluded that more work remains to gather and use data to drive improvements to health disparities in the State. The Task Force recommends the adoption by all Minnesota health data collection and reporting systems of the standardized approach and best practices being developed for SQRMS. Across its discussions, the Task Force frequently acknowledged the critical importance of social determinants of health and the relationship between socio-economic factors and health status and health disparities. Therefore, the Task Force also recommends that the State expand data collection efforts to include socio-economic measures, and recommends that MDH be charged with developing a standardized socio-economic data set. Finally, the Task Force recommends the continued evaluation and improvement of data collection and reporting, informed by the engagement and perspectives of the racial and ethnic communities most affected by disparities.

COSTS/SAVINGS: Costs/savings were not estimated for these recommendations, however, MDH noted that expanding SQRMS to all Minnesota health data collection and reporting systems would generate new State costs.

STATE/FEDERAL AUTHORITY: State legislative action would be necessary to implement this recommendation. With respect to federal authorities and any potential limitations under federal law, due to time constraints, the Workgroup did not undertake an analysis of whether federal law would bar any of the listed entities from carrying out this recommendation if enacted by state law.

OTHER OPTIONS CONSIDERED: None.

Recommendation 5:

Provide access to coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status by using State funding to provide MinnesotaCare benefits to children and adults with incomes up to 200% FPL.

Provide coverage for services included in the elderly waiver package and nursing facility benefits to individuals under 138% FPL who are eligible for these benefits.

In all instances, maintain confidentiality of applicants to ensure information collected is only used for health coverage and maximize available federal funding (i.e., federal funding for EMA and coverage of lawfully present MinnesotaCare individuals).

¹⁷ Minnesota Department of Health; *Advancing Health Equity in Minnesota, Report to the Legislature*. February 2014. Available at:

http://www.health.state.mn.us/divs/chs/healthequity/ahe_leg_report_020414.pdf

¹⁸ Minnesota Laws 2014, Chapter 312, Article 23, Section 10

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JUSTIFICATION: Between 80,000 and 100,000 undocumented immigrants are estimated to reside in Minnesota today.¹⁹ Undocumented immigrants represent 22% of the total immigrant population and 2.5% of the Minnesota workforce; over three-fourths of undocumented immigrants have resided in Minnesota for at least five years and nearly half have resided in Minnesota for more than ten years.²⁰ Roughly one-third of undocumented immigrants have a U.S.-born child and 65% have a GED.²¹ The Task Force and Barriers Workgroup received considerable testimony directly from consumers as well as from advocacy groups about barriers for undocumented immigrants in accessing affordable health care. The issue has also been the subject of past legislative action, including most recently a 2012 legislative directive for DHS to develop a plan to provide coordinated and cost-effective care to people eligible for the Emergency Medical Assistance (EMA) program and who are ineligible for other state programs.²²

The Barriers Workgroup of the Task Force affirmed that providing access to affordable coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status is a key priority and particularly critical to one of the key goals of the Task Force to address and reduce health disparities. From an equity perspective, the Barriers Workgroup of the Task Force agreed that the eligibility and benefits should not be more expansive for individuals ineligible due to immigration status than coverage options available for U.S. citizens or lawfully present individuals. The Barriers Workgroup of the Task Force considered four options for covering individuals without access to health coverage due to their immigration status:

- Providing MinnesotaCare benefits to individuals with incomes up to 200% FPL.
- Providing MinnesotaCare benefits to individuals with incomes up to 138% FPL.
- Providing MinnesotaCare benefits to children ages 0-21 with incomes up to 138% FPL and DACA individuals up to 138% FPL.
- Provide MinnesotaCare benefits to children ages 0-21 with incomes up to 138% FPL.

¹⁹ Warren, R. and Warren, J. R. , *Unauthorized Immigration to the United States: Annual Estimates and Components of Change, by State, 1990 to 2010*. International Migration Review, 47: 296–329. 2013. Migration Policy Institute (MPI) analysis of U.S. Census Bureau data from the 2013 American Community Survey (ACS), 2009-2013 ACS pooled, and the 2008 Survey of Income and Program Participation (SIPP) by James Bachmeier of Temple University and Jennifer Van Hook of The Pennsylvania State University, Population Research Institute.

²⁰ John Keller, Immigrant Law Center of Minnesota; Presentation to the Barriers to Access Workgroup. October 2015. Migration Policy Institute; *Profile of the Unauthorized Population: Minnesota*. Pew Research Center; *Unauthorized Immigrants in the U.S.* 2012.

²¹ John Keller, Immigrant Law Center of Minnesota; Presentation to the Barriers to Access Workgroup. October 2015. Migration Policy Institute; *Profile of the Unauthorized Population: Minnesota*. Pew Research Center; *Unauthorized Immigrants in the U.S.* 2012.

²² Only those unauthorized immigrants with incomes under 138% FPL qualify for EMA coverage, which is limited to treatment of an “emergency medical condition (acute symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of a bodily organ or part).” Unauthorized immigrants do not otherwise qualify for Medical Assistance, MinnesotaCare, or QHPs through MNsure due to their immigration status.

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Ultimately, the Workgroup centered on the option with the broadest eligibility – children and adults up to 200% FPL – and providing coverage for services included in the elderly waiver package and nursing facility benefits to individuals under 138% FPL who are eligible for these benefits.

To mitigate a particular barrier to accessing care by individuals not currently eligible for health coverage based on their immigration status – fear of deportation – the Workgroup recommends an explicit requirement that applicants' confidentiality be maintained and that any information collected by the State only be used for health coverage.

COSTS/SAVINGS: DHS modeled the estimated cost of providing MinnesotaCare benefits, the elderly waiver package of services and nursing facility care services to people with incomes up to 138% FPL and estimated state annual costs of \$70.3 million for coverage of all children and adults and between \$10 and \$12 million for coverage for children only. The estimates assume the State would continue to maximize available federal funding (i.e., federal Medicaid funding for EMA and federal MinnesotaCare funding for coverage of lawfully present MinnesotaCare individuals 0 – 138% FPL) and beneficiaries would be subject to cost-sharing at current MinnesotaCare levels. At this time, DHS was unable to model estimated costs for people with incomes between 138% and 200% FPL who are not currently eligible for health coverage based on their immigration status.

STATE/FEDERAL AUTHORITY: Expanding coverage to individuals not currently eligible for health coverage based on their immigration status would require state legislation.

OTHER OPTIONS CONSIDERED: The Barriers Workgroup of the Task Force considered options from the report responding to the 2012 legislative mandate on EMA as well as emerging models for covering undocumented individuals from New York City, the City of San Francisco, and the State of California.²³ The Workgroup considered: (1) creating a Medical Assistance wraparound coverage program for EMA beneficiaries; (2) expanding the Portico Healthnet Program model to broader areas; (3) creating a pool to support unreimbursed services provided to undocumented immigrants; (4) creating a grant program to allocate funds to providers who deliver services to significant numbers of undocumented immigrants; and (5) providing access to care through a defined network of providers similar to the New York City Direct Access or Healthy SF programs. After robust discussion, the Workgroup reached consensus that, because Minnesota (unlike cities with concentrated urban areas of individuals not currently eligible for health coverage based on their immigration status) has a unique statewide distribution of undocumented residents, it should advance a recommendation that would provide more comprehensive coverage not limited to certain geographies or delivery systems.

Recommendation 6:

Rationalize affordability definition for families with access to employer sponsored insurance (ESI) (i.e., fix the “family glitch”), provided, however, that there is no impact on employer tax penalty related to affordability of coverage for dependents.

JUSTIFICATION: Under the ACA, individuals who have access to affordable health coverage may not access MinnesotaCare or federal subsidies for QHP coverage through the Marketplace. Employer-sponsored insurance (ESI) – for employed individuals as well as their spouses and dependents – is defined as affordable where the contribution for employee only coverage is less than 9.66% of annual income. This

²³ Minnesota Department of Human Services. *Emergency Medical Assistance*. April 2013. Available at: <http://archive.leg.state.mn.us/docs/2013/mandated/130683.pdf>

is true even when family coverage exceeds the 9.66% threshold²⁴ and as a result, some low- to moderate-income Minnesota families are not able to qualify for MinnesotaCare or APTC/CSR to purchase affordable health insurance coverage.²⁵ This issue has been well documented by State and national policymakers.²⁶ Attempts to fix the family glitch through federal legislative or regulatory change have not gained traction to date. Minnesota Senator Al Franken (D-MN) introduced the Family Coverage Act (S. 2434) in June 2014, to resolve the glitch, but legislation is unlikely to advance. The Departments of Health and Human Services and Treasury, which some perceive as possessing the authority to address the affordability definition administratively, have also declined to act.

COSTS/SAVINGS: Based on Milliman estimates, fixing the “family glitch” would cost roughly \$6.7 million annually for 2016 to cover an average of 2,405 additional Minnesotans in either MinnesotaCare or QHP coverage.

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

OTHER OPTIONS CONSIDERED: The Task Force also discussed seeking 1332 waiver approval to allow families to use their APTC/CSRs for their employer sponsored insurance as another mechanism for encouraging and rationalizing family coverage. This would allow families to enroll in the same employer plan using available APTCs to offset the cost of that coverage in cases where the employer provides affordable coverage for the employee member of the family, but not his or her spouse and dependents. Conversely the State could consider seeking 1332 approval to use a premium aggregator to allow families to pool employer contributions to coverage and APTC/CSRs to purchase family coverage through the individual market. Some Task Force members perceived both alternatives to be too administratively complex. The Task Force, however, did not complete a robust analysis of either option due to time constraints.

Recommendation 7:

Adopt 12 month continuous eligibility for Medical Assistance (MAGI only) & MinnesotaCare enrollees.

JUSTIFICATION: The State is required to re-determine Medical Assistance eligibility every 12 months and if an enrollee experiences a change in circumstances during the year that may affect eligibility, he or she is obligated to report the change and the State must re-determine his or her eligibility mid-year. Changes that could affect eligibility include changes in: income (e.g., a new job, a pay raise), household size (e.g., new baby, marriage), and age (e.g., turning 19). One study estimated that 48% of consumers within the income eligibility range for Medical Assistance, MinnesotaCare, or subsidized QHP coverage through MNsure will experience a change in program eligibility during each coverage year.²⁷ Consumers who are

²⁴ IRS 36B(c)(2)(C)(i)

²⁵ IRS 36B(c)(2)(C)(i)

²⁶ Joint Committee on Taxation; *Technical Explanation of the Revenue Provisions of the “Reconciliation Act of 2010,” as Amended, in Combination with the “Patient Protection and Affordable Care Act,”* p. 33, n. 70. 2010. Available at:

https://www.ict.gov/publications.html?func=download&id=3673&chk=3673&no_html=1

²⁷ Sommers, B., Graves, J., Swartz, K., Rosenbaum, S.; Health Affairs; April, 2014. Note, however, that preliminary signs indicate that churn has been less common than initially expected. See Dickson, V.;

within the income eligibility range for Medical Assistance and MinnesotaCare are particularly prone to experiencing income fluctuations due to instability and seasonality in employment. Income volatility has increased over the last decade, exacerbating this problem.²⁸ Income fluctuations may result in significant churning, meaning Minnesotans transitioning from one coverage program to another or off or on coverage entirely.

Adopting 12 month continuous eligibility for Medical Assistance and MinnesotaCare increases stability of coverage, consistency of patient-provider relationships, and continuity of care, care management, and quality improvement, particularly for people with chronic conditions. Longer periods of eligibility also reduce administrative cost and burden for the Department of Human Services, counties, plans, and providers and improves stability in revenue for plans and providers. At least 23 states have implemented 12 month continuous eligibility for children in Medicaid and 2 states have authority to implement 12 month continuous eligibility for adults in Medicaid.²⁹

The Task Force acknowledged that, if Minnesota policy makers elect to implement 12 month continuous eligibility, the State may want to consider the impact of the policy for individuals obtaining access to affordable, employer-sponsored insurance mid-year. Additionally, Task Force members agreed that the State may want to consider using projected income, to the extent permitted by federal law, when determining Medicaid eligibility in order to mitigate churn related to predictable income changes. Finally, Task Force members noted that data from MNSure on churn would be essential in understanding the extent to which churn is impacting Minnesotans and the value of policies like 12 month continuous coverage in minimizing churn.

COSTS/SAVINGS: The State estimates that providing 12 month continuous eligibility for all Medical Assistance enrollees whose eligibility is based on their Modified Adjusted Gross Income (MAGI)—generally, non-elderly, non-disabled Medical Assistance enrollees—and all MinnesotaCare enrollees would cost the State \$61 million in FY 2018 and \$70 million in FY 2019. Providing 12 month continuous eligibility may reduce the administrative costs at both the State- and county-levels for processing churn-related disenrollments and reenrollments. Additionally, continuous eligibility may reduce medical costs, since individuals with continuous access to coverage are less likely to skip or delay needed care.³⁰ The State did not model the potential magnitude of potential administrative or medical cost savings.

Modern Healthcare; *Income-Based ‘Churn’ in Coverage Less Common than Feared*. April 2015. The Workgroup encourages the State to analyze the amount of churn experienced in Minnesota.

²⁸ Dynan, K.; Brookings Institute; *The Income Rollercoaster: Rising Income Volatility and Its Implications*. Brookings Institution, April 2010. Available at: http://www.brookings.edu/~media/research/files/articles/2010/4/01-income-volatility-dynan/0401_income_volatility_dynan.pdf

²⁹ Kaiser Family Foundation; *State Adoption of 12-Month Continuous Eligibility for Children’s Medicaid and CHIP*. January 2015. Available at: <http://www.kff.org/health-reform/state-indicator/state-adoption-of-12-month-continuous-eligibility-for-childrens-medicaid-and-chip/>

³⁰ L. Ku; Center on Budget and Policy Priorities. *New Research Shows Simplifying Medicaid Can Reduce Children’s Hospitalizations*. June 2007. Available at: <http://www.cbpp.org/research/new-research-shows-simplifying-medicaid-can-reduce-childrens-hospitalizations>; Kaiser Family Foundation; *The Uninsured and the Difference Health Insurance Makes*. September 2012. Available at: <http://www.kff.org/health-reform/fact-sheet/the-uninsured-and-the-difference-health-insurance/>

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

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

B. Improving Affordability of Coverage and Care for Consumers

Currently, individuals transitioning from MinnesotaCare to QHPs offered through the Marketplace face a significant financial “cliff” or increase in premiums, cost-sharing, and deductibles. Specifically, annual premiums increase from \$960 at 200% FPL to \$1,509 at 201% FPL. Similarly, deductibles increase from \$34.20 to \$1,450. These significant increases in premiums and cost-sharing may cause gaps in coverage because of families’ inability to maintain adequate and affordable coverage as they move up the income ladder. Additionally, families transitioning to higher cost coverage may delay or forego needed care in response to significant increases in cost-sharing that come with potentially modest increases in income.

Recommendation 8:

Require standard Qualified Health Plan offerings in the Marketplace to improve consumer choice and experience and ensure availability of no- or low-deductible options. Look to federal standardized designs as a potential model.

- Require carriers to offer low and no deductible plan options, in addition to other products they choose to offer.
- Require carriers to offer standard plan designs that exempt certain services from deductibles to incentivize utilization of primary care and other high value preventive services.
- Study option of 1332 waiver to allow for 60 to 100% actuarial value and how this will improve consumer choice.

JUSTIFICATION: Throughout the Task Force convenings, stakeholders testified that the absence of low and no deductible product choices is problematic for Minnesota’s lower-income residents: in plan year 2016, there is one silver qualified health plan offered through the Marketplace that has a deductible below \$600 and the average deductible for all silver-level plans offered in 2016 is \$2,236. To ensure that Minnesotans have sufficient choice of low and no deductible plans, the Task Force recommends that each carrier on MNsure be required to offer products: (1) with low or no deductible options, and (2) exempting certain high-value services—such as primary care visits to treat injury or illness other than the annual check-up—from the deductible so that people are able to receive these services with only a co-payment or co-insurance (co-payments in these products may be higher than products with deductibles applying to a broader array of services).

Both product design recommendations would increase consumer choice, allowing enrollees to select a product most appropriate for both their financial and health situation. The availability of low and no deductible products that allow consumers to spread cost-sharing throughout the year may also reduce disparities in access to care among low-income, minority Minnesotans.

Federal law requires individual and small group coverage to meet standardized actuarial values (AV) in four metal tiers – bronze (60%), silver (70%), gold (80%) and platinum (90%). Compliance with the actuarial value tiers is determined through the federal AV calculator and plans that vary within two percentage points of the standard are still considered to fall within the metal tier (i.e., a silver plan may have an AV between 68% and 72%). While Minnesota's guaranteed renewability law requires that coverage to be continued from year to year so long as the consumer continues to pay premiums, in some situations, plans may be compliant with the federal AV standards in one year but fall outside of the AV standard in the subsequent year, rendering the coverage noncompliant under federal law and therefore ineligible for purchase. The interaction of these two dynamics creates significant consumer confusion. To mitigate this confusion, the Task Force recommends evaluating an option that allows for plans that vary more than two percentage points from the current AV standards to be considered compliant with federal law. The Task Force agreed this concept requires further study on the opportunity under the federal 1332 waiver option and how it would improve consumer experience.

COST/SAVINGS: Costs/savings were not estimated for these recommendations. Commerce staff estimate that the proposals for standardized plan designs would have little impact to State costs or to premiums in the Marketplace.

STATE/FEDERAL AUTHORITY: To implement this recommendation, the State would need to at least define the parameters for low and no deductible plan options. The Barriers Workgroup discussed potential options for a lead entity that would develop the parameters – MNsure, Department of Commerce, or a separate Task Force or advisory body – but ultimately did not specify a lead entity. Notably, the U.S. Department of Health and Human Services' (HHS) draft Notice of Benefit and Payment Parameters for 2017 – annual rulemaking in which HHS sets policies for ACA's Marketplaces and QHPs – proposes to create standardized bronze, silver and gold cost-sharing designs, as well as standardized designs for silver plan variants available to individuals eligible for CSRs and gives the option for QHP issuers in the federally facilitated Marketplace (FFM, or healthcare.gov) to offer these designs. In its deliberations, the Barriers Workgroup of the Task Force reviewed HHS's proposed designs and agreed to look to federal standardized designs to inform Minnesota's policies.

OTHER OPTIONS CONSIDERED: The Barriers Workgroup of the Task Force deliberated on a recommendation to create standard plan designs for low and no deductible plan options. However a Barriers Workgroup member highlighted that Minnesota's guaranteed renewability requirements require insurers to maintain all products and expressed concern that standard plan designs would introduce even more products that must remain on the market and create administrative burden for insurers. The recommendation was subsequently amended to strike the creation of standard plan designs so that carriers that currently offer low or no deductible options would be able to maintain these products. The Barriers Workgroup of the Task Force also considered reducing the total number of non-standard QHPs that a carrier may offer in an effort to reduce the consumer confusion regarding the number of available plan choices. Several Workgroup members were concerned, however, that reducing the number of QHPs offered would reduce consumer choice and carrier flexibility and this recommendation was ultimately not advanced.

Recommendation 9:

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

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

Minnesota's robust coverage continuum ensures access to affordable coverage for individuals with incomes up to 200% FPL. But these subsidies also create "cliffs" in both premiums and cost-sharing for individuals as they transition to ACA premium and cost-sharing levels above 200% FPL. See Figures 2 and 3 below for a comparison of Minnesota's current affordability scale to the one established under the Affordable Care Act.

Figure 2: 2016 Premium Affordability: MinnesotaCare Compared to the ACA

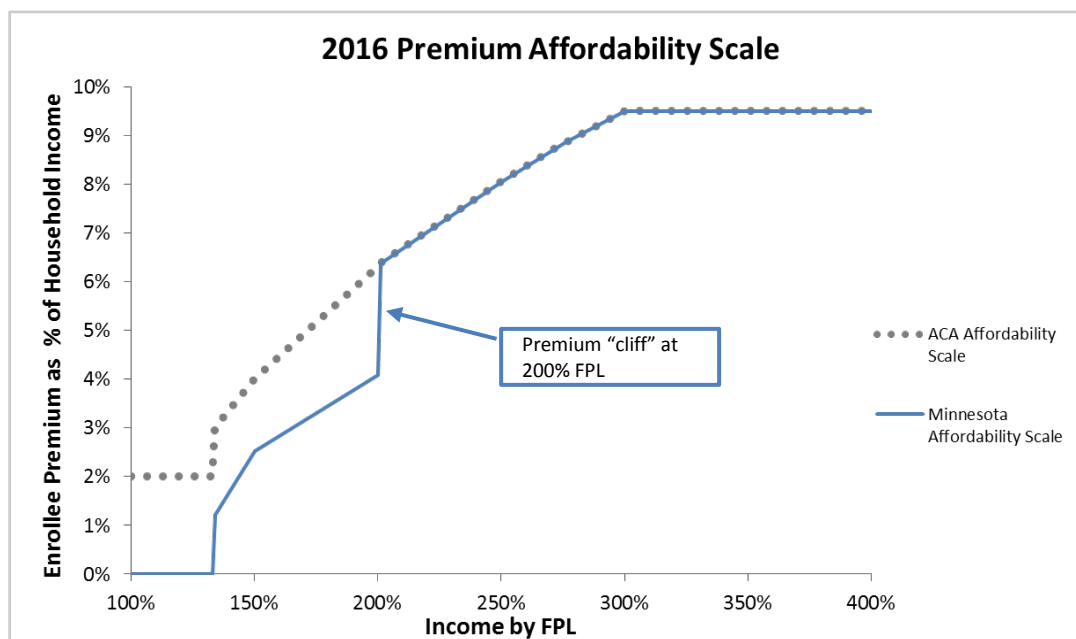
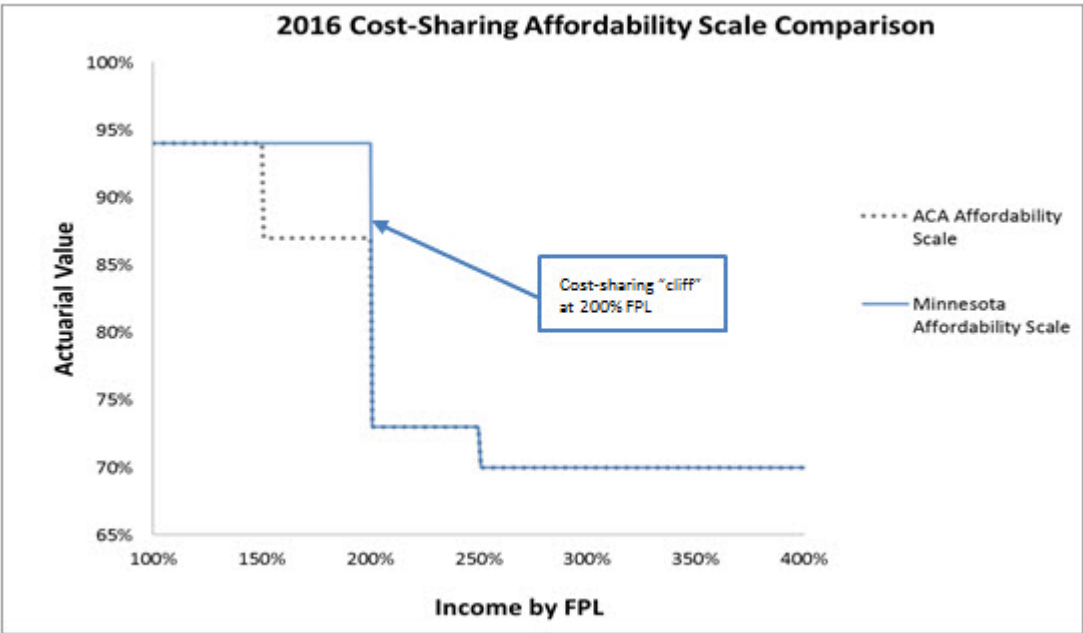
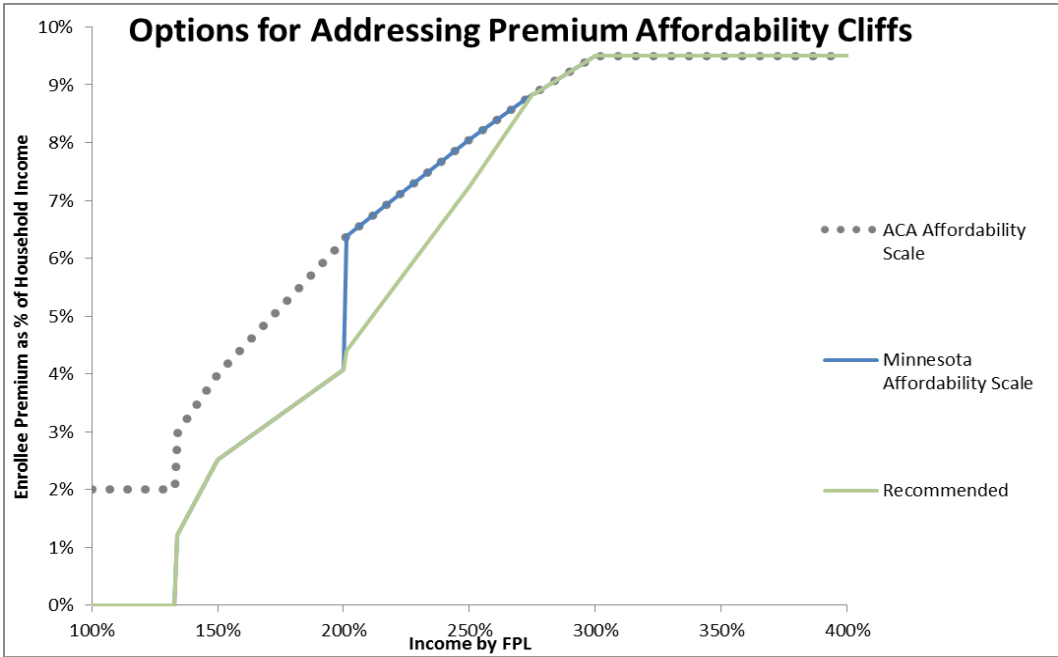


Figure 3: 2016 Cost-Sharing Affordability: MinnesotaCare Compared to the ACA



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

Figure 4: Recommended Approach to Smoothing the Premium Affordability Cliff



Additional details on the recommended affordability scale are described in **Appendix L – Recommended Premium Affordability and AV Affordability Scales**.

Improving affordability for consumers at this income level would be expected to improve insurance coverage rates among individuals who have declined enrollment to date due to concerns about affordability. Additionally, making point-of-service cost sharing more affordable would be expected to improve consumer access to health services. Smoothing the premium and cost-sharing cliffs also may help with the State's efforts to reduce rates of health disparities among priority populations, such as racial and ethnic minorities, low-income groups, residents of rural areas and inner cities, and individuals with disabilities and special health care needs.³¹

COST-SAVINGS: The estimated costs related to implementing the Minnesota affordability scale vary depending on the type of program used to implement the scale. Cost estimates are discussed further in Recommendation 10.

STATE/FEDERAL AUTHORITY: Increasing subsidies for individuals from 200 to 275% FPL would require State legislation and as discussed in Recommendation 10, may also require a 1332 waiver. If the State seeks federal Medicaid funding to cover a portion of the cost of enhanced subsidies, an 1115 waiver would also be required.

OTHER OPTIONS CONSIDERED: Several Task Force members supported reducing the premium cliff at 200% FPL by increasing premiums and cost sharing in MinnesotaCare for the population from 138 to 200% FPL. Some Task Force members further suggested that the State should not provide any additional subsidies for populations above 138% FPL, which would shift the premium and cost-sharing cliff from 200% FPL to 138% FPL. Several other members, however, objected to these proposals based on Minnesota's long-standing commitment to providing low-cost coverage to populations below 200% FPL. Still others believed that these alternatives were incompatible with improving affordability of and access to coverage. Additionally, numerous public commenters expressed strong support for maintaining MinnesotaCare's current affordability levels and urged the Task Force to restore the program to its pre-ACA eligibility level of 275% FPL.

The Task Force members also discussed increasing State subsidies to improve affordability of coverage for the population from 138 to 200% FPL (the current MinnesotaCare population) by eliminating the premium and cost-sharing increase established in legislation passed last session, but ultimately rejected this option because it did not address the cliff at 200% (and if not paired with increased subsidies above 200% FPL would worsen this cliff). Additionally, several Task Force members raised concerns about the longer-term financial sustainability of further subsidizing coverage for the population from 138 to 200% FPL.

Finally, several Task Force members expressed interest in further developing an affordability scale that applies to coverage outside of insurance affordability programs. This affordability scale could be used by policymakers and employers when developing plan designs for individuals receiving coverage through their employers or in the individual Marketplace subsidies. Due to time and data constraints, the Task Force was not able to explore this option further.

³¹ Agency for Healthcare Research & Quality; *Disparities in Healthcare Quality Among Racial and Ethnic Minority Groups*. October 2014. Available at: <http://archive.ahrq.gov/research/findings/nhqdr/nhqdr10/minority.html>

Recommendation 10:

Expand MinnesotaCare up to 275% FPL, using the recommended affordability scale under Recommendation 9 for those between 200 and 275% FPL, and maintain Marketplace coverage for consumers >275% FPL.

JUSTIFICATION: Expanding MinnesotaCare up to 275% FPL³² would improve the affordability of coverage and smooth the premium and cost-sharing cliffs at 200% FPL. By offering coverage based on the affordability scale described in Recommendation 9 and in Appendix L – Recommended Premium Affordability and AV Affordability Scales, individuals with incomes from 200 to 275% FPL would save on average \$1,100 per year, when compared to the average silver-level product sold in the Marketplace. Under this option, individuals with incomes between 200 and 275% FPL would also have access to the MinnesotaCare benefit set.

Task Force members acknowledged that this option also provides the State with an opportunity to better align and streamline eligibility and coverage for families, especially those in “mixed” households where family members they are split between private and public market product eligibility. For example, today, children between 200 and 275% FPL in Minnesota are covered under Medical Assistance, while their parents are eligible for private products in the Marketplace. Still, other members noted that this option would reduce enrollment for the Marketplace and that, if policy markets implement this recommendation, they should explore further its impact on the individual and small group markets.

COST/SAVINGS: Modeling conducted by Milliman indicates that an expansion of MinnesotaCare up to 275% FPL would cover an additional 41,200 Minnesotans at an estimated cost of \$68 million per year. If the State were to seek federal funding through either an 1115 or a 1332 waiver for this option, the State estimates that the net fiscal impact to the State budget for 2016 would range from a savings of \$26 million (under a 1332 waiver) to a cost of \$34 million (with an 1115 waiver). This figure does not include any administrative or start-up costs that may be associated with implementation of such an expansion.

The low capitation payments in MinnesotaCare play a key role in the potential savings associated with this option. When compared to the cost of covering enrollees in private market products, MinnesotaCare is less expensive due to its lower administrative costs and lower provider reimbursement rates. Acknowledging that MinnesotaCare’s reimbursement levels for providers are lower than commercial market rates, the Task Force recommends that policy makers consider the impact of this option on providers and evaluate whether the delivery system will remain sustainable at these reimbursement rates. The Task Force further suggests that the State and policymakers consider using savings generated through this model to increase provider reimbursement rates in MinnesotaCare, to the extent necessary.

The Workgroup also acknowledges that the impact of lower provider reimbursement rates could potentially be offset by the reduction in bad debt from patients—which occurs when lower income individuals forego insurance coverage as unaffordable or enroll in high-deductible plans in the private market and are unable to pay cost-sharing for medical services.

³² Some Workgroup members noted that under this approach, a family of four with incomes up to \$66,687.50 (using 2015 FPL numbers) would enroll in MinnesotaCare. According to the U.S. Census Bureau, Minnesota’s median household income was \$60,828 in 2014 dollars. See U.S. Census Bureau; *QuickFacts: Minnesota*. Retrieved January 2015. Available at: <http://www.census.gov/quickfacts/table/INC110214/27,00>.

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

OTHER OPTIONS CONSIDERED: As is discussed further in Recommendation 9, some Task Force members supported increasing premiums and cost-sharing below 200% to eliminate the cliff at 200% FPL. This option did not move forward for the reasons discussed above.

Having agreed to increase affordability from 200 to 275% FPL, the Task Force considered two other options for covering the population from 200 to 275% FPL. First, the Task Force considered the “private model,” under which all individuals with incomes from 138 to 275% FPL would purchase coverage through the Marketplace and the State would provide additional subsidies to reduce premiums and cost-sharing³³ and provide any benefits included in the MinnesotaCare benefit package but not otherwise covered by QHPs through MNsure. Several Task Force members noted that, while the public model would cut MNsure/Marketplace enrollment in half, the private model would strengthen it by increasing QHP enrollment. Milliman estimated significant costs to the State to implement this model—up to \$378 million³⁴ in additional costs for 2016. The Task Force did not ultimately favor this option.

Second, the Task Force considered a “hybrid model.” In this model, individuals with incomes from 138 to 200% FPL would continue to receive coverage through the MinnesotaCare program, while individuals with incomes from 200 to 275% FPL would continue to purchase coverage in MNsure/Marketplace with the State providing additional premium and cost-sharing subsidies to meet the recommended affordability scale for this population. Task Force members noted that this model preserves the existing size of MNsure/Marketplace, while improving affordability for individuals with incomes from 200 to 275% FPL. This model was less expensive than the private model, with an estimated additional State cost of \$46 million for 2016.³⁵ However, the hybrid model may be complex to administer, since the State would need to maintain one program for individuals with incomes from 138 to 200% FPL and create a second subsidy program for higher-income populations. Despite these limitations and the Task Force’s clear preference for expanding MinnesotaCare, the hybrid model remains a viable option for increasing affordability for individuals with incomes between 200 and 275% FPL in the event that the State is unable to obtain the 1332 waiver necessary to expand MinnesotaCare up to 275% FPL through a single public program.

Finally, the Task Force briefly discussed the option of enrolling all Medical Assistance and MinnesotaCare enrollees in private coverage, as well as the option of establishing a single payer system in Minnesota and concluded this would require further study by the State. As discussed under Recommendation 23, the Task Force recommends a study that examines various long-term payment options for health care delivery, including a single payer or “universal” system.

³³ The affordability scale used for this option was the same as that provided under the expanded MinnesotaCare option. This included the current MinnesotaCare affordability scale for those between 138 and 200% FPL, and the recommended affordability scale for those between 200 and 275% FPL.

³⁴ Up to half of this amount, or \$189 million, might be funded through an 1115 waiver.

³⁵ Up to half of this amount, or \$23 million, might be funded through an 1115 waiver.

C. Sustainably Financing the Coverage Continuum

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

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

Recommendation 11:

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

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

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

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

OTHER OPTIONS CONSIDERED: None.

Recommendation 12:

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

JUSTIFICATION: The Health Care Access Fund has long supported subsidized health coverage for eligible low-income Minnesotans, providing a dedicated funding stream and year-to-year funding certainty for

Medical Assistance and MinnesotaCare. Without the 2% provider tax, current projections show revenue into the Health Care Access Fund would fall short of projected uses by 2021. While the Task Force members recommended to continue the provider tax, they also expressed concerns that the Health Care Access Fund has been used for purposes other than MinnesotaCare and other health-related initiatives. For this reason, the Task Force also recommends that the State establish more stringent limits on the use of Health Care Access Fund dollars and a new and more reliable mechanism to reduce the provider tax when the Health Care Access Fund has a considerable surplus. The law establishing the Health Care Access Fund currently provides for a contingent tax reduction in the event of a surplus, but a reduction has never been implemented given some of the rules surrounding its current structure.

COST/SAVINGS: The repeal of the provider tax sunset is projected to result in \$207 million in revenue to the Health Care Access Fund in FY 2020 and \$765 million in FY 2021.

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

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

Recommendation 13:

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

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

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

COST/SAVINGS: The Task Force did not expressly address the appropriate rate for the user fee, but MNsure and DHS developed estimates of user fee revenue under different scenarios for illustrative purposes. Assuming the size of Minnesota's individual market were to remain constant, applying the premium withhold to both on- and off-Marketplace coverage would yield \$22 million in revenue, even if the withhold were reduced by 2 percentage points to 1.5% of premium. By contrast, the current premium withhold of 3.5% of premium applied only inside the Marketplace generates \$10.7 million in revenue.

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

OTHER OPTIONS CONSIDERED: During the discussion of Recommendation 10 by the Seamless Workgroup of the Task Force, several Workgroup members supported maintaining the user fee for plans purchased through the Marketplace only, reasoning that the fee is more accountable, comparable to the FFM fee, and ensures that those benefiting from the Marketplace are the ones "paying for it." Others maintained that the Marketplace is a public good: many individuals and small businesses may use the Marketplace to shop and compare QHPs while not ultimately purchasing through the Marketplace. Some members also noted that carriers are required to spread the cost of the user fee across all of their QHP premiums, and not apply it only to QHPs sold through the Marketplace. Finally, some members noted that if the State pursues an expansion of MinnesotaCare, it would also likely need to expand the premium withhold to products off the Marketplace to stabilize the funding stream for MNsure.

D. Assessing the Future of MNsure

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

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

Over the past two years, MNsure has actively addressed many of its early challenges by: (1) improving the web portal to better serve consumers, augmented by a robust and well-funded consumer assistance infrastructure including Navigators, consumer assistants, agents and brokers; (2) communicating more transparently with the Legislature, State agencies and the public regarding its performance; and (3) improving the IT project governance structure and process to reflect shared responsibility for the mix of programs served by the IT platform. The Marketplace reports a smooth 2016 open enrollment period in which many of the web portal functionality issues of years past have been resolved.³⁶ Additionally, premium increases for 2016 have enhanced the value of the subsidies and are expected to drive

³⁶ Rao, A., White, J., Allen, K.; Clear Choices; *2016 Health Insurance Exchanges: The Good, the Bad, and the Ugly; Policy Recommendations to Improve Consumer Choices*. December 2015. Available at: <http://www.clearchoicescampaign.org/s/CC-2016-HealthInsExchanges-webv.pdf>

additional enrollment through MNsure. As of December 31, roughly 70% of individuals enrolling in coverage through MNsure during the 2016 open enrollment period are eligible for subsidies. Despite these efforts, significant back-end functionality at MNsure related to enrollment transactions with the carriers has yet to be fully implemented.

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

Recommendation 14:

The Task Force does not recommend transitioning to either the Federally Facilitated Marketplace (FFM) or Supported State-Based Marketplace (SSBM) at this time. A partially-privatized State-Based Marketplace (SBM) model could be considered following the evaluation of MNsure's 2016 open enrollment period. Therefore, the Task Force recommends continuing a SBM at this time.

JUSTIFICATION: The Task Force discussed potential alternatives for Minnesota's Marketplace and for each alternative considered the benefits and drawbacks against those of retaining its SBM. A brief summary of considerations related to each Marketplace model discussed by the Task Force is reflected in the chart below:

Figure 5. Comparison of Administrative Flexibility & Costs across Marketplace Options

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

A more detailed description of each of the Marketplace models is contained in [Appendix M – Overview of Marketplace Models](#).

Based on evaluation of the benefits, drawbacks and costs of each Marketplace option, the Task Force ultimately endorsed a recommendation to continue its SBM model at this time rather than transition to

a different Marketplace model. The SSBM³⁷ and the FFM both rely on the HealthCare.gov platform for eligibility and enrollment functionality and These models ultimately garnered very little support as viable alternatives to MNsure because of HealthCare.gov's lack of flexibility to have a streamlined eligibility system with Minnesota's public programs and its inability to administer MinnesotaCare or additional subsidies needed for a Minnesota-specific affordability scale. Additionally, the Task Force expressed concerns about the potential loss of State control over the Minnesota Navigator and assister programs in the FFM model, as well as the proposed SSBM fees of 3% of premiums for products sold through HealthCare.gov.

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

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

Figure 6. State Funding Needs under Federal Exchange (Figures are in 000's)

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

³⁷ In the proposed Notice of Benefit and Payment Parameters for 2017, the federal government proposed referring to this as a State-Based Marketplace using the federal platform or SBM-FP.

STATE/FEDERAL AUTHORITY: None needed to retain an SBM.

OTHER OPTIONS CONSIDERED: None.

Recommendation 15:

Develop framework to evaluate MNSure's 2016 open enrollment period performance, including the criteria and Marketplace goals listed in this report.

JUSTIFICATION: MNSure has improved substantially since its initial rollout, but significant gaps related to enrollment functionality remain. To develop a foundation for decisions about MNSure's future, the Task Force recommends evaluating MNSure's performance during the 2016 open enrollment period ending January 31, 2016 to identify strengths and limitations of the current model. In the course of their discussions, the Seamless Workgroup of the Task Force identified several goals for Minnesota's Marketplace to inform their discussions regarding the future of and potential alternatives to MNSure. The Task Force recommends that the evaluation framework include:

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

COST/SAVINGS: Potential costs of a MNSure evaluation, including potential costs related to hiring an independent evaluator, were not modeled for Task Force consideration.

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

OTHER OPTIONS CONSIDERED: None.

Recommendation 16:

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

JUSTIFICATION: Although MNSure is most closely associated with QHP coverage, it also shares the integrated eligibility and enrollment IT system with the Department of Human Services, through which

MARKETPLACE GOALS

Ranked in Order of Priority

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

Minnesotans apply for and are determined eligible for Medical Assistance, MinnesotaCare and APTC/CSRs subsidized QHP coverage. Further, the vast majority, (roughly 80%) of individuals applying for coverage through MNsure, qualify for Medical Assistance or MinnesotaCare—meaning that the Department of Human Services covers a significant portion of the expense of this shared IT system through cost-allocation of federal and state Medicaid dollars.³⁸

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

COST/SAVINGS: The State does not anticipate any costs related to potential implementation of this recommendation.

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

OTHER OPTIONS CONSIDERED: None.

E. Ensuring the Stability of the Insurance Market

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

Recommendation 17:

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

- Studying and modeling potential Minnesota-tailored rate-stability mechanisms for the individual market, such as a reinsurance program
- Studying and modeling merging Minnesota's individual and small group markets
- Considering the impact of establishing maximum limits on health plan carriers' excess capital reserves or surplus³⁹

³⁸ A portion of costs for MNsure's IT system that are attributable to Medical Assistance and MinnesotaCare are allocated to the Department of Human Services. The Department of Human Services receives federal matching funds to cover the administrative costs for its public programs.

³⁹ Further study by the Department of Commerce should consider the March 2014 study by the Minnesota Department of Health. See Minnesota Department of Health; *Study of Capital Reserve Limits in Minnesota*. March 2014. Available at: <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/capitalreservesreport0314.pdf>.

- Studying options for making Minnesota’s rate review process more transparent with public information and hearings.

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

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

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

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

OTHER OPTIONS CONSIDERED: None.

F. Expanding Innovative Health Care Purchasing and Delivery Systems Strategies and Advancing the Triple Aim

1. Enhancements to Data Sharing

Sharing data among providers on a patient’s care team is critical for effective coordination and to improve the quality and safety of health care, while ensuring patient privacy is essential for building trust between patients and providers. Restrictions on health information sharing must strike a balance between promoting coordination and protecting privacy. Minnesota’s Health Records Act provides considerable privacy protections, including requiring that patients consent to having their information shared for treatment, and that they be given an opportunity to opt-out of having their information included in certain exchange mechanisms, such as Record Locator Services. These protections may, at times, limit coordination across providers, which significantly impacts the care received by patients with

multiple physical and behavioral comorbidities or other complex conditions. The Task Force considered ways to improve data sharing to enable more effective care coordination, while maintaining the strong privacy protections Minnesotans expect.

Recommendation 18:

Modify the Minnesota Health Records Act to conform with HIPAA and make technical updates and clarifications to the Minnesota Health Records Act to leave a patient's ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.

JUSTIFICATION: Under the Minnesota Health Records Act, a patient may specify how their information may be shared among providers. However, the act is more restrictive than federal HIPAA regulations in how it defines the situations when a patient must give consent for data to be shared. Additionally, other provisions of the Health Records Act have created barriers for providers seeking to operationalize patient consent preferences; even when a patient has consented to a provider sharing information with another provider on his or her care team, technical challenges with the law limit the ability of providers to implement the patient's preferences by sharing their data. By recommending the Health Records Act be aligned with federal HIPAA regulations, similar to the majority of other states, the Task Force seeks to maintain a high level of patient privacy, while enabling more effective coordination across providers.

COST/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Changes to the existing Minnesota Health Records Act would require state legislation.

OTHER OPTIONS CONSIDERED: Some members of the Delivery Design Workgroup of the Task Force recommended more modest changes to Minnesota's Health Records Act that would leave its current overarching consent framework intact, suggesting that larger, whole-sale changes may be more appropriate following the comprehensive study requested under Recommendation 20 below. However, the majority of the Task Force felt that patient and provider testimony and background from federal and other state's experiences strongly indicated that Minnesota's Health Records Act needs to be consistent with federal HIPAA regulations in order to enable successful care coordination while protecting Minnesotans. Depending on the results of the study under Recommendation 20, the Task Force does anticipate that additional changes may be required.

Recommendation 19:

Provide ongoing education and technical assistance to health and health care providers and patients, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing inappropriate use.

JUSTIFICATION: Because of the complexity of federal and state patient privacy laws, providers are often wary of sharing health information—even in situations where such sharing is legally permissible. The Task Force recommends establishing ongoing educational and technical assistance to providers and patients to clarify how information may be stored, used, and shared. Additionally, the education and technical assistance would highlight best practices for securing information. Armed with knowledge about the legal guardrails, providers on a patient's care team will be better able to share information while maintaining appropriate patient privacy. Patients, too, will have easy to access resources to help them understand how providers may and may not use their health information.

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COSTS/SAVINGS: Costs/savings were not estimated for this recommendation; however expanding education and technical assistance to providers would likely generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 20:

Conduct a broad study that will make recommendations on the appropriate future structure, legal/regulatory framework, financing, and governance for health information exchange (HIE) in Minnesota, building on lessons learned in Minnesota and from other states and countries.

Study questions will include, but not be limited to:

1. Whether Minnesota should continue to use a market-based approach to HIE, or develop a single statewide HIE entity;
2. Whether additional ‘shared services,’ such as consent management, should be developed;
3. The appropriate funding source(s), and needed level of funding, to support core HIE transactions and shared services for all health and health care provider statewide; and
4. Whether Minnesota’s current legal/regulatory framework for HIE supports or hinders secure HIE that is aligned with patient preferences.

JUSTIFICATION: Providers are increasingly adopting electronic medical records to manage patient data. But storing data in an electronic format does not enable dramatic improvements in care coordination and population health management unless the data can be shared readily. Sharing patient data consistently across a wide range of providers in a secure, reliable manner is therefore the next frontier in using data to improve health. Given the complex policy and operational issues that arise when a state seeks to encourage or establish health information exchange, and data sharing barriers encountered by providers that are unique to Minnesota, the Task Force recommends that the State study a wide range of issues related to health information exchange in Minnesota, and provide concrete recommendations for enhancements.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation; however conducting a broad study of HIE in Minnesota would generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: See the discussion of other options considered in Recommendation 18.

Longer-term recommendations and considerations related to data sharing:

- Dependent on results of health information exchange study (see Recommendation 20), consider other modifications to Minnesota’s Health Records Act, to further align with federal HIPAA standards or to update opt-in or opt-out requirements.
- Support expanded health information technology capabilities (ex. EHRs) in a broad range of care settings, to enable smaller and specialty providers to participate in HIE.

- Consider developing a funding mechanism for core HIE transactions, such as admission/discharge/transfer alerts, care summaries, or care plans, to ensure basic information can be exchanged statewide.
- Support the establishment of robust, sustainable HIE “shared services,” such as consent management, which would be available statewide through a central vendor.

2. Enhancements that Support Integrated Care Delivery

Recognizing the need to improve quality, enhance care, and reduce costs in the healthcare system—the so-called “Triple Aim”—providers, payers, and policymakers across the United States have developed a plethora of care models and incentive programs intended to promote provider accountability for the cost and quality of care. By holding providers accountable for the cost and quality of care, payers and policymakers intend to create strong incentives for providers to more closely integrate care across primary care, specialty care, and behavioral health. Further, these programs are intended to encourage stronger linkages with community resources so that the full range of a patient’s needs are addressed.

The following recommendations are intended to decrease barriers and catalyze care delivery reform in a way that effectively coordinates care across the continuum, tying care together more effectively, particularly for those with the most significant disparities. There are several value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs currently taking place within Minnesota; the Task Force’s recommendations identify several immediate enhancements that should be applied across these programs. The Task Force also identifies several longer-term recommendations that are necessary to stabilize and enhance the care delivery system in Minnesota.

Recommendation 21:

Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots should not be significantly expanded until an evaluation of cost/benefits is conducted. At a minimum, the evaluation should address the following domains:

- Health disparities - Does the model worsen or improve health disparities? If so, by what mechanism or mechanisms? Does the model sufficiently account for variation in the complexity of patients across providers?
- Financial stability and cost of health care system – What is the impact of the model on costs across the system, including all payers? What costs are associated with the model at the provider level? What is the return on investment (ROI) of the program?
- Patient choice and provider attachment - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider?
- Multi-payer alignment – What are the areas of alignment across payers under the model? What additional areas could be aligned?
- Quality of patient care – How has the model impacted the quality of patient care?
- Population health – How does the model address population health?
- Social determinants of health – How does the model address the determinants of health beyond medical care (e.g. flexible payment options that enable payment for non-medical services)?

- Impact on provider work force - What impact has the model had on the provider work force? If it has an impact, what mechanism caused the impact?

JUSTIFICATION: Health Care Homes, health homes, accountable care organizations, integrated health partnerships, and bundled payment programs, among many others, have grown in the past decade. Although each model and program is promising in concept, and several have shown lower costs and improved quality of care in early results, the findings in larger scale or national evaluations have so far been mixed. Rather than immediately expanding these programs and investing increasing amounts of resources in care models or incentive programs, the Task Force recommends that the State evaluate on an on-going basis each of these demonstrations, pilots, and programs for effectiveness in furthering the Triple Aim. Once the State has identified models proven to work for Minnesotans, the State may consider additional expansion of such programs.

The University of Minnesota's State Health Access Data Assistance Center (SHADAC) is conducting the state evaluation of Minnesota's State Innovation Model (SIM), the Minnesota Accountable Health Model. Minnesota's SIM comprises of: (1) expansion of e-health; (2) improved data analytics across the State's Medicaid ACOs (i.e., Integrated Health Partnerships); (3) practice transformation to achieve interdisciplinary, integrated care; (4) accountable communities for health; and (5) ACO evolution and alignment related to performance measurement, competencies, and payment methods. As part of its evaluation, SHADAC will identify emerging forms or models of innovation from the SIM, barriers to/facilitators of implementation, and key outcomes. A Center for Medicare and Medicaid Innovation (CMMI) sponsored evaluation of model test states across the country is also underway. Any evaluation activities carried out under this recommendation will be coordinated with and build upon the existing evaluations to ensure optimal use of resources.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation; however including a robust evaluation within existing programs would likely generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require appropriations authority to implement, tied to each specific demonstration.

OTHER OPTIONS CONSIDERED: None.

Recommendation 22:

To the extent possible, seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.

JUSTIFICATION: With myriad value-based purchasing programs emerging in Minnesota, there is a risk that each program differs in terms of quality measures, payment methodologies, and attribution models. Providers participating in multiple value-based purchasing programs are less able to develop a single, evidence-based, patient-centered model for delivering care; instead, they may need to tweak their care model to account for the unique features of the value-based purchasing arrangement under which the patient falls. By contrast, alignment of measures and methodologies across payers amplifies the ability of each value-based purchasing program to drive delivery system reform.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Depending on how this recommendation is implemented, it could require legislative authority to ensure compliance. If implemented through existing stakeholder or advisory bodies, it may not require any additional authority.

OTHER OPTIONS CONSIDERED: The Delivery Design Workgroup of the Task Force considered requiring payers to have a certain percentage of provider payments linked to value or quality. Similarly, the Delivery Design Workgroup considered requiring that providers have a certain percentage of revenue tied to quality or value. In both cases, the Workgroup rejected imposing requirements on providers and payers; instead favoring a more flexible approach that encourages providers and payers to adopt alternative payment models, as appropriate. The Workgroup also considered whether to establish requirements for care coordination payments, attribution, and quality measures. Again, the Delivery Design Workgroup opted to afford providers and payers more flexibility to design their alternative payment arrangements.

Recommendation 23:

Conduct a study that examines various long-term payment options for health care delivery. Study will do a comparative cost/benefit analysis of the health care system under the following approaches:

1. Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels;
2. Expansion of value-based purchasing within current system;
3. Publicly-financed, privately-delivered universal health care system.

The study would additionally examine the stability and sustainability of health care system under the approach and identify any data or information needed to design and implement the system.

JUSTIFICATION: Although there was consensus among the Task Force that Minnesota (and the United States, generally) must improve quality and reduce cost in order to get its health care system on sustainable footing, there is less consensus on how to achieve this. Some Task Force members favored an expansion of value-based purchasing while maintaining the current patchwork of public and private programs; some Task Force members favored further analysis to evaluate whether additional value-based purchasing would be necessary or effective to drive improved outcomes. Finally, some suggested that expanding value-based purchasing would be unable to improve the health care system, favoring wholesale shift to a publicly financed, privately delivered universal health care system. Given the widespread impact of each of these options, the Task Force recommends further study of each of these three options.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation, however conducting a study examining various long-term health care delivery payment options would likely generate new State costs.

STATE/FEDERAL AUTHORITY: This recommendation would require appropriations authority to implement.

OTHER OPTIONS Considered: None.

Recommendation 24:

Incorporate enhancements, as described in Recommendations 25 through 33 below, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Consider any new arrangements as pilots or demonstrations, with expansion only following robust evaluation (as described in Recommendation 21 above).

JUSTIFICATION: Minnesota has several on-going demonstrations, pilots, and programs that have shown promise in achieving the Triple Aim. The Task Force recommends that the State enhance these existing programs, where appropriate, to build on their current success and to correct course, where needed. Because many of these models remain unproven, the Task Force recommends that any new arrangements begin as pilots or demonstrations and be expanded only after a robust evaluation.

COSTS/SAVINGS: Milliman modeled the annual savings to the State and Federal government if several enhancements were made to existing programs, including Integrated Health Partnership demonstration and Health Care Homes. The specific enhancements included a prospective “pre-payment” tied to retrospective savings measurement under an ACO arrangement, and for the population not in this ACO arrangement (such as certified Health Care Homes), a monthly prospective care management payments without retrospective shared savings that is modeled on the existing HCH tiering/payment structure but adds a ‘tier zero’ for patients without chronic diseases.

The modeling assumed that the enhancements would make the programs more attractive to providers, resulting in a net increase in participation. Additionally, the modeling assumed the programs would apply across Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare), and the on-exchange individual market plans (QHP). Broadly, the modeling assumed approximately 45% of the population would be attributed to the ACO arrangement, 40%-45% would be enrolled in the monthly prospective payment program, and 10% to 15% of the population would fall outside of either arrangement.

Based on these assumptions, Milliman identified a net single-year savings of approximately \$48.1 million, with \$17.8 million of that accruing to the State.

STATE/FEDERAL AUTHORITY: Implementation will be dependent on the status of the active demonstrations, pilots, and programs currently in place. Each agency responsible for the active demonstration or program will need to evaluate on a case-by-case basis which enhancements are relevant to their demonstration or program, and determine if the enhancement will require additional authorization or funding. For example, several of the enhancements to Integrated Health Partnerships (IHP) will require changes to the State’s current State Plan Amendment. Changes to the HCH program may require changes to either statute or administrative rule.

OTHER OPTIONS CONSIDERED: The Delivery Design Workgroup of the Task Force considered recommending more aggressive expansion of existing value-based purchasing models across the state, but determined that expansion would be premature until additional evidence of their impact was gathered through a robust evaluation (see above). The Delivery Design Workgroup of the Task Force also discussed recommending a “Primary Care Case Management” model, where the State would contract directly with providers to provide care management and medical services to patients. However, several Workgroup members believed that some of the aspects of this model would be captured in the enhancements to existing demonstrations.

3. Immediate Enhancements to Pilots, Demonstrations and Existing Programs

Minnesota currently has several pilots, demonstrations and programs in place that have generated promising preliminary results. For example, providers participating in the Integrated Health Partnership (IHP) Medicaid ACO demonstration over its first two years exhibited a savings to their total cost of care of approximately \$75 million to the Medicaid program, while enhancing the care of over 200,000

Minnesotans. The Task Force evaluated immediate steps that the State could take to strengthen and expand these programs, with an eye toward achieving the Triple Aim and reducing health disparities.

Recommendation 25:

Enhance community partnerships by:

- Encouraging or incentivizing partnerships and care coordination activities with broad range of community organizations within care coordination models, and
- Funding innovation grants and contracts to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.

JUSTIFICATION: Medical care alone is not sufficient to ensure the lasting health of communities. Instead, medical care must be coupled with community resources to address a patient's full range of needs. Some findings attribute as much as 40% of health outcomes to social and economic factors, such as access to food and shelter. The needs of each community vary, making it challenging to develop a single initiative to tackle social determinants of health across the entire State. Further, it is members of that community—not health care professionals—who are best positioned to identify ongoing and emerging needs. The Task Force therefore recommends that Minnesota more actively engage communities in identifying and prioritizing their needs. Specifically, the Task Force recommends that the State encourage community groups to participate actively in care coordination activities and fund innovative community – provider collaboratives.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation, however funding innovation grants within existing programs such as IHP or HCH would generate new State costs.

STATE/FEDERAL AUTHORITY: Depending on the type and nature of incentive, encouraging partnerships within existing care delivery demonstrations and programs may not require any additional authorization. Providing innovation grants to participating collaboratives would likely require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 26:

Encourage or incentivize participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.

JUSTIFICATION: Although Minnesota is a national leader in many aspects of its health care system, it consistently lags behind other states on measures related to health disparities. Despite the State's low rate of uninsurance and its world class network of providers, Minnesota too often falls short in ensuring the health of its most vulnerable residents. To meet the medical and social needs of these vulnerable populations, the State should ensure that the provider – community collaborations or advisory teams reflect the diverse perspectives of the vulnerable populations.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Depending on the type and nature of incentive, encouraging partnerships within existing care delivery demonstrations and programs may not require any additional authorization. However, if additional funds are tied to the incentive, additional appropriations authority may be needed.

OTHER OPTIONS CONSIDERED: The Delivery Design Workgroup of the Task Force also considered whether to recommend establishing incentive payments tied directly to reducing health care disparities, but the Delivery Design Workgroup of the Task Force ultimately rejected this based on concerns about the limits of providers to address health disparities and the potential to create disincentives to caring for high-need populations.

Recommendation 27:

Base measurement on the following principles: (1) Measures include risk adjustment methodology that reflects medical and social complexity; and (2) Existing pilots, demonstrations, and programs that tie a portion of a provider's payment to costs and/or quality performance should reward providers for both performance or improvement vs. provider's previous year and performance or improvement vs. peer group, to incentivize both lower and higher performing, efficient providers.

JUSTIFICATION: Increasingly linking provider evaluations and payments to quality and value has the potential to drive delivery system reform. But it also could increase health disparities if providers are incented to avoid caring for high-need populations. Providers may face greater challenges managing diabetes, for example, in patients with complex social needs. Rather than risk reduced quality scores, providers may seek to avoid caring for these complex patients. To ensure that measures linked to quality and value promote the Triple Aim without increasing inequity, the Task Force recommends that the State adjust any quality or value measures to reflect both the medical and social complexity of the population.

Similarly, the Task Force members acknowledge that some providers have long-standing experience improving quality and promoting value, while other providers have just begun to do so. Additionally, providers vary in the complexity of their patient populations and the financial and other resources available. Recognizing the need to ensure that a wide-range of providers can be successful under quality or value measurement, the Task Force recommends that measures targets account for both a provider's year-over-year improvement, as well as a provider's performance relative to his or her peer group. By measuring performance on both these fronts, Minnesota will ensure that lagging, but improving, providers are rewarded, as well as consistently stand-out providers.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: The recommendation would likely not require additional legislative authority; however, depending on the demonstration or program may require additional authority from CMS through a State Plan Amendment or other mechanism, or changes to administrative rules.

OTHER OPTIONS CONSIDERED: The Delivery Design Workgroup of the Task Force considered eliminating the approach of tying a portion of a provider's payment to costs and/or quality performance under any model, due to concern that it might discourage providers from caring for patients with the most complex social and medical needs. However, most members agreed that current models within the State did not seem to encourage this type of patient avoidance, and that enhancement of the current models, coupled with sufficient evaluation, was preferable.

The Delivery Design Workgroup of the Task Force also considered whether to recommend including the costs of non-medical services in total-cost-of-care measurements. The Delivery Design Workgroup considered this option to be important, but felt that we didn't currently have the ability to accurately capture this information and include it in total cost of care (TCOC) measurement. Members agreed that understanding the scope and scale of these costs was an important component of managing the overall

costs and care of Minnesotans, and should be considered for inclusion in TCOC calculations if they can be captured accurately in the future.

Recommendation 28:

Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions; appropriate use of preventive services and outpatient management of chronic conditions and risk factors) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.

JUSTIFICATION: Statewide trends provide useful context for understanding the performance of both individual providers and care models. Accordingly, the Task Force recommends that system-wide utilization measures are incorporated into individual provider performance measures. For example, the ED usage rates statewide should inform the evaluation of the ED usage rates for an individual provider's attributed population. Similarly, when aggregating measures across providers to evaluate the overall success of an incentive program or care model, statewide measures and trends are essential context for interpreting results.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: The recommendation would likely not require additional legislative authority; however, depending on the demonstration or program may require additional authority from CMS through a State Plan Amendment or other mechanism, or changes to administrative rules.

OTHER OPTIONS CONSIDERED: The Delivery Design Workgroup of the Task Force discussed potentially including a broader set of population health measures in the quality measurement methodologies of existing demonstrations and programs. However, members were concerned with a provider's ability to meaningfully impact these population-wide measures and the additional burden this might pose to providers. The Delivery Design Workgroup members did agree that population health measurement was an important area for the State to explore for public reporting and analysis purposes, but should not be tied to individual provider performance metrics.

Recommendation 29:

For participants not attributed to an ACO (such as certified Health Care Homes), provide a prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for enrolled patients with complex medical and non-medical needs.

JUSTIFICATION: Accountable care organizations (like the integrated health partnership program) are investing heavily on the infrastructure and staff needed to coordinate care effectively. Providers not affiliated with an ACO, by contrast, may lack the resources needed to invest in care coordination. Patients not served by an ACO, therefore, may miss the benefits of increased care coordination. To ensure that all patients receive coordinated care, the Task Force recommends that the State develop a prospective payment system for providers that are providing team-based, patient-centered coordinated care, such as certified HCHs, for care coordination that includes non-medical services, and for infrastructure development to support team-based, coordinated care.

COSTS/SAVINGS: Savings under this enhancement were included in the modeling discussed above.

STATE/FEDERAL AUTHORITY: Enhanced, prospective payments would likely require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 30:

For participants attributed to an ACO (including risk-taking IHP program), provide a prospective “pre-payment” of a portion of their anticipated total cost of care (TCOC) savings.

JUSTIFICATION: Building a robust program to coordinate care effectively requires considerable investment. Providers must hire care managers, redesign workflows, and strengthen IT capabilities. Some hospitals and large physician groups may have sufficient cash to make investments upfront, recouping them at the end of the year through payments tied to quality and value. Smaller providers, however, lack the cash flow necessary to make these prospective investments. To enable providers large and small to invest in care coordination infrastructure, the Workgroup recommends that the State advance providers a portion of their anticipated total-cost-of-care savings.

COSTS/SAVINGS: Savings under this enhancement were included in the modeling discussed above.

STATE/FEDERAL AUTHORITY: Providing a “pre-payment” of shared savings would likely require State statutory and appropriations authority, as well as CMS authorization through a State Plan Amendment or other mechanism, to implement.

OTHER OPTIONS CONSIDERED: None

Recommendation 31:

Establish consistency of payment approach for care coordination and alternate payment arrangements across all payers. Areas for consistency include: (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.

JUSTIFICATION: Many payers have recognized the need to pay for care coordination, but payers have differed considerably in how they have designed those payments. Specifically, payers vary in the following respects: (1) how much they pay for care coordination activities; (2) whether and how they scale payments for care coordination based on the complexity of the patient; (3) whether care coordination services are subject to co-payments; and (4) how providers bill for care coordination activities. Promoting consistency across payers in these key areas will streamline administration for providers and reduce patient confusion.

COSTS/SAVINGS: Costs/savings were not estimated for this recommendation.

STATE/FEDERAL AUTHORITY: Depending on how this recommendation is implemented, it could require legislative authority and regulation.

OTHER OPTIONS CONSIDERED: None.

Recommendation 32:

Ensure care coordination payments are sufficient to cover costs for the patients with the most intensive needs; the State (MDH and DHS) shall make modifications to the current HCH tiering process to incorporate social and non-medical complexity, and enhance payment rates to incorporate costs associated with care coordination for patients experiencing these conditions. Modifications may include enhancing the payment tiers to include an additional, higher tier payment for patients with intense needs and social complexity.

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JUSTIFICATION: Care coordination requires a significant investment both in terms of staff time and infrastructure costs. Payers should ensure that providers are rewarded for coordinating care for the most complex patients by appropriately tiering care coordination payments. The Workgroup recommends that payments be sufficient to cover the costs of coordinating care for even the most complex patients.

COSTS/SAVINGS: Costs/savings were not separately estimated for this recommendation, although a move to prospective payment is assumed to reduce provider administrative costs are thus incorporated indirectly into the modeling discussed above.

Depending on their level, and the impact on health outcomes and spending, increased payments to providers for patients with complex medical and non-medical needs and for needed infrastructure and workforce changes could add new State net costs.

STATE/FEDERAL AUTHORITY: Depending on how this recommendation is implemented, it might require statutory and appropriations authority to implement.

OTHER OPTIONS CONSIDERED: None.

Recommendation 33:

Strengthen the patient attribution and provider selection process by:

- Allowing patients to choose a provider during the enrollment process and change their primary provider outside of enrollment;
- Giving providers data about who enrolled with them so they have the opportunity to proactively engage with those enrollees;
- Using consistent methods for attaching patients to providers across payers;
- Attributing or assigning patients prospectively to a primary care provider or care network for the purposes of payment (not for care delivery) under an ACO or similar model, with back-end reconciliation.

JUSTIFICATION: Primary care providers are at the center of their patients' care team, coordinating with specialists and supporting linkages with community resources. Given the crucial role of primary care providers, patients should have flexibility to choose their provider both at enrollment and throughout the year. Further, providers are increasingly being held accountable for the quality and cost of care for attributed patients, and thus they are eager to receive a patient roster prospectively so that they may identify and engage high-risk patients. Finally, the Task Force recommends that when patients are attributed or assigned to primary care providers or a care network for payment purposes, such as advances of a portion of the expected total cost-of-care savings, it should be done prospectively to minimize burden on the provider's side, while ensuring that this prospective assignment or attribution does not constrain patients' choice of providers.

COSTS/SAVINGS: Costs/savings were not separately estimated for this recommendation. Depending on how they are implemented, recommendations may lead to new State costs.

STATE/FEDERAL AUTHORITY: Enabling patients to choose a provider during the enrollment process may require legislative authority and changes to existing enrollment systems. Adjustments to attribution of patients within existing ACO-type models likely would not require additional state authority, but may require additional CMS authorization.

OTHER OPTIONS CONSIDERED: None.

Longer Term Recommendations Related to Supporting Integrated Care Delivery:

- Identify ways of enhancing existing payment models to more comprehensively include the dual eligible population.
- Identify methods to report on the costs and savings associated with non-medical services, with potential integration into TCOC calculations.
- Address increasing costs of prescription drug costs in excess medical inflation.
- Develop an approach to managing the growth of long-term care costs, especially in light of the aging population.
- Address workforce shortages, particularly in the areas of primary care and mental health practitioners.
- Identify ways to capture the savings from care delivery and payment modifications back into the health care system.

VI. Conclusion

The Final Report is the culmination of the intensive and collaborative work of the Task Force members over a six month period, through 46 Workgroup and full Task Force meetings. In the course of their work, the Task Force members endeavored to develop high value, meaningful and practical recommendations to the Governor and Legislature with regard to reforming Minnesota's health care delivery system. The Task Force tackled complex problems, and while members did not always agree on the optimal solutions to these problems, their work and this Report reflect a serious and committed effort to inform health care policy development in Minnesota in order to advance the Task Force vision of providing sustainable, quality health care for all Minnesotans.

About Manatt Health

Established in 1965, Manatt, Phelps & Phillips, LLP is a full-service, fully integrated law and consulting firm of more than 400 professionals, with primary offices in New York, Washington, D.C., and California. Manatt is proud to represent a sophisticated client base in a range of industries on a diverse set of issues including healthcare, government and regulatory affairs, financial services, entertainment, media and advertising, real estate, technology, energy and natural resources, consumer goods and services, and transportation.

Healthcare-related legal and consulting services are a principal focus of the firm, and more than 80 professionals devote substantially all of their time and attention to the healthcare practice. Manatt Health ("Manatt") is the interdisciplinary health policy and business strategy advisory division of the firm. Manatt has one of the leading health reform practices in the country, with an array of healthcare attorneys, consultants, project managers, analysts, and policy advisors providing their knowledge and expertise to a wide range of clients, including state and federal policymakers and agencies, insurers, foundations, associations, and health care providers. Manatt provides specialized services such as strategic and business advice, policy analysis and research, project implementation, alliance building/advocacy, and government relations.

VII. Appendices

A. *Appendix A – Task Force Statute*

Laws of Minnesota 2015, Chapter 71, Article 11

Sec. 62. **TASK FORCE ON HEALTH CARE FINANCING.**

Subdivision 1. **Task force.** (a) The governor shall convene a task force on health care financing to advise the governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans. These strategies shall include options for sustainable health care financing, coverage, purchasing, and delivery for all insurance affordability programs, including MNsure, medical assistance, MinnesotaCare, and individuals eligible to purchase coverage with federal advanced premium tax credits and cost-sharing subsidies.

(b) The task force shall consist of:

(1) seven members appointed by the senate, four members appointed by the majority leader of the senate, one of whom must be a legislator; and three members appointed by the minority leader of the senate, one of whom must be a legislator;

(2) seven members of the house of representatives, four members appointed by the speaker of the house, one of whom must be a legislator; and three members appointed by the minority leader of the house of representatives, one of whom must be a legislator;

(3) 11 members appointed by the governor, including public and private health care experts and consumer representatives. The consumer representatives must include one member from a nonprofit organization with legal expertise representing low-income consumers, at least one member from a broad-based nonprofit consumer advocacy organization, and at least one member from an organization representing consumers of color; and

(4) the commissioners of human services, commerce, and health, and the executive director of MNsure, or their designees.

(c) The commissioner of human services and a member of the task force voted by the task force shall serve as co-chairs of the task force. The commissioner of human services shall convene the first meeting and the members shall vote on the co-chair position at the first meeting.

Subd. 2. **Duties.** (a) The task force shall consider opportunities, including alternatives to MNsure, options under section 1332 of the Patient Protection and Affordable Care Act, and options under a section 1115 waiver of the Social Security Act, including:

(1) options for providing and financing seamless coverage for persons otherwise eligible for insurance affordability programs, including medical assistance, MinnesotaCare, and advanced premium tax credits used to purchase commercial insurance. This includes, but is not limited to: alignment of eligibility and enrollment requirements; smoothing consumer cost-sharing across programs; alignment and alternatives to benefit sets; alternatives to the individual mandate; the employer mandate and penalties; advanced premium tax credits; and qualified health plans;

(2) options for transforming health care purchasing and delivery, including, but not limited to: expansion of value-based direct contracting with providers and other entities to reward improved health outcomes and reduced costs, including selective contracting; contracting to provide services to public

programs and commercial products; and payment models that support and reward coordination of care across the continuum of services and programs;

(3) options for alignment, consolidation, and governance of certain operational components, including, but not limited to: MNsure; program eligibility, enrollment, call centers, and contracting; and the shared eligibility IT platform; and

(4) examining the impact of options on the health care workforce and delivery system, including, but not limited to, rural and safety net providers, clinics, and hospitals.

(b) In development of the options in paragraph (a), the task force options and recommendations shall include the following goals:

(1) seamless consumer experience across all programs;

(2) reducing barriers to accessibility and affordability of coverage;

(3) improving sustainable financing of health programs, including impact on the state budget;

(4) assessing the impact of options for innovation on their potential to reduce health disparities;

(5) expanding innovative health care purchasing and delivery systems strategies that reduce cost and improve health;

(6) promoting effectively and efficiently aligning program resources and operations; and

(7) increasing transparency and accountability of program operations.

Subd. 3. **Staff.** (a) The commissioner of human services shall provide staff and administrative services for the task force. The commissioner may accept outside resources to help support its efforts and shall leverage its existing vendor contracts to provide technical expertise to develop options under subdivision 2. The commissioner of human services shall receive expedited review and publication of competitive procurements for additional vendor support needed to support the task force.

(b) Technical assistance shall be provided by the Departments of Health, Commerce, Human Services, and Management and Budget.

Subd. 4. **Report.** The commissioner of human services shall submit recommendations by January 15, 2016, to the governor and the chairs and ranking minority members of the legislative committees with jurisdiction over health, human services, and commerce policy and finance.

Subd. 5. **Expiration.** The task force expires the day after submitting the report required under subdivision

B. Appendix B – Task Force and Workgroup Membership

Name	Title	Organization	Workgroup
Benson, Michelle	Senator	MN Senate	Seamless Workgroup
Blewett, Dr. Lynn	Director	University of Minnesota State Health Access Data Assistance Center	Seamless Workgroup
Coleman, Dannette	Sr. Vice President & General Manager Individual Business	Medica	Seamless Workgroup
Cryan, Phillip	Executive Vice President	SEIU Healthcare Minnesota	Seamless Workgroup
Dean, Matt	Representative	MN House of Representatives	Delivery Workgroup
Doyle, Elizabeth	Associate Director / Policy Director	TakeAction Minnesota	Seamless Workgroup
Ehlinger, Dr. Edward	Commissioner	Department of Health	Barriers Workgroup
Hayden, Jeff	Deputy Majority Leader	MN Senate	Barriers Workgroup
Hurtado, Monica	Health Equity / Racial Justice Organizer	Voices for Racial Justice	Barriers Workgroup
Jesson, Lucinda ⁴⁰	Commissioner	Department of Human Services	Co-Chair
Jungbauer, Molly	Chief Executive Officer	Hollstadt & Associates, Inc.	Seamless Workgroup
Keefer, Scott	Vice President, Public Affairs & Communications	Blue Cross Blue Shield	Barriers Workgroup
Kiscaden, Sheila	Commissioner	Olmstead County	Seamless Workgroup
Lourey, Tony	Senator	MN Senate	Seamless Workgroup
Mack, Tara	Representative	MN House of Representatives	Barriers Workgroup
Marty, John	Senator	MN Senate	Delivery Workgroup
Nelson, Peter	Senator	MN Senate	Seamless Workgroup
Noor, Sahra	CEO	People's Center Health Services	Co-Chair
O'Toole, Allison	CEO	MNsure	Delivery Workgroup
Peitso, Dr. Marilyn	Pediatrician	CentraCare Health	Barriers Workgroup
Roach, Rosemarie	Executive Director	Minnesota Nurses Association	Delivery Workgroup
Rothman, Michael	Commissioner	Department of Commerce	Seamless Workgroup
Schneeman, Chris	Owner	SevenHills Benefit Partners	Barriers Workgroup
Schowalter, Jim	President, CEO	Minnesota Council of Health Plans	Delivery Workgroup

⁴⁰ Emily Johnson Piper, Commissioner of Human Services, assumed role of Task Force Member and Co-Chair effective December 14, 2015 upon Commissioner Lucinda Jesson's judicial appointment.

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Name	Title	Organization	Workgroup
Schultz, Jennifer	Representative	MN House of Representatives	Seamless Workgroup
Schulz, Larry	CEO	Lake Region Healthcare	Delivery Workgroup
Sheran, Kathy	Senator	MN Senate	Barriers Workgroup
Stivland, Dr. Todd	CEO	Bluestone Physician Services	Delivery Workgroup
Wheeler, Dr. Penny	President, CEO	Allina Health	Delivery Workgroup

C. Appendix C – Task Force Vision

TASK FORCE VISION

VISION: *Sustainable, quality health care for all Minnesotans.*

GUIDING PRINCIPLES:

Realistic

The task force will make recommendations that can realistically be implemented.

High Value Impact

The task force will seek recommendations that have high value and are meaningful to Minnesota's health care reform efforts.

Holistic Perspective

The Task Force understands that health care finance and our recommendations do not exist in a vacuum, and are components of the health care and population health systems.

Focus

The task force recognizes that health care financing and system reform is extremely complex and it will contribute to the broader policy debates by focusing its time and attention on the issues it is charged with addressing.

Innovation

The task force is encouraged to identify opportunities for innovation in Minnesota's health care financing and delivery systems which show promise for lowering costs, improving population health and improving the patient experience.

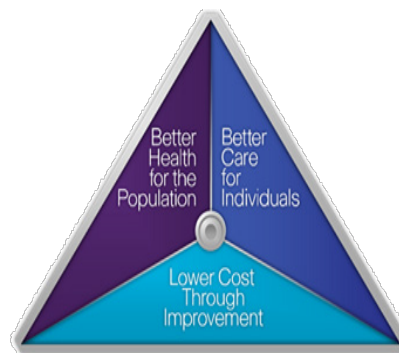
WORKGROUP CATEGORIES

- #1 - Health Care Delivery Design & Sustainability
- #2 - Seamless Coverage Continuum and Market Stability
- #3 - Barriers to Access

CHARGE

Within the context of the triple aim, The Health Care Financing Task Force will develop innovative recommendations in order to create a health care financing and delivery system which:

1. *Provides seamless access to health care insurance across the public programs and private markets;*
2. *Reduces barriers to accessibility and affordability of coverage, including transitions from the public to private markets;*
3. *Addresses sustainable financing of health insurance programs, including their impact on the state budget;*
4. *Assesses the impact of innovative financing options for reducing health disparities;*



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5. *Develops or expands innovative health care purchasing and delivery system strategies that reduce cost and improve health;*
6. *Promotes effective and efficient alignment of program resources and operations;*
7. *Increases transparency and accountability of program operations.*

D. Appendix D – Meeting Schedule and Topics

Meeting Type	Date	Topics/Deliverables
Task Force	08/07/15	Introduction of Task Force members Background information Election of co-chair Presentation on commercial insurance coverage, cost, trends
Task Force	08/20/15	Draft overall vision/principles/charge for Task Force Draft workgroup priority areas Draft Task Force meeting frequency and locations Review RFP response and recommend Task Force facilitator and technical assistance vendor
Task Force	08/26/15	Presentation on recommended priority areas, Workgroup structure, and process Update on recommended vision, guiding principles, and charge for Task Force Panel presentation on changing insurance market from provider, small business, and consumer perspectives
Delivery Workgroup	09/11/15	Workgroup charter review, meeting schedule, and priorities
Barriers Workgroup	09/11/15	Workgroup meeting schedule, background information requests, and charter review
Task Force	09/11/15	Panel presentation on disparities from navigator, consumer services, provider, and persons with disabilities perspectives Approval of Workgroup charters
Seamless Workgroup	09/18/15	Seamless coverage continuum discussion Overview of Medical Assistance, MinnesotaCare, Advance Premium Tax Credits, and Cost-sharing Reductions
Barriers Workgroup	09/18/15	Review of cost sharing and premiums for Medical Assistance and MinnesotaCare Review of market rules for commercial market Review demographics of Medical Assistance, MinnesotaCare, and commercial market
Delivery Workgroup	09/22/15	Review, discuss, and determine Workgroup priorities Discuss background information needed
Seamless Workgroup	09/25/15	Continued discussion on Advance Premium Tax Credits and Cost-sharing Reductions Private insurance market rules and coverage trends in Minnesota Economic stability indicators in Minnesota Churning and coverage cliffs
Barriers Workgroup	09/25/15	Continuation of demographics of commercial market discussion Potential program transitions and cliffs Economic stability indicator tool
Barriers Workgroup	10/02/15	Options & considerations for reducing financial barriers/seamless coverage continuum

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Meeting Type	Date	Topics/Deliverables
Seamless Workgroup	10/02/15	Options & considerations for reducing financial barriers/seamless coverage continuum
Delivery Workgroup	10/02/15	Development of Integrated Care Models/Value-based Purchasing Refine workgroup priorities
Task Force	10/02/15	Workgroup report outs State policy tools: 1332, 1115, etc.
Barriers Workgroup	10/09/15	Options & considerations for reducing structural barriers, part 1 (differences in benefits, plans, providers and managing transitions) Preliminary recommendations for reducing financial barriers/seamless coverage continuum
Seamless Workgroup	10/09/15	Preliminary recommendations for reducing financial barriers/seamless coverage continuum Options & considerations for ensuring a stable Marketplace and coverage platform (MNsure/Marketplace)
Delivery Workgroup	10/16/15	Options & considerations for eliminating barriers to data sharing that impact the care continuum
Barriers Workgroup	10/16/15	Review preliminary recommendations for reducing financial barriers: affordability scale, standard benefit design Discuss preliminary recommendations for reducing structural barriers and disparities: benefit alignment Testimony on disparities
Seamless Workgroup	10/16/15	Options & considerations for ensuring a stable Marketplace and coverage platform (MNsure/Marketplace) (cont'd)
Seamless Workgroup	10/22/15	Review preliminary recommendations for ensuring a stable Marketplace and coverage platform (MNsure/Marketplace) Options & considerations for consolidation, alignment, and innovation to achieve seamlessness & market stability <ul style="list-style-type: none"> Aligning eligibility rules, benefits, and plans Ensuring a stable coverage continuum, including the private market
Delivery Workgroup	10/23/15	Options, considerations and preliminary recommendations for eliminating barriers to data sharing that impact the care continuum
Barriers Workgroup	10/23/15	Review joint preliminary recommendations on financial barriers Review preliminary recommendations for reducing structural barriers: affordability scale, standard benefit design, benefit alignment Options & considerations for reducing structural barriers and disparities, part 3 (disparities in access due to language, culture, health literacy)
Task Force	10/23/15	Update on Marketplace/MNsure issues and Seamlessness Workgroup discussions Joint recommendations on financial barriers/seamless coverage continuum

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Meeting Type	Date	Topics/Deliverables
Barriers Workgroup	11/06/15	<p>Discuss rural health access issues and discuss preliminary recommendations.</p> <p>Review options, considerations and preliminary recommendations on:</p> <ul style="list-style-type: none"> • Consumer assistance/health literacy • Provider/plan alignment • Plan design • Benefits alignment <p>Discuss path to final recommendations (joint with Seamless)</p>
Seamless Workgroup	11/06/15	<p>Discuss path to final recommendations (joint with Barriers)</p> <p>Discuss premium stability issues and preliminary recommendations</p> <p>Options & considerations for financing a sustainable & seamless coverage continuum (MA, MinnesotaCare, MNsure)</p>
Delivery Workgroup	11/06/15	<p>Finalize preliminary recommendations on eliminating or reducing data-sharing barriers to ensure seamless care.</p> <p>Enhancing care delivery across care continuum through alternate payment arrangements with providers across public programs and commercial markets, potentially including:</p> <ul style="list-style-type: none"> • Impact of payment models on care delivery, health disparities, and safety-net providers • Identification of challenges and areas for enhancement of payments to support integration of care • Continued expansion and alignment of payment models across markets, including public and private • Short and long-term considerations for implementing care delivery reforms in Minnesota <p>Potential options for enhancements to payments that support integrated care delivery, may include, but is not limited to:</p> <ul style="list-style-type: none"> • Direct contracting opportunities with providers to enhance care delivery and reduce health disparities • Accountable Care, Health Care Homes, or other models that incent care delivery through enhanced payment, risk arrangements or other mechanisms • Prospective payment models that support Integrated Care Delivery and reduce disparities • Enhanced attribution of patients to primary care providers through a prospective model
Delivery Workgroup	11/09/15	<p>Continue discussions on enhancing and accelerating coordinated care delivery systems and payment reforms</p> <p>Identify workgroup's broad priorities on enhancements to care delivery across care continuum through alternate payment arrangements with providers across public programs and commercial markets</p>

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Meeting Type	Date	Topics/Deliverables
Seamless Workgroup	11/12/15	<p>Review Preliminary Recommendations on Premium Stability (as necessary)</p> <p>Review Preliminary Recommendations for Financing a Sustainable & Seamless Coverage Continuum (MA, MinnesotaCare, MNsure)</p> <p>Review Preliminary Recommendations on Ensuring a Stable Marketplace and discuss and refine Marketplace recommendation: Marketplace goals, narrow Marketplace options, and identify next steps for developing framework for OEP 3 evaluation</p> <p>Review modeling approach for:</p> <ul style="list-style-type: none"> • Smoothing the Cliff • Alignment/Consolidation of MinnesotaCare • Family Glitch
Barriers Workgroup	11/13/15	<p>Review and refine Preliminary Recommendations on Reducing Structural Barriers and Disparities:</p> <ul style="list-style-type: none"> • Consumer assistance/health literacy • Plan design • Benefits alignment • Rural health (if any) <p>Review and finalize Affordability Scale</p> <p>Review modeling approach for:</p> <ul style="list-style-type: none"> • Affordability Scale/Smoothing the Cliff • Benefits Alignment
Task Force	11/13/15	<p>Panel Presentation</p> <p>Preliminary Recommendations</p> <ul style="list-style-type: none"> • Ensuring a Stable Marketplace and Coverage Platform (Seamless) • Reducing Structural Barriers and Disparities (Barriers) • Reducing Data-Sharing Barriers to Improve Care Continuum (Delivery) • Directional Guidance on Enhancements to Payment Model(s) that Support Integrated Care (Delivery) <p>Milliman: review modeling approach</p>
Delivery Workgroup	11/13/15	<p>Continue discussions on enhancing and accelerating coordinated care delivery systems and payment reforms</p> <ul style="list-style-type: none"> • PCCM proposal review • Evaluation framework
Barriers Workgroup	11/20/15	<p>Discussion on undocumented individuals:</p> <ul style="list-style-type: none"> • Data relating to undocumented individuals • Assistance for undocumented individuals to access care • Emergency Medical Assistance for undocumented individuals (eligibility and services) • Potential options to improve access to care for undocumented individuals

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Meeting Type	Date	Topics/Deliverables
Delivery Workgroup	11/20/15	Continue discussions on enhancing and accelerating coordinated care delivery systems and payment reforms <ul style="list-style-type: none"> • Overview of Health Care Homes • Evaluation framework for proposals • Review cross-walk of existing and proposed care delivery, payment models Develop preliminary proposed recommendations
Delivery Workgroup	12/04/15	Review Milliman modeling results Refine Preliminary Recommendations on: <ul style="list-style-type: none"> • Enhancements to Payment Model(s) that Support Integrated Care
Barriers Workgroup	12/04/15	Review final recommendation voting process and meeting schedule Review workgroup feedback on potential options to improve access to care for undocumented individuals, potentially advancing preliminary recommendation Review modeling results on NEMT benefit and refine preliminary recommendation on benefit alignment Refine preliminary recommendation on standard QHP design Refine preliminary recommendation on telehealth study Refine preliminary recommendation on data collection
Seamless Workgroup	12/04/15	Review final recommendation voting process and upcoming meeting schedule Review modeling results on Marketplace options & IT governance structure Refine preliminary recommendations on Marketplace & IT governance structure Review modeling results on continuous eligibility & refine preliminary recommendations Review modeling results on fixing the family glitch & refine preliminary recommendations Review of HCAF November Forecast
Delivery Workgroup	12/18/15	Finalize recommendations for enhancements that support integrate care delivery for potential inclusion in proposal package Review of voting process Review modeling results
Seamless Workgroup	12/18/15	Review final recommendation voting process and upcoming meeting schedule Refine preliminary recommendations on Marketplace options & governance Refine preliminary recommendation on continuous eligibility

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Meeting Type	Date	Topics/Deliverables
Barriers Workgroup	12/18/15	Review agency/Milliman modeling on benefit alignment: <ul style="list-style-type: none"> • Add adult dental benefits to QHPs • Add NEMT to MinnesotaCare Refine recommendations Review agency modeling results on coverage for undocumented individuals, refine recommendations Review new federal policy on standard QHP design, refine recommendation Review current data collection efforts, refine recommendation
Task Force	12/18/15	Proposals being considered by Workgroups Review draft report (without recommendations), voting processes Examine impact of recommendations on Triple Aim and health disparities
Seamless Workgroup	12/21/15	Review Milliman modeling results for affordability scale/smoothing the cliff & refine preliminary recommendations Review modeling results on fixing the family glitch & refine recommendations Review Milliman modeling results on financing & refine recommendations Review Milliman modeling results for program consolidation & refine preliminary recommendations
Delivery Workgroup	01/08/16	Workgroup reviews, votes, amends and approves recommendations package
Barriers Workgroup	01/08/16	Workgroup reviews, votes, amends and approves recommendations package
Seamless Workgroup	01/11/16	Workgroup reviews, votes, amends and approves recommendations package
Task Force	01/15/16	Task Force reviews, votes, amends and approves final recommendations

E. Appendix E – Recommendations By Workgroup

RECOMMENDATION AREA	RECOMMENDATION
Workgroup 1 – Delivery Design	
<i>Expanding Innovative Health Care Purchasing and Delivery Systems Strategies and Advancing the Triple Aim</i>	Enhancements to Data Sharing
	Recommendation 18: Modify the Minnesota Health Records Act to conform with HIPAA and make technical updates and clarifications to the Minnesota Health Records Act to leave a patient’s ability to specify how their information can be shared intact but allow patient consent preferences to be more easily operationalized at the provider level.
	Recommendation 19: Provide ongoing education and technical assistance to health and health care providers and patients, about state and federal laws that govern how clinical health information can be stored, used, and shared, and about best practices for appropriately securing information and preventing inappropriate use.
	Recommendation 20: Conduct a broad study that will make recommendations on the appropriate future structure, legal/regulatory framework, financing, and governance for health information exchange (HIE) in Minnesota, building on lessons learned in Minnesota and from other states and countries.
	<p>Longer-term recommendations and considerations related to data sharing:</p> <ul style="list-style-type: none"> • Dependent on results of health information exchange study (see Recommendation 20), consider other modifications to Minnesota’s Health Records Act, to further align with federal HIPAA standards or to update opt-in or opt-out requirements. • Support expanded health information technology capabilities (ex. EHRs) in a broad range of care settings, to enable smaller and specialty providers to participate in HIE. • Consider developing a funding mechanism for core HIE transactions, such as admission/discharge/transfer alerts, care summaries, or care plans, to ensure basic information can be exchanged statewide. • Support the establishment of robust, sustainable HIE “shared services,” such as consent management, which would be available statewide through a central vendor.
	Enhancements that Support Integrated Care Delivery

RECOMMENDATION AREA	RECOMMENDATION
	<p>Recommendation 21: Evaluate, on an ongoing basis, current value-based purchasing, accountable care, and care coordination demonstrations, pilots, and programs for effectiveness in meeting Triple Aim goals. Programs and pilots should not be significantly expanded until an evaluation of cost/benefits is conducted. At a minimum, the evaluation should address the following domains:</p> <ul style="list-style-type: none"> • Health disparities - Does the model worsen or improve health disparities? If so, by what mechanism or mechanisms? Does the model sufficiently account for variation in the complexity of patients across providers? • Financial stability and cost of health care system – What is the impact of the model on costs across the system, including all payers? What costs are associated with the model at the provider level? What is the return on investment (ROI) of the program? • Patient choice and provider attachment - How is the patient attached to the provider for purpose of service delivery, care coordination, and payment (prospective or otherwise)? How does the model incorporate patient choice of provider? • Multi-payer alignment – What are the areas of alignment across payers under the model? What additional areas could be aligned? • Quality of patient care – How has the model impacted the quality of patient care? • Population health – How does the model address population health? • Social determinants of health – How does the model address the determinants of health beyond medical care (e.g. flexible payment options that enable payment for non-medical services)? • Impact on provider work force - What impact has the model had on the provider work force? If it has an impact, what mechanism caused the impact? <p>Recommendation 22: To the extent possible, seek alignment of approaches across public and private payers, including, but not limited to, consistent measurement and payment methodologies, attribution models, and definitions.</p>

RECOMMENDATION AREA	RECOMMENDATION
	<p>Recommendation 23: Conduct a study that examines various long-term payment options for health care delivery. Study will do a comparative cost/benefit analysis of the health care system under the following approaches:</p> <ul style="list-style-type: none"> • Maintenance of current financing mechanism, without expansion of value-based purchasing beyond existing levels; • Expansion of value-based purchasing within current system; • Publicly-financed, privately-delivered universal health care system. <p>The study would additionally examine the stability and sustainability of health care system under the approach and identify any data or information needed to design and implement the system.</p>
	<p>Recommendation 24: Incorporate enhancements, as described in recommendations 25 through 33 below, as appropriate, into existing demonstrations, pilots, and programs, such as Integrated Health Partnerships, Health Care Homes, Behavioral Health Homes, and other value-based purchasing and accountable care arrangements across Medicaid and commercial beneficiaries. Consider any new arrangements as pilots or demonstrations, with expansion only following robust evaluation (as described in Recommendation 21 above).</p>
	<p><i>Immediate Enhancements to Pilots, Demonstrations and Existing Programs</i></p>
	<p>Recommendation 25: Enhance community partnerships by:</p> <ul style="list-style-type: none"> • Encouraging or incentivizing partnerships and care coordination activities with broad range of community organizations within care coordination models, and • Funding innovation grants and contracts to collaboratives that include providers and community groups, to meet specific goals related to community care coordination tied to social determinants of health, population health improvement, or other priorities.
	<p>Recommendation 26: Encourage or incentivize participation of diverse patients in provider or provider/community collaborative leadership or advisory teams.</p>
	<p>Recommendation 27: Base measurement on the following principles: (1) Measures include risk adjustment methodology that reflects medical and social complexity; and (2) Existing pilots, demonstrations, and programs that tie a portion of a provider's payment to costs and/or quality performance should reward providers for both performance or improvement vs. provider's previous year and performance or improvement vs. peer group, to incentivize both lower and higher performing, efficient providers.</p>

RECOMMENDATION AREA	RECOMMENDATION
	<p>Recommendation 28: Incorporate system wide utilization measures to assess impact of care coordination (such as preventable ED visits, admissions, or readmissions; appropriate use of preventive services and outpatient management of chronic conditions and risk factors) into performance measurement models; for use in evaluation of pilots, programs, and demonstrations; or as part of certification processes.</p>
	<p>Recommendation 29: For participants not attributed to an ACO (such as certified Health Care Homes), provide a prospective, flexible payment for care coordination, non-medical services and infrastructure development that is sufficient to cover costs for enrolled patients with complex medical and non-medical needs.</p>
	<p>Recommendation 30: For participants attributed to an ACO (including risk-taking IHP program), provide a prospective “pre-payment” of a portion of their anticipated total cost of care (TCOC) savings.</p>
	<p>Recommendation 31: Establish consistency of payment approach for care coordination and alternate payment arrangements across all payers. Areas for consistency include: (1) level of payments for care coordination activities, (2) identification of complexity tiers, (3) policies for copayments for care coordination services, and (4) billing processes.</p>
	<p>Recommendation 32: Ensure care coordination payments are sufficient to cover costs for the patients with the most intensive needs; the State (MDH and DHS) shall make modifications to the current HCH tiering process to incorporate social and non-medical complexity, and enhance payment rates to incorporate costs associated with care coordination for patients experiencing these conditions. Modifications may include enhancing the payment tiers to include an additional, higher tier payment for patients with intense needs and social complexity.</p>
	<p>Recommendation 33: Strengthen the patient attribution and provider selection process by:</p> <ul style="list-style-type: none"> • Allowing patients to choose a provider during the enrollment process and change their primary provider outside of enrollment; • Giving providers data about who enrolled with them so they have the opportunity to proactively engage with those enrollees; • Using consistent methods for attaching patients to providers across payers; • Attributing or assigning patients prospectively to a primary care provider or care network for the purposes of payment (not for care delivery) under an ACO or similar model, with back-end reconciliation.

RECOMMENDATION AREA	RECOMMENDATION
	<p>Longer Term Recommendations Related to Supporting Integrated Care Delivery:</p> <ul style="list-style-type: none"> • Identify ways of enhancing existing payment models to more comprehensively include the dual eligible population. • Identify methods to report on the costs and savings associated with non-medical services, with potential integration into TCOC calculations. • Address increasing costs of prescription drug costs in excess medical inflation. • Develop an approach to managing the growth of long-term care costs, especially in light of the aging population. • Address workforce shortages, particularly in the areas of primary care and mental health practitioners. • Identify ways to capture the savings from care delivery and payment modifications back into the health care system.
Workgroup 2 – Seamless Coverage	
<i>Removing Barriers to Access to Coverage and Care and Addressing Disparities</i>	<p>Recommendation 6: Rationalize affordability definition for families with access to employer sponsored insurance (ESI) (i.e., fix the “family glitch”), provided, however, that there is no impact on employer tax penalty related to affordability of coverage for dependents.</p>
	<p>Recommendation 7: Adopt 12 month continuous eligibility for Medical Assistance (MAGI only) & MinnesotaCare enrollees.</p>
	<p>Recommendation 9: Improve affordability and reduce the cliff in premiums, cost-sharing and deductibles for health coverage at 200% FPL in Minnesota’s coverage continuum by establishing a Minnesota-tailored health coverage affordability scale and provide enhanced subsidies to consumers with incomes 200 to 275% FPL (pre-ACA MinnesotaCare eligibility levels).</p>
	<p>Recommendation 10: Expand MinnesotaCare up to 275% FPL, using the recommended affordability scale under Recommendation 9 for those between 200 and 275% FPL, and maintain Marketplace coverage for consumers >275% FPL.</p>
<i>Sustainably Financing the Coverage Continuum</i>	<p>Recommendation 11: Seek Medicaid match to provide additional federal funding for enhanced subsidies to the MinnesotaCare population with incomes from 138 to 275% FPL.</p>
	<p>Recommendation 12: Repeal the sunset of provider tax to continue a dedicated state funding stream to support health care for low-income Minnesotans. With continuation of the provider tax, establish more stringent parameters for: (a) uses of Health Care Access Fund (HCAF) revenue and (b) the mechanism for contingent tax reduction based on program funding needs.</p>
	<p>Recommendation 13: Expand the MNsure user fee to on- and off-Marketplace products, provided that the Legislature statutorily reduces the user fee/premium withhold level.</p>

RECOMMENDATION AREA	RECOMMENDATION
<i>Assessing the Future of MNsure</i>	<p>Recommendation 14: The Task Force does not recommend transitioning to either the Federally Facilitated Marketplace (FFM) or Supported State-Based Marketplace (SSBM) at this time. A partially-privatized State-Based Marketplace (SBM) model could be considered following the evaluation of MNsure’s 2016 open enrollment period. Therefore, the Task Force recommends continuing a SBM at this time.</p> <p>Recommendation 15: Develop framework to evaluate MNsure’s 2016 open enrollment period performance, including the criteria and Marketplace goals listed in this report.</p> <p>Recommendation 16: Codify the current IT executive steering committee structure for overseeing the IT modernization plan, including MNsure’s IT system.</p>
<i>Ensuring Stability of the Insurance Market</i>	<p>Recommendation 17: The Department of Commerce should explore options to stabilize Marketplace premiums by:</p> <ul style="list-style-type: none"> • Studying and modeling potential Minnesota-tailored rate-stability mechanisms for the individual market, such as a reinsurance program • Studying and modeling merging Minnesota’s individual and small group markets • Considering the impact of establishing maximum limits on health plan carriers’ excess capital reserves or surplus <p>Studying options for making Minnesota’s rate review process more transparent with public information and hearings.</p>
Workgroup 3 – Barriers to Access	
<i>Removing Barriers to Access to Coverage and Care and Addressing Disparities</i>	<p>Recommendation 1: Improve and enhance community based consumer assistance resources, including Navigators, consumer assisters and agents/brokers:</p> <ul style="list-style-type: none"> • Develop expanded community based, consumer assistance capacity to support consumers in accessing health coverage, understanding how to use their health coverage, and addressing social determinants of health (e.g., food and nutrition, housing); • Provide adequate and timely payment to, and appropriate training for, community based consumer assisters; • Utilize currently available race/ethnicity/data to identify type and level of consumer needs and target deployment of consumer assistance resources; and • Ensure that the State’s selection of Navigators prioritizes entities able to provide linguistically and culturally appropriate assistance and that new state-developed consumer assistance tools are culturally and linguistically appropriate.

RECOMMENDATION AREA	RECOMMENDATION
	<p>Recommendation 2: Create benefit alignment across the coverage continuum and provide access to high value benefits:</p> <p>Transportation</p> <ul style="list-style-type: none"> • Provide non-emergency medical transportation (NEMT) as a covered benefit in MinnesotaCare. • Build volunteer transportation provider capacity through a grant program. • Assess the impact of enacted NEMT legislation on improving access to care and provider capacity. <p>Dental</p> <ul style="list-style-type: none"> • Require that QHP issuers make available dental benefits on par with coverage in Medical Assistance and MinnesotaCare. • Seek 1332 waiver to allow QHP enrollees to apply Advance Premium Tax Credits/ Cost Sharing Reductions to available dental coverage. • Raise Medical Assistance dental reimbursement rates. <p>Recommendation 3: Evaluate the impact of 2015 telemedicine (health) legislation on payment for and access to broad based telehealth/telemedicine (including mobile applications) services and effectiveness in addressing geographic barriers and health disparities.</p> <p>Recommendation 4: Improve demographic data collection and reporting to inform development of solutions to address disparities in health access and care:</p> <ul style="list-style-type: none"> • Ensure that all Minnesota health data collection and reporting systems including state agencies, providers, payers, and systems that collect health data comply with the State Quality Reporting and Measurement System's (SQRMS') standardized best practices (i.e., allowing patients to identify themselves, allowing a multi-racial category) for collection and reporting of race, ethnicity, language and country of origin data and data elements. • Charge MDH with development of a standardized set of additional socio-economic measures affecting health and health disparities. • Develop mechanism for continuous improvement of health data collection and reporting in partnership with racial and ethnic communities disproportionately affected by disparities.

RECOMMENDATION AREA	RECOMMENDATION
	<p>Recommendation 5: Provide access to coverage for uninsured, low-income individuals ineligible for Medical Assistance, MinnesotaCare and QHPs through MNsure due to immigration status by using State funding to provide MinnesotaCare benefits to children and adults with incomes up to 200% FPL.</p> <p>Provide coverage for services included in the elderly waiver package and nursing facility benefits to individuals under 138% FPL who are eligible for these benefits.</p> <p>In all instances, maintain confidentiality of applicants to ensure information collected is only used for health coverage and maximize available federal funding (i.e., federal funding for EMA and coverage of lawfully present MinnesotaCare).</p>
<p><i>Improving Affordability of Coverage and Care for Consumers</i></p>	<p>Recommendation 8: Require standard Qualified Health Plan offerings in the Marketplace to improve consumer choice and experience and ensure availability of no- or low-deductible options. Look to federal standardized designs as a potential model.</p> <ul style="list-style-type: none"> • Require carriers to offer low and no deductible plan options, in addition to other products they choose to offer. • Require carriers to offer standard plan designs that exempt certain services from deductibles to incentivize utilization of primary care and other high value preventive services. • Study option of 1332 waiver to allow for 60 to 100% actuarial value and how this will improve consumer choice.

F. Appendix F – Milliman Modeling Documentation



**Minnesota Department of Human Services
Health Care Financing Task Force
Financial Modeling**

Prepared for:
Minnesota Department of Human Services

Prepared by:
Milliman, Inc.

Kelly S. Backes, FSA, MAAA
Consulting Actuary

Michael C. Cook, FSA, MAAA
Principal and Consulting Actuary

Amy R. Giese, FSA, MAAA
Consulting Actuary

15800 Bluemound Road
Suite 100
Brookfield, WI 53005
USA
Tel +1 262 784 2250
Fax +1 262 923 3680

milliman.com

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EXHIBITS

Exhibit 1	Changes to Provider Payment Mechanisms
Exhibit 2	MNCare Public Option up to 275% FPL
Exhibit 3	MNCare Private Option up to 275% FPL
Exhibit 4	Proposed On-Exchange and Off-Exchange Premium / Cost Sharing Subsidies
Exhibit 5	Fix Family Glitch

The material was prepared solely to provide assistance to the State of Minnesota in modeling potential program structure, eligibility and benefits. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety. This material assumes the reader is familiar with Minnesota Qualified Health Plans and Public Programs, their benefits, eligibility, administration and other factors.

I. EXECUTIVE SUMMARY

INTRODUCTION

The Department of Human Services (DHS) retained Milliman to model the financial impacts associated with potential changes to Minnesota insurance affordability programs defined and considered by the Health Care Financing Task Force (HCFTF). This report documents the development of the financial models and estimated financial impacts. The broad goal of the HCFTF is to develop strategies to increase access and improve the quality of health care for Minnesotans.

This report only models the estimated fiscal impact of the HCFTF-defined scenarios. Other documents and information are being made available to the HCFTF by organizations other than Milliman to assist in evaluating the scenarios. Many other potential issues, such as changes in administrative burdens, level of costs at risk to the state, stability of the MNsure risk pool, provider and health plan reimbursement, and service access levels, should be considered in addition to estimated financial impacts when the state evaluates the implementation of various program changes. Neither the authors of this report, nor Milliman as an organization, are making any recommendation about which HCFTF scenarios to implement, if any.

Following are brief descriptions of each scenario modeled.

- Scenario A – Expand the prevalence of risk-based provider contracting and monthly prospective care management payments in Prepaid Medical Assistance Program (PMAP), MinnesotaCare (MNCare) and On-Exchange individual market plans
- Scenario B – Add coverage On-Exchange for benefits, primarily adult vision and dental, that are already covered in MNCare
- Scenario C – Expand eligibility for MNCare from 200% FPL to 275% FPL, while keeping it a Public Program. Member premiums and cost sharing for individuals with incomes between 200 - 275% will be greater than the current MNCare levels.
- Scenario D – Expand eligibility for MNCare from 200% FPL to 275% FPL, while transitioning all of MNCare to a “wraparound” program supplementing coverage received On-Exchange. Individuals with incomes greater than 200% FPL have reduced premiums and cost sharing below the current On-Exchange levels.
- Scenario E – Enhanced cost sharing (Cost Sharing Reductions or “CSR”) and premium subsidies (Advance Premium Tax Credits or “APTC”) are provided On-Exchange up to 275% FPL and 400% FPL, respectively. Off-Exchange members are eligible for the same subsidy structure as On-Exchange, with the exception that cost sharing subsidies are only provided up to 250% FPL.
- Scenario F – Fix the “family glitch,” which would allow certain individuals with access to employee-sponsored coverage to obtain On-Exchange subsidies. Individuals with access to “affordable,” employee-only coverage, but “unaffordable” family coverage, would become eligible for subsidies.

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RESULTS

Table 1a outlines the estimated combined state and federal financial impacts associated with each proposed HCFTF program change relative to current MNCare and On-Exchange member subsidy and eligibility levels, benefit coverage and provider payment mechanisms. Impacts associated with each program change are estimated as the difference in costs to the state and federal governments with and without the impact of aligning benefits between programs (i.e., providing additional benefits covered by MNCare to the On-Exchange population up to 400% FPL). Table 1b estimates the associated member financial impacts. Additional details supporting the development of these values and estimated enrollee financial impacts are provided in the remainder of the report.

Table 1a
HCFTC Proposed Program Changes
Estimated State and Federal Financial Impacts (\$Millions – Calendar Year 2016 Level)
With and Without On-Exchange Benefit Alignment

Scenario	Program Change	Without On-Exchange Benefit Alignment	With Benefit Alignment up to 400% FPL ¹
A	Changes to Provider Payment Mechanisms	(\$48.1)	N/A
B	Benefit Alignment between all Programs	N/A	\$15.8
C	MNCare Public Option up to 275% FPL	(\$26.8)	(\$20.0)
D	MNCare Private Option up to 275% FPL	\$387.9	\$394.7
E	MNCare Public Option up to 200% FPL, Subsidies up to 400% off Marketplace	\$194.7	\$216.6
F	Fix “Family Glitch”	\$6.7	N/A

¹ Excludes impact of adding non-emergency transportation to MNCare; Impact for Scenarios C and D only reflects costs for the 275 - 400% population, since the 200 - 275% population impact is already reflected in the first column.

Table 1b
HCFTC Proposed Program Changes
Estimated Member Financial Impacts (\$Millions – Calendar Year 2016 Level)
With and Without On-Exchange Benefit Alignment

Scenario	Program Change	Without On-Exchange Benefit Alignment	With Benefit Alignment up to 400% FPL ¹
A	Changes to Provider Payment Mechanisms	(\$1.2)	N/A
B	Benefit Alignment between all Programs ¹	N/A	(\$15.8)
C	MNCare Public Option up to 275% FPL	(\$73.1)	(\$78.7)
D	MNCare Private Option up to 275% FPL	(\$42.7)	(\$48.3)
E	MNCare Public Option up to 200% FPL, Subsidies up to 400% Off-Exchange	(\$191.5)	(\$209.9)
F	Fix “Family Glitch”	(\$8.4)	N/A

¹ Excludes impact of adding non-emergency transportation to MNCare.

Other than the interaction between the program structure changes (Scenarios C – E) and benefit alignment, the modeled financial impacts are quantified in isolation from each other. We are able to concurrently incorporate multiple program changes into modeling once potential options have been winnowed down at DHS’ request.

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All of the modeling in this report was performed on the statewide basis. No specific consideration was given to variation in metrics by rating regions.

We attempted to retain consistency between our modeled MNCare financial impacts and those developed by DHS for separate potential program changes. To that end, we generally placed all estimated dollar impacts on a calendar year 2016 basis and utilized the same baseline MNCare membership projection as DHS has budgeted. We developed the baseline On-Exchange enrollment estimate from MNsure-provided information. While the cost metrics are generally on a 2016 basis, in certain cases we also incorporated financial program changes that would not be realized in 2016. Two examples of this are 1) incorporating the full projected decrease in medical costs in Scenario A and 2) adding an adjustment for the ending of the federal transitional reinsurance program which expires at the end of 2016.

Unless identified otherwise in the methodology descriptions, we independently developed the modeling data and assumptions from the data sources listed in Section II. A of this report. Certain assumptions, as outlined in Section II. B, were developed using a variety of considerations, including significant discussion with state staff.

Our modeling is limited to estimating changes in program enrollment and combined state and federal program expenditures. In Scenarios C – E, we estimate the split between state and federal member subsidy level changes. Projecting changes in program funding sources is outside the scope of this report. Estimated member cost impacts are provided for many of the program changes.

This report is structured as a brief discussion of the data sources utilized and assumption development, followed by a description of the results and methodology associated with each potential program change. More detailed calculations for each program change are included in tables in each section or the exhibits at the end of the report.

CAVEATS AND LIMITATIONS

This report is not a fiscal note and, as such, is not intending to represent a full estimate of the first year fiscal impact associated with implementing a particular scenario. Additional consideration that will need to be made for a fiscal note analysis include, but are not limited to:

- 1) Policy change phase-in timing,
- 2) Member take-up phase-in,
- 3) Administrative and implementation costs,
- 4) Fiscal analyses performed by DHS and excluded from this report, and
- 5) Funding sources – The level of federal funding available for these scenarios may vary significantly. Projecting changes in program funding sources is outside the scope of this report.

Neither the authors of this report, nor Milliman as an organization, are making any recommendation about which HCFTF scenarios to implement, if any. Many other potential issues, such as changes in administrative burdens, level of costs at risk to the state, stability of the MNsure risk pool, provider and health plan reimbursement, and service access levels, should be considered in addition to estimated financial impacts when the state weighs the implementation of various program changes.

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We utilized a wide variety of data sources and assumptions when developing the models outlined in this report, including historical claim and enrollment information, current program premiums, uninsured and health plan surveys and other sources. We had many conversations with DHS, the Minnesota Department of Health (MDH), MNsure, Department of Commerce and other stakeholders to confirm the best readily available data was utilized in the analysis and modeling assumptions were as accurate as possible given current information. That being said, it is certain the actual financial results will differ from those in this report, since future experience will not conform exactly to historical results and assumptions to project those results to the future. DHS and other stakeholders should update these projections as new information is known and monitor emerging results as any changes are implemented.

In addition, a number of potential assumptions and data sources, should be revisited for any future analysis, should new information become available. Other assumptions and data sources may require further review in the future, as well.

- 1) Proposed cost sharing and premium subsidy scale.
- 2) 2016 health plan paid claims per member per month (PMPM).
- 3) Provider reimbursement differential between On-Exchange / Off-Exchange and MinnesotaCare (MNCare).
- 4) Uninsured take-up rate.
- 5) 2014 to 2016 uninsured rate and income mix, including changes in income distribution from the 2013 survey results.
- 6) Penetration levels in special provider payment mechanisms amongst populations insured through Public Programs or On-Exchange.

There is a significant amount of uncertainty underlying many of the assumptions, and results are sensitive to the assumptions chosen.

The scope of the modeling included populations up to 400% FPL, due to the potential existence of state and federal member subsidies up to that point. However, it is possible that some of the HCFTF scenarios would ultimately impact premiums and enrollment for individuals with incomes greater than 400% FPL due to changes in On-Exchange populations and morbidity.

The individual insurance market is subject to a wide range of factors influencing member and health plan behavior. The Minnesota market, in particular, continues to realize large shifts in enrollment and premiums both on and off the Exchange. Given this environment it is certain that actual enrollment, premium levels and fiscal impacts will vary from those estimated in this report. In particular, this volatility has the potential to materially change many metrics from historical levels, including, but not limited to:

- 1) Uninsured rate, including take-up rate from currently uninsured.
- 2) Relationship between Off-Exchange and On-Exchange premiums and resulting membership mix between the two.
- 3) Percentage of members eligible for premium tax credits (APTC) and cost sharing reductions (CSR) and the magnitude of those subsidies.

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In addition, the HCFTF prescribed scope excluded the modeling of certain potential outcomes of HCFTF recommendations, including, but not limited to:

- 1) Impacts on employer group insurance products, including transitions to the individual market.
- 2) Impacts on the individual market and uninsured population with incomes greater than 400% FPL.
- 3) Certain second order, multi-year impacts such as changes in premium levels over time associated with changes in the average morbidity of the insured population.

This report is intended for use by DHS in understanding estimated financial impacts associated with HCFTF recommended changes to Minnesota insurance affordability programs. The information contained in this report may not be suitable for other purposes or audiences. This report should only be viewed in its entirety. Milliman does not intend to benefit any third party and assumes no duty or liability to other parties who receive this work. It is our understanding that DHS will incorporate certain results and assumptions from this report into broader presentations to HCFTF members.

Differences between the modeled financial impacts and actual experience will depend on the extent to which future experience conforms to the assumptions made in the model calculations. It is certain that actual experience will not conform exactly to the assumptions used.

We relied on data and information supplied to us by DHS, MDH, MNsure, the Department of Commerce, Public Programs health plans, MNsure health plans and other public sources in the development of these financial projections. While we reviewed the data for reasonableness, we did not audit or attempt independent verification of such data. If this data is incomplete or inaccurate, then our conclusions will be incomplete or inaccurate.

We are actuaries for Milliman, members of the American Academy of Actuaries and meet the Qualification Standards of the Academy to render the actuarial opinions contained herein. To the best of our knowledge and belief, this letter is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles and practices.

This report and its exhibits are subject to the terms and conditions of the contract between Milliman and the State of Minnesota #67920.

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II. PROGRAM CHANGE FINANCIAL MODELING

This section of the report outlines the data sources, assumptions, methodologies and estimated combined state and federal financial impacts associated with each proposed HCFTF program change. For each program change we also project the corresponding financial impact to the enrollees. Differences between state and federal and enrollee financial impacts are primarily driven by changes to assumed managed care organization (MCO) reimbursement (e.g., retention levels) and medical provider reimbursement levels. Additional detail around model calculation for each program change impact is included in the exhibits.

A. DATA SOURCES

We utilized several data sources to model the financial impact of each program change. Following is a description of the key sources. All data sources were provided to us by DHS, MNSure, MDH or Commerce other than the Milliman PMAP / MNCare rate development analyses, Milliman *Health Cost Guidelines* and the Unified Rate Review Templates (URRTs), which we accessed through the <https://filingaccess.serff.com/sfa/home/MN> website.

- Detailed encounter data and enrollment records for PMAP and MNCare for dates of service in calendar years 2012 to 2014.
- Analysis underlying the 2014, 2015 and 2016 PMAP and MNCare capitation rate development related to benefit differences between PMAP and MNCare.
- 2014 PMAP and MNCare retrospective risk scores.
- Results of 2016 PMAP and MNCare health plan bidding, including premiums, medical cost and retention metrics.
- 2014 and 2015 Integrated Health Partnership (IHP) risk share calculations.
- Detailed 2013 Minnesota Health Access Survey (MNHA) uninsured and individual market and 2014 Federal American Community Survey (ACS) results.
- Health plan enrollment, claim costs and premiums from the 2014 Small Group and Individual Health Insurance Market Survey summarized at the Metal Level, age and rating region levels.
- Summaries of 2015 enrollment, premiums, APTC and CSR for On-Exchange and Off-Exchange plans.
- 2014 to 2016 estimates of program-wide enrollment for On-Exchange and Off-Exchange individual plans and percentage of On-Exchange eligible for subsidies.
- DHS estimates of the number of individuals impacted by the “family glitch” by type of coverage.
- 2016 filed health plan Individual market Unified Rate Review Templates (URRTs), including premiums, medical cost and retention metrics.

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B. KEY ASSUMPTIONS

Assumptions Not Directly Calculated

Many of the assumptions underlying the financial impact models were directly calculated from the detailed data sources listed above, such as premium, claim costs and health plan retention levels. We outline the development of those assumptions in Section II. C of this report. However, certain other assumptions cannot be directly calculated and must be estimated using a variety of considerations. Following is a discussion of those assumptions and the rationale supporting them.

- **2016 uninsured rate and income mix without HCFTF changes** – We assume the number of uninsured in 2016 absent HCFTF changes would remain at the 2014 level for Minnesota (equivalent to 5.9% in 2014). For this report, we assume no material changes in the mix of income levels for the uninsured population from the 2013 MNHA results.
- **Uninsured take-up rate for individuals receiving enhanced subsidies** – We assume 10% of the estimated uninsured population who are impacted by a particular enhanced member subsidy will enroll in the affordability program. A relatively low number is appropriate because of the significant reductions in the uninsured rates already realized between 2013 and 2014. It is also consistent with state studies that indicate approximately 75% of those without insurance are long-term uninsured, which indicates the existence of structural issues or resistance to coverage. With the significant increase in coverage between 2013 and 2014 driven by member subsidies and program promotion, it is unlikely that many of the long-term uninsured would enroll simply due to additional premium and cost subsidies.

Due to the lack of precision of the uninsured enrollment percentage, we do not vary this estimate between the various HCFTC scenarios.

- **2016 On-Exchange Enrollment and Subsidy Eligibility** – Consistent with recent MNsure projections and analyses, we assume 83,000 members will participate in the On-Exchange market, with 70% of those individuals being subsidy-eligible.
- **Age-related premium impacts between uninsured population assumed to newly enroll in an affordability program and existing plans** – For purposes of this analysis, we assume the morbidity for previously uninsured enrollees in the On-Exchange or MNCare markets is lower than the current average enrolled population. This is estimated from an analysis of several data sources listed in the previous section which indicates the average uninsured age is about 32, versus the average On-Exchange age of 36. Using the MNsure age factor curve, this results in a premium differential of about 3.8%.
- **Average provider reimbursement relativities between MNCare and On-Exchange plans** – DHS and MDH have historically performed surveys of health plans and analyzed fee schedules to estimate differences in service provider reimbursement between Public Programs and Commercial business. In addition, the Minnesota Community Measurement organization publishes average Commercial and Medicaid fees for a number of representative physician services. DHS has recently discussed Individual market provider reimbursement levels relative to Public Programs with individuals familiar with health plan provider contracting. These analyses and discussions indicate an assumption of Individual Market reimbursement being 50% higher than Public Programs would be appropriate. However, there is significant uncertainty around the actual reimbursement relativity. We provide estimates of the sensitivity of the estimate financial impacts in the Sensitivity

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section below. Additional research into this assumption would provide valuable information for any future analysis.

- **Average morbidity between current MNCare and On-Exchange members** – When MNCare was first being established as a Basic Health Program, DHS and Milliman capitation rate development staff anticipated the average morbidity for MNCare members will be higher than for On-Exchange members. However, with the significant decrease in the 2014 MNCare risk scores and the significant increases in 2016 On-Exchange premiums, we now assume there is no material difference in average morbidity between MNCare and On-Exchange members.
- **Transitional federal reinsurance** – The federal transitional reinsurance program is expected to expire at the end of 2016 for the non-grandfathered Individual market in the Affordable Care Act. For modeling purposes, we increased Individual market On-Exchange and Off-Exchange premium and claims by a percentage from Milliman research for the removal of this program when modeling both the baseline scenario and HCFTF proposed program changes.
- **Off-Exchange population enrollment in MNCare** – The 2016 baseline enrollment scenario assumes some shift from Off-Exchange to On-Exchange for the 200% to 400% FPL population. As such, we assume some Off-Exchange population with incomes between 200% and 275% FPL will enroll in MNCare if MNCare eligibility is expanded to 275%. For our modeling purposes, we do not assume material Off-Exchange migration occurs beyond the 2016 baseline changes due to enhanced subsidies.

For sensitivity purposes, if the entire 200% - 275% Off-Exchange population would enroll, we estimate the combined state and federal increased cost would be about \$22.7 million (\$146.94 PMPM * 154,496 member months) for MNCare and \$50.8 million (\$328.69 PMPM * 154,496 member months) for On-Exchange.

- **Off-Exchange population enrollment in On-Exchange** – As mentioned in the previous bullet, the 2016 baseline enrollment scenario assumes some shift from Off-Exchange to On-Exchange for the 200% to 400% FPL population. For our modeling purposes, we do not assume material Off-Exchange migration occurs beyond the 2016 baseline changes due to enhanced subsidies.

For sensitivity purposes, if the entire 275% - 400% Off-Exchange population would enroll On-Exchange, we estimate the combined state and federal increased cost would be about \$96.4 million (\$128.84 PMPM * 748,270 member months).

Note on retention loads: Differences in modeled provider reimbursement and health plan retention are major drivers of the variation in cost impacts between Scenarios C and D. While there is significant uncertainty around the provider reimbursement, we were able to estimate health plan retention loads directly from health plan Public Programs bid and Individual market filings. The modeled Individual market percentage retention loads (15.7% to 17.1%) are materially higher than the Public Programs load (8.2% - 8.5%). Following are several factors that influence this result:

- 1) Individual market retention includes consideration for the Exchange Fee.
- 2) Most Individual market plans are subject to the Health Insurer Fee, while most Public Programs plans are not.

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- 3) Public Programs plans generally target lower profit margins than Individual market plans in their bids or filings.

When the Individual market retention loads used in modeling populations receiving CSRs (i.e., actuarial value of plan is greater than 70%) for this report, we dampened the retention load to be equivalent to a 70% actuarial value plan, as reflected in the plan URRT filings.

Sensitivity of Results

All of the results in this report are sensitive to changes in assumptions made. For assumptions such as premium, claims, retention and historical membership that are directly estimated from various data sources, if actual results vary from those projected in our analysis, the financial impacts will vary similarly. For example, in our modeling with a nearly static population morbidity, if impacted membership increases by 10%, financial impacts will increase by 10% as well. APTCs will generally increase dollar for dollar in our modeling as premiums increase, assuming most individuals are already paying their maximum premiums. CSRs will generally increase as premiums increase, though dampened by the actuarial value (AV) of the plan.

As mentioned previously, differences in health plan retention between Public Programs and the Individual market is one material component of the estimated financial impacts for populations that are modeled to move between the two markets. While the retention assumptions in this report are built from known bids and filings, this assumption should be revisited for any future analysis to determine if there is more recent data available from which to build a revised assumption.

The assumptions not directly calculated that could be most financially impactful in the three HCFTF scenarios with eligibility and subsidy changes (Scenarios C – E) are the enrollment level of the uninsured population and the provider reimbursement relativity between MNCare and On-Exchange. Tables 2 and 3 below illustrate the sensitivity of the state and federal impacts with different values for these assumptions.

Table 2 Uninsured Take-Up Assumptions State and Federal Cost Sensitivity (\$Millions)				
Scenario	Program Change	5%	10% (baseline)	20%
C	MNCare Public Option up to 275% FPL	(\$29.6)	(\$26.8)	(\$21.2)
D	MNCare Private Option up to 275% FPL	\$380.8	\$387.9	\$402.2
E	MNCare Public Option up to 200% FPL, Subsidies up to 400% Off-Exchange	\$188.5	\$194.7	\$207.2

Table 3 Provider Reimbursement Assumptions – On-Exchange to MNCare Ratio State and Federal Cost Sensitivity (\$Millions)				
Scenario	Program Change	2.00	1.50 (baseline)	1.11
C	MNCare Public Option up to 275% FPL	(\$61.0)	(\$26.8)	\$21.2
D	MNCare Private Option up to 275% FPL	\$687.1	\$387.9	\$155.2
E	MNCare Public Option up to 200% FPL, Subsidies up to 400% Off-Exchange	\$194.7	\$194.7	\$194.7

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Baseline Scenarios

As mentioned in Section I of this report, we attempted to estimate MNCare program change financial impacts on a consistent basis with other DHS HCFTF modeling. Table 4 outlines the baseline scenario enrollment assumptions provided by DHS for the MNCare population, absent the impacts associated with HCFTF program changes. The On-Exchange and Off-Exchange baseline membership scenarios and all premium values in Table 4 are developed from the data sources outlined in Section II. A of this report.

Table 4 Baseline Scenarios 2016 Metrics		
Segment	2016 Member Months	2016 Premiums (\$Millions)
MNCare (133 - 200% FPL)	1,410,840	\$557.4
On-Exchange (200 - 275% FPL)	445,728	\$162.0
On-Exchange (275 - 400% FPL)	251,472	\$91.4
Uninsured (200 - 275% FPL)	504,557	N/A
Uninsured (275 - 400% FPL)	358,977	N/A
Off-Exchange (200 - 275% FPL)	154,496	\$65.9
Off-Exchange (275 - 400% FPL)	748,270	\$319.2

C. METHODOLOGY AND RESULTS

Following are high level descriptions and estimated financial impacts associated with each proposed HCFTF program change. The three scenarios that change program structures (Scenarios C – E) are modeled both with and without potential benefit alignment changes. Additional calculation detail for all scenarios is provided in the exhibits at the end of this report.

Scenario A – Changes to Provider Payment Mechanisms

To inform the potential financial impacts associated with the state requiring Public Program and On-Exchange health plans to implement changes to provider payment mechanisms, we worked with DHS to develop assumptions around the percentages of Public Programs (both MNCare and PMAP) populations and the On-Exchange population who participate in the following types of special provider payment arrangements:

- Integrated Health Partnerships (IHP) or similar program with retrospective shared savings.
- Monthly prospective care management payments without retrospective shared savings (currently estimated by DHS to be about 0.5% of medical costs).
- No special arrangement.

After considering the current penetration levels of IHP in Public Programs and the number of individuals ineligible for participation in these arrangements due to issues such as age or short enrollment duration, we are using the following assumptions for the percentage of the population participating in each provider payment mechanism.

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- PMAP: 45% IHP; 40% monthly prospective payment; 15% none.
- MNCare: 45% IHP; 40% monthly prospective payment; 15% none.
- On-Exchange QHP: 45% IHP; 45% monthly prospective payment; 10% none.

To estimate the fiscal impact associated with adding an IHP-like arrangement, we examined the 2014 IHP experience for PMAP and MNCare, including recent calculations by DHS of IHP provider settlement amounts for 2014. Those results implied a total reduction of 1% in medical cost savings across all Public Programs members (including the 75% of the population not participating in the arrangement). We estimate the impact if the entire population had enrolled to be about 3%.

For the monthly prospective care management payment arrangement, we estimate the net savings will be lower. The prospective nature of the arrangement reduces the provider incentive to achieve savings, and any savings realized will first be netted against the monthly payment itself before net savings are realized. Therefore, we assume savings of 0.5% for this arrangement.

In Exhibit 1, we apply the estimated savings to the Public Programs and On-Exchange populations to calculate revised Public Programs and On-Exchange capitation / premiums. For the On-Exchange plans we also then estimate the reduction to APTCs and CSRs.

To estimate the On-Exchange enrollee financial impact associated with lower medical costs, we assumed cost sharing would decrease by the same percentage. We do not assume Public Programs cost sharing would change materially since average cost sharing is very low.

The PMAP and MNCare population has already realized some savings through the implementation of the IHP program to date. The values in this report assume continued savings comparable to those already realized for this population, though the authors of this report do not make a recommendation on whether this is likely to occur or not. Emerging experience should be monitored to determine if savings are continued to be realized for populations already enrolled in IHP.

Please note these Public Programs premium and On-Exchange CSR and APTC savings will not be realized until Public Programs actuaries and On-Exchange MCOs actually incorporate the medical cost savings into their rate development exercises. In particular, while the state and federal savings are on a 2016 basis, they will not be realized in 2016, since the 2016 premiums are already set. Ultimately, once provider savings targets are rebased, premiums may incorporate the total realized savings.

Scenario B – Benefit Alignment

We estimate the combined state and federal financial impact associated with aligning benefit designs between Public Programs and On-Exchange plans up to 400% FPL for the baseline enrollment scenarios outlined in this section. In addition, Scenarios C – E below includes financial impacts with and without benefit alignment.

There are two components of the HCFTF program change: 1) adding benefits covered under Public Programs to On-Exchange plans and 2) adding non-emergency transportation (NEMT) coverage to MNCare to match PMAP coverage. NEMT will not be covered under On-Exchange plans. We understand DHS has estimated the financial impacts associated with adding NEMT coverage to MNCare. Therefore, we did not model the impact of NEMT coverage in this report.

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In modeling the financial impact of aligning benefit coverage between Public Programs and On-Exchange plans, we considered the cost of providing adult vision, dental, acupuncture and enhanced outpatient mental health and substance abuse services. We estimate the cost of covering other MNCare benefits under On-Exchange plans, such as incremental DME and prosthetic coverage, to have immaterial costs. We examined historical service costs from MNCare when developing the projected per member per month (PMPM) costs to apply to the baseline membership scenario. We validated the PMPM dental results against the Milliman *Health Cost Guidelines* for reasonability. The resulting total state and federal projected cost associated with adding the benefits is \$15.9 million.

Since dental and vision coverage will be mandated in conjunction with medical coverage for On-Exchange plans, the potential for member anti-selection associated with these lower cost benefits will be limited. However, there is still potential for increased early year utilization associated with “pent-up demand.” We estimate this impact could increase first year costs by 20%, based on Milliman research. However, consistent with our approach for other changes to generally model “ultimate” impacts, we do not include the 20% in our modeled results.

For the member cost impact, we assume increases to benefits and On-Exchange premiums will flow directly to reduce member out of pocket costs or premium payments versus assuming that similar benefit coverage would otherwise be purchased elsewhere. In reality, the member impact will likely include some combination of reduced premium cost (potentially with materially different premium rates before and after the HCFTF changes), reduced out of pocket costs, and increased service utilization that was forgone when a member was uninsured. We did not attempt to quantify these separate drivers for this report. For members at 200 - 275% FPL, there would also be very small increases to cost sharing, which we did not model.

Table 5 outlines the calculation development for the state and federal and member cost impacts.

Table 5 Benefit Alignment Development up to 400% FPL		
Impacted Member Months	697,200	
	PMPM	Total (\$ Millions)
Base Cost of Additional Services	\$21.14	\$14.7
* <i>Provider Reimbursement Adjustment</i>	1.500	1.500
Allowed Cost of Additional Services	\$31.71	\$22.1
Less Member Cost Sharing (28%)	\$8.84	\$6.2
Federal / State Cost (72%)	\$22.86	\$15.9

Tables 6.a and 6.b below illustrate the historical MNCare PMPM costs for these services and the estimated equivalent costs at a variety of AV levels and at assumed MNCare versus Exchange provider reimbursement levels. Some of these values are utilized in modeling for other HCFTF program changes. Note, while the benefits are covered under MNCare with very little member cost sharing, we are targeting AV levels for the total benefit sets under the various scenarios modeled. Since we make AV adjustments to costs for current benefit sets separately, it is appropriate to also apply an adjustment to these additional benefits.

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Table 6.a
Services Covered by MNCare that are not Essential Health Benefits
Summary of Paid Costs (at MNCare Reimbursement and Cost Sharing)

Service	Paid Cost (PMPM)
Outpatient Mental Health Services	\$1.11
Adult Vision	\$4.73
Adult Dental / Dentures	\$15.03
Acupuncture	\$0.27
Total	\$21.14

Table 6.b
Services Covered by MNCare that are not Essential Health Benefits
Summary of Paid Costs after Reimbursement and Cost Sharing Adjustments

Scenario	Proposed AV	Reimbursement Level Commercial	Medicaid
On-Exchange (200 - 275% FPL):			
Baseline Scenario	72.1%	\$22.86	\$15.24
Moving to MNCare (Exhibit 2)	82.9%	\$26.27	\$17.51
Remaining on Exchange (Exhibit 3)	82.9%	\$26.27	\$17.51
Remaining on Exchange (Exhibit 4)	82.0%	\$25.99	\$17.33
On-Exchange (275 - 400% FPL):			
Remaining on Exchange (Exhibit 4)	70.0%	\$22.20	\$14.80
Off-Exchange (200 - 400% FPL):			
Remaining on Exchange (Exhibit 4)	71.5%	\$22.68	\$15.12

Introduction to Scenarios C – E

Scenarios C – E include more fundamental changes to the structure or characteristics of MNCare, On-Exchange and Off-Exchange programs. In each scenario, APTC and CSR subsidies are enhanced for certain populations. Tables 7 and 8 below outline the proposed changes to CSR and APTC for Scenarios C– E.

Table 7
Current and Proposed Plan Actuarial Values

Income Level (as % of FPL)	MNCare		On-Exchange		Off-Exchange	
	Current	Proposed	Current	Proposed	Current	Proposed
138% - 150%	94%	94%	94%	94%	N.S.*	N.S.*
151% - 200%	94%	94%	87%	94%	N.S.*	N.S.*
201% - 250%	N/A	87%	73%	87%	N.S.*	**
251% - 275%	N/A	73%	70%	73%***	N.S.*	N.S.*
276% - 400%	N/A	N/A	70%	70%	N.S.*	N.S.*

*"N.S." = "No Subsidy." No CSR is available for Off-Exchange products, so the Current AV for Silver plans is 70%.

**For Scenario E, the actuarial value is increased to 87%, and APTC is made available.

***For Scenario E, this actuarial value is reduced to 70% as CSR are not available off the exchange above 250% of FPL.

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Table 8
Premium Tax Credits
Current (2016) and Proposed Member Premiums as a Percent of Income

Income Level (as % of FPL)	MNCare		On- and Off-Exchange*	
	Current	Proposed	Current	Proposed
138% - 150%	1.60% - 2.51%	1.60% - 2.51%	3.35% - 4.07%	1.60% - 2.51%
151% - 200%	2.54% - 4.08%	2.54% - 4.08%	4.12% - 6.41%	2.54% - 4.08%
201% - 250%	N/A	4.14% - 7.25%	6.45% - 8.18%	4.14% - 7.25%
251% - 275%	N/A	7.31% - 8.83%	8.21% - 8.92%	7.31% - 8.83%
276% - 400%	N/A	N/A	8.95% - 9.66%	8.86% - 9.66%

*Off-Exchange premiums only receive subsidies for scenario E.

Scenario C – MNCare Public Option up to 275% FPL

This option expands the MNCare program from 200% to 275% FPL with member cost sharing and member contribution levels that are lower than the current On-Exchange 200 - 275% segment but higher than the current MNCare 138 - 200% FPL program.

There are two segments of enrollees modeled as being impacted by this option to expand MNCare to 275% FPL:

- On-Exchange (200 - 275% FPL)
- Uninsured (200 - 275% FPL)

While it is possible that premiums and enrollment for other populations may be influenced by this change, we do not estimate that to have a material impact on these results beyond the enrollment changes already reflected in the baseline scenarios.

On-Exchange (200 - 275% FPL)

To estimate the impact of state and federal funding for the current 200 - 275% FPL On-Exchange segment, our modeling involves several steps as follows:

1. Estimate projected 2016 MNCare MCO revenue requirement for the 200 - 275% FPL On-Exchange segment.
 - a. The following adjustments are applied to the projected 2016 average On-Exchange paid amount:
 - i. Large claim adjustment: Reflects expiration of federal transitional reinsurance program.
 - ii. Benefit level: Reflects changes from 2014 On-Exchange segment actuarial value to proposed MNCare actuarial value.
 - iii. Provider reimbursement: Accounts for estimated provider reimbursement differences between 2016 MNCare and the 2014 On-Exchange segment.

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- iv. Additional MNCare benefits: Additive adjustment to include enhanced MNCare mental health and substance abuse benefits that are not covered in the 2014 On-Exchange market.
 - v. Retention: Includes administrative expenses, profit margin, and tax and surcharge for MNCare.
2. Calculate MNCare state payment to MCOs net of member premium as the total revenue requirement estimated in the prior step less the 2016 proposed MNCare member premium.
3. Estimate current 2016 On-Exchange combined premium and cost sharing subsidy.
- a. The following adjustments are applied to the projected 2016 average On-Exchange paid amount:
 - i. Large claim adjustment: Reflects expiration of federal transitional reinsurance program.
 - ii. Retention: Includes administrative expenses, profit margin, and tax and surcharge for the On-Exchange market.
4. State and federal funding impact is estimated by subtracting Steps 2 and 3.

The member impact is estimated by combining the differences between the 2016 MNCare member premium contribution and cost-sharing from the 2016 On-Exchange premium contribution and cost-sharing.

Uninsured (200 - 275% FPL)

For the impact of the 200 - 275% FPL uninsured population, our modeling involves several steps as follows:

- 1. Calculate projected 2016 MNCare revenue requirement for the 200 - 275% FPL uninsured segment.
 - a. The following adjustments are applied to the 2016 Proposed MNCare Paid amount (estimated from Step 1 above).
 - i. Benefit level: Reflects changes from Uninsured segment actuarial value to proposed MNCare actuarial value. Note this value is slightly different from the 200 - 275% FPL On-Exchange actuarial value due to differences in estimated income level distribution.
 - ii. Morbidity – Average Age: Adjusts for difference in average age between the Uninsured and On-Exchange segments.
 - iii. Retention: Includes administrative expenses, profit margin, and tax and surcharge for MNCare.
- 2. Calculate MNCare state payment to MCOs (i.e., state and federal cost impact PMPM) as the total revenue requirement estimated in the prior step less the 2016 proposed MNCare member premium.

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The member impact is estimated by adding the projected MNCare member premium and cost-sharing together and subtracting the assumed member claims cost if uninsured.

Combined Population

The above estimates were multiplied by the projected member months for each segment to estimate total costs. All members in the current On-Exchange 200 - 275% FPL segment were assumed to have MNCare coverage for 2016. For the uninsured 200 - 275% FPL segment, we estimated the number of members currently in the segment and multiplied by a 10% take-up rate, which represents the rate at which members decide to pay premiums for MNCare coverage versus remaining uninsured.

We estimate the portion of the of the governmental financial impact attributable to changes in federal member subsidies and state MNCare costs including enhanced subsidies and benefit alignment (Scenario B). For Scenario C, we assume federal member subsidy funding will continue at current levels for the 200 - 275% FPL On-Exchange population and become effective at On-Exchange equivalent levels for the 200% - 275% Uninsured population. The estimated change in federal member subsidy funding more than offsets the change in net state MNCare costs, including enhanced subsidies and benefits, resulting in negative incremental net costs to the state. ***DHS should utilize their own expectation of the federal funding methodology for this scenario when developing budget projections.***

Exhibit 2 summarizes the calculation development.

Scenario D - MNCare Private Option up to 275% FPL

This option moves the MNCare program into the private On-Exchange market and improves current On-Exchange premium and claim subsidies for 200% to 275% FPL. There are three segments of enrollees modeled as being impacted by this option:

- MNCare (138 - 200% FPL)
- On-Exchange (200 - 275% FPL)
- Uninsured (200 - 275% FPL)

While it is possible that premiums and enrollment for other populations may be influenced by this change, we do not estimate that to have a material impact on these results beyond the enrollment changes already included in the Baseline Scenario projections.

MNCare (138 - 200% FPL)

To estimate the impact of state and federal funding for the current 138 - 200% FPL MNCare segment, our modeling involves steps as follows:

1. Estimate proposed 2016 On-Exchange revenue requirement for the current 138 - 200% FPL MNCare segment.
 - a. The following adjustments are applied to the average 2016 MNCare paid amount:
 - i. Provider reimbursement: Accounts for estimated provider reimbursement differences between MNCare and On-Exchange.

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- ii. Retention: Includes administrative expenses, profit margin, and tax and surcharge for On-Exchange.
2. Estimate current 2016 MNCare revenue requirement for the 138 - 200% FPL MNCare segment.
 - a. The following adjustments are applied to the average 2016 MNCare paid amount:
 - i. Retention: Includes administrative expenses, profit margin, and tax and surcharge for MNCare.
3. Calculate proposed 2016 On-Exchange premium and cost sharing subsidies as the total revenue requirement estimated in Step 1 less the 2016 proposed On-Exchange member premium.
4. Calculate current 2016 net MNCare state payment to MCOs as the total revenue requirement estimated in Step 2 less the current 2016 MNCare member premium.
5. State and federal funding impact is estimated by subtracting Steps 3 and 4.

Note the additional MNCare benefits that are not covered in the 2016 On-Exchange market will still be covered for the 138 - 200% FPL population in this scenario. We identify these amounts in Tables 6.a and 6.b in order for DHS to incorporate in its budgeting.

The member impact is estimated by combining the differences between the proposed 2016 On-Exchange member premium and cost-sharing from the current 2016 MNCare premium and cost-sharing.

On-Exchange (200 - 275% FPL)

To estimate the impact of state and federal funding for the current 200 - 275% FPL On-Exchange segment, our modeling involves several steps as follows:

1. Estimate projected 2016 proposed On-Exchange premium and cost sharing subsidies.
 - a. The following adjustments are applied to the average projected 2016 On-Exchange paid amount:
 - i. Large Claim Adjustment: Reflects expiration of federal reinsurance program.
 - ii. Benefit level: Reflects changes from 2016 On-Exchange segment actuarial value to proposed On-Exchange actuarial value.
 - iii. Additional MNCare benefits: Additive adjustment to include MNCare benefits that are not covered in the 2016 On-Exchange market.
 - iv. Retention: Includes administrative expenses, profit margin, and tax and surcharge for On-Exchange.
 - v. Reduce proposed 2016 On-Exchange total revenue requirement by proposed 2016 On-Exchange member premium.

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2. Estimate current 2016 On-Exchange premium and cost sharing subsidies.
 - a. The following adjustments are applied to the average projected 2016 On-Exchange paid amount:
 - i. Large Claim Adjustment: Reflects expiration of federal reinsurance program.
 - ii. Retention: Includes administrative expenses, profit margin, and tax and surcharge for On-Exchange.
3. State and federal funding impact is estimated by subtracting Steps 1 and 2.

The member impact is estimated by combining the differences between the proposed 2016 On-Exchange member premium and cost-sharing from the current 2016 On-Exchange premium and cost-sharing.

Uninsured (200 - 275% FPL)

For the impact of the 200 - 275% FPL uninsured population, our modeling involves several steps as follows:

1. Calculate projected 2016 On-Exchange revenue requirement for the 200 - 275% FPL uninsured segment.
 - a. The following adjustments are applied to the 2016 proposed On-Exchange Paid amount (based on MNCare 138 - 200% FPL population development discussed above).
 - i. Benefit level: Reflects changes from the current MNCare segment actuarial value to proposed On-Exchange actuarial value.
 - ii. Morbidity – Average Age: Adjusts for difference in average age between the Uninsured and MNCare segments.
 - iii. Retention: Includes administrative expenses, profit margin, and tax and surcharge for On-Exchange.
2. State and federal funding impact is estimated by subtracting steps 1 and the proposed On-Exchange member premium.

The member impact is estimated by adding the projected On-Exchange member premium and cost-sharing together and subtracting the assumed member claims cost if uninsured.

Combined Population

The above estimates were multiplied by the projected member months for each segment to estimate total costs. For the uninsured 200 - 275% FPL segment, we estimated the number of members currently in the segment and multiplied by a take-up rate, which represents the rate at which members decide to pay premiums for MNCare coverage versus remaining uninsured.

We estimate the portion of the governmental financial impact attributable to the changes in federal member subsidies and state-enhanced member subsidies and benefit alignment (Scenario B). For Scenario D, we assumed federal member subsidy funding for current MNCare members would continue at current levels

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after they move to the Exchange. Therefore, the full governmental impact for both the current MNCare and On-Exchange members is associated with state-enhanced member subsidies and benefit alignment. The total governmental cost for the previously uninsured population is split between new federal member subsidies and new costs for additional state-enhanced member subsidies and benefits. ***DHS should utilize their own expectation of the federal funding methodology for this scenario when developing budget projections.***

Exhibit 3 summarizes the calculation development.

Scenario E - MNCare Public Option remains up to 200% FPL, Expand Subsidies to Off-Exchange and Increase Premium and Cost Sharing Subsidies

This option expands premium subsidies to the Off-Exchange market in addition to increasing premium subsidy levels for 200 - 275% FPL and cost sharing subsidies for 200 - 250% FPL. There are three segments of enrollees modeled as being impacted by this option:

- Off-Exchange (200 - 400% FPL)
- On-Exchange (200 - 275% FPL)
- Uninsured (200 - 275% FPL)

While it is possible that premiums and enrollment for other populations may be influenced by this change, we do not estimate that to have a material impact on these results beyond the enrollment changes already included in the Baseline Scenario projections.

Off-Exchange (200 - 400% FPL)

To estimate the impact of state and federal funding to expand premium subsidies to the Off-Exchange 200 - 400 % FPL segment, our modeling followed the steps below:

1. Estimate projected combined state and federal impact.
 - a. The following adjustments are applied to the average projected 2016 Off-Exchange paid amount:
 - i. Large Claim Adjustment: Reflects expiration of federal reinsurance program.
 - ii. Benefit level: Reflects changes from current Off-Exchange segment actuarial value to proposed Off-Exchange actuarial value aligned with On-Exchange values.
 - iii. Retention: Includes administrative expenses, profit margin, and tax and surcharge for Off-Exchange.
 - b. Reduce proposed 2016 Off-Exchange total revenue requirement by proposed 2016 Off-Exchange member premium (As there are currently no Off-Exchange premium and claim subsidies the answer in this step is the combined state and federal impact).

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The member impact is estimated by the difference between the proposed 2016 Off-Exchange member premium and cost sharing from the current 2016 Off-Exchange member premium and cost sharing.

On-Exchange and Uninsured (200 – 275% FPL)

To estimate the impact of state and federal subsidies to the 200 - 275% FPL On-Exchange and Uninsured segments, our modeling follows the same steps as described for Scenario D. We assume the Uninsured population will enroll in On-Exchange plans at the same 10% take-up rate as other scenarios, due to the enhanced APTC and CSR available under this scenario. The estimated financial impacts are different as this scenario has enhanced CSRs up to 250% FPL rather than 275% FPL. In addition, we did not include the estimated impact of aligning benefits for the 200% to 275% FPL population segments with MNCare for Exhibit 4. If these benefits were to be added, we estimate the additional annual cost to be \$15.1 million.

For the On-Exchange population, the member impact is estimated by the difference between the proposed 2016 On-Exchange member premium and cost sharing from the current 2016 On-Exchange member premium and cost sharing. For the Uninsured population, the member impact is estimated by adding the projected On-Exchange member premium and cost-sharing together and subtracting the assumed member claims cost if uninsured. The estimates were then multiplied by the projected member months for each segment to estimate total costs.

Combined Population

We estimate the portions of the governmental financial impact attributable to the changes in federal member subsidies and state-enhanced member subsidies and benefit alignment (Scenario B). For Scenario E, there is no change to the federal member subsidy funding for current On-Exchange members, so the full governmental financial impact is associated with state-enhanced member subsidies and benefit alignment. The total governmental cost for the Off-Exchange is split between new federal member subsidies and new costs for additional state-enhanced member subsidies and benefits. ***DHS should utilize their own expectation of the federal funding methodology for this scenario when developing budget projections.***

Exhibit 4 summarizes the calculation development.

Scenario F - Fix “Family Glitch”

For an individual to be eligible to receive APTC and CSR subsidies On-Exchange, among other requirements, the individual must not have access to “affordable” health insurance coverage through his or her employer. In determining the affordability of employee-sponsored coverage, the employee financial contribution to employee-only coverage is compared to their income. For this HCFTF program change, individuals with family members would instead have the larger required employee financial contribution to the appropriate family tier of coverage compared to their income. The impact of this change is that family members of employees with access to employer-sponsored coverage will be eligible to receive subsidies.

In order to estimate the financial impact of this program change, we utilized previous MDH estimates of individuals impacted by the “family glitch.” These estimates vary by the source of coverage (Individual, Uninsured, Public Programs and Employer Group) and three income ranges. We understand the MDH effort to estimate the number of individuals impacted by the family glitch included material uncertainty around the precision and completeness of the underlying data and results. The total population identified by MDH might be understated as it is somewhat lower than we would have expected given other, national studies on the family glitch. However, because of the state-specific nature of the analysis, we believe the

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MDH study is the best data source to use for this report. If implementation of fixing the family glitch is considered in the future, further updates to the impacted population estimates and their behavior should be considered as the financial results could be significantly impacted.

We assume the Uninsured population with incomes greater than 200% of FPL will enroll in an On-Exchange plan and the On-Exchange market population will remain in such a plan and start receiving subsidies. We assume that individuals identified as currently being enrolled in Public Programs will not switch to an On-Exchange plan.

The MDH estimates include a material population identified as being uninsured with incomes less than 200% of FPL. Such individual are eligible for MNCare, we assumed all these individuals will move to MNCare as part of our financial modeling.

For the Employer Group population, we assume there will not be a material number of individuals switching to an On-Exchange plan. In discussions with DHS and MDH, they believe it is unlikely for a material number of individuals to become aware of the financial benefit of the program change and then go through the effort of switching from an employer plan that typically has a simple enrollment process. This is one reasonable outcome and is the assumption utilized for this report. *However, there is potential for employers to gain a financial advantage in this scenario by significantly increasing family contribution levels unless there are changes made to the employer mandate requirements. Such increases could result in significant movement from the employer to the On-Exchange markets and increase state and federal costs.* To develop an estimate of the potential sensitivity of the financial estimate to this assumption, if the full number of members identified by MDH as having employer coverage and being subject to the family glitch moved to On-Exchange and received APTCs and CSRs comparable to the Uninsured 200 - 275% population, we estimate the value of the additional member subsidies to be \$28.0M.

To estimate the total impact across populations, we multiplied the projected number of individuals newly receiving subsidies by the average annual subsidies as calculated for previous program changes in this report. For the projected new MNCare enrollees, we multiplied the projected number of individuals newly receiving coverage by the average state MNCare net premium cost for the current MNCare enrollees. This results in an estimated net increase in state and federal costs of \$6.7 million. This value is equivalent to the combined increase in state and federal costs as well as the decrease in enrollee costs.

The estimated PMPM member cost impact for the current uninsured is equal to the value previously calculated in Exhibit 3. The impact for individuals currently enrolled On-Exchange is equal to the value of the newly available APTCs and CSRs.

Exhibit 5 summarizes the calculation development.

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Exhibits 1 – 5

Scenario Financial Impacts

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Minnesota Department of Human Services
Health Care Financing Task Force Modeling

January 13, 2016

Exhibit 1
Scenario A: Changes to Provider Payment Mechanisms
Summary of Impact Estimates

Segment	2016 Impacted Member Months	State and Federal Cost Impact		Member Cost Impact	
		PMPM	\$ (in Millions)	PMPM	\$ (in Millions)
Current On-Exchange (200 - 400% FPL) - IHP Savings Impact	313,740	(\$11.85)	(\$3.7)	(\$3.88)	(\$1.2)
Current On-Exchange (200 - 400% FPL) - Prospective Care Management Impact	313,740	(\$1.98)	(\$0.6)	(\$0.65)	(\$0.2)
Current On-Exchange (200 - 400% FPL) - No Impact	69,720	\$0.00	\$0.0	\$0.00	\$0.0
Current MNCare - IHP Savings Impact	634,878	(\$7.98)	(\$5.1)	N/A	N/A
Current MNCare - Prospective Care Management Impact	564,336	(\$1.98)	(\$1.1)	N/A	N/A
Current MNCare - No Impact	211,626	\$0.00	\$0.0	N/A	N/A
Current PMAP - IHP Savings Impact	3,785,870	(\$8.13)	(\$30.8)	N/A	N/A
Current PMAP - Prospective Care Management Impact	3,365,218	(\$2.01)	(\$6.8)	N/A	N/A
Current PMAP - No Impact	1,261,956.6	\$0.00	\$0.0	N/A	N/A
Total	10,521,084	(\$4.57)	(\$48.1)	(\$0.14)	(\$1.4)

Exhibit 2
Scenario C: MNCare Public Option up to 275% FPL
Summary of Impact Estimates

Segment	Projected 2016 Segment		2016 Impacted Member Months	State and Federal Cost Impact		Federal Subsidies Impact	State Enhanced Benefits and Subsidies Impact*	Member Cost Impact	
	Member Months	Take-Up Rate		PMPM	\$ (in Millions)	\$ (in Millions)	\$ (in Millions)	PMPM	\$ (in Millions)
Current On-Exchange (200 - 275% FPL)	445,728	N/A	445,728	(\$72.63)	(\$32.4)	\$0.0	(\$32.4)	(\$132.67)	(\$59.1)
Current Uninsured (200 - 275% FPL)	504,557	10%	50,456	\$111.00	\$5.6	\$9.6	(\$4.0)	(\$276.93)	(\$14.0)
Total	950,286		496,184	(\$53.96)	(\$26.8)	\$9.6	(\$36.4)	(\$147.34)	(\$73.1)

*The state impact includes:

- Change in provider reimbursement: On-Exchange population (\$62.0) million, Uninsured population (\$6.5) million
- Change in retention rate: On-Exchange population (\$20.2) million

Exhibit 3
Scenario D: MNCare Private Option up to 275% FPL
Summary of Impact Estimates

Summary of Impact Estimates										
Segment	Projected 2016 Segment		2016 Impacted Member Months	State and Federal Cost Impact		Federal Subsidies Impact		State Enhanced Benefits and Subsidies Impact*	Member Cost Impact	
	Member Months	Take-Up Rate		PMPM	\$(in Millions)	\$(in Millions)	\$(in Millions)	PMPM	\$(in Millions)	
Current MNCare (133 - 200% FPL)*	1,410,840	N/A	1,410,840	\$230.38	\$325.0	\$0.0	\$325.0		\$11.53	\$16.3
Current On-Exchange (200 - 275% FPL)	445,728	N/A	445,728	\$109.12	\$48.6	\$0.0	\$48.6		(\$104.54)	(\$46.6)
Current Uninsured (200 - 275% FPL)	504,557	10%	50,456	\$282.38	\$14.2	\$9.6	\$4.6		(\$245.67)	(\$12.4)
Total	2,361,126		1,907,024	\$203.41	\$387.9	\$9.6	\$378.3		(\$22.40)	(\$42.7)

*The state impact includes:
-Changes in provider reimbursement, \$278.7 million
-Changes in retention rates, \$46.3 million

Exhibit 4
Scenario E: Proposed On-Exchange and Off-Exchange Premium / Cost Sharing Subsidies
Summary of Impact Estimates

Segment	Projected 2016 Segment		2016 Impacted Member Months	State and Federal Cost Impact		Federal Subsidies Impact		State Enhanced Benefits and Subsidies Impact*	Member Cost Impact	
	Member Months	Take-Up Rate		PMPM	\$ (in Millions)	\$ (in Millions)	\$ (in Millions)	\$ (in Millions)	PMPM	\$ (in Millions)
Current On-Exchange (200 - 275% FPL)	445,728	N/A	445,728	\$74.17	\$33.1	\$0.0	\$33.1		(\$74.17)	(\$33.1)
Current Off-Exchange (200 - 400% FPL)	902,767	N/A	902,767	\$165.28	\$149.2	\$138.6	\$10.6		(\$165.28)	(\$149.2)
Current Uninsured (200 - 275% FPL)	504,557	10%	50,456	\$247.06	\$12.5	\$9.6	\$2.8		(\$183.05)	(\$9.2)
Total	1,853,052		1,398,951	\$139.20	\$194.7	\$148.2	\$46.6		(\$136.89)	(\$191.5)

Exhibit 5
Scenario F: Fix Family Glitch
Summary of Impact Estimates

Segment	2016 Impacted Member Months	State and Federal Cost Impact		Member Cost Impact	
		PMPM	\$ (in Millions)	PMPM	\$ (in Millions)
Current Uninsured (200 - 275% FPL)	9,079	\$190.68	\$1.7	(\$126.66)	(\$1.2)
Current On-Exchange (200 - 275% FPL)	793	\$248.37	\$0.2	(\$248.37)	(\$0.2)
Current Uninsured (138 - 200% FPL)	18,993	\$251.64	\$4.8	(\$373.42)	(\$7.1)
Total	28,865	\$232.38	\$6.7	(\$292.37)	(\$8.4)

G. Appendix G – Presenter List

Presenters:

Name	Organization	Date	Meeting
Peter Brickwedde	Minnesota Department of Commerce	09/25/15	Seamless Workgroup
Katie Burns	MNsure	09/18/15, 09/25/15, 12/21/15	Seamless Workgroup
Kim Carolan	Minnesota Department of Human Services	11/20/15	Barriers Workgroup
Jim Chase	MNCM	10/02/15	Task Force
Liz Cinqueonce	Southern Prairie Community Care	11/06/15	Delivery Workgroup
Sara Drake	Minnesota Department of Human Services	11/20/15	Barriers Workgroup
Stefan Gildemeister	Minnesota Department of Health	09/18/15, 09/25/15	Barriers Workgroup Seamless Workgroup
Karen Giusto	Minnesota Department of Human Services	09/18/15, 12/04/15	Seamless Workgroup
Bentley Graves	Minnesota Department of Commerce	10/02/15	Task Force
Amy Harris-Overby	Hennepin County Medical Center	11/06/15	Delivery Workgroup
Chuck Johnson	Minnesota Department of Human Services	12/04/15	Seamless Workgroup
John Keller	Immigrant Law Center	10/16/15	Barriers Workgroup
Steve Knutson	FQHC Urban Health Network	11/06/15	Delivery Workgroup
Rebecca Lozano	Portico Health	11/20/15	Barriers Workgroup
Dr. Sanne Magnan	ICSCI	10/02/15	Task Force
Julie Marquardt	Minnesota Department of Human Services	11/20/15	Barriers Workgroup
Ahna Minge	MMB	11/12/15, 12/04/15, 12/21/15	Seamless Workgroup
Allison O'Toole	MNsure	12/04/15	Seamless Workgroup
Scott Peterson	MN.IT	10/16/15, 12/04/15, 12/18/15	Seamless Workgroup
Commissioner Mike Rothman	Minnesota Department of Commerce	10/22/15, 11/12/15	Seamless Workgroup
Diane Rydrych	Minnesota Department of Health	10/23/2015	Delivery Workgroup
Rosemond Sarpong Owens	CentraCare Health	10/16/15	Barriers Workgroup

2015 Health Care Financing Task Force Final Report

Name	Organization	Date	Meeting
Mark Schoenbaum	Minnesota Department of Health	10/16/15, 11/06/15, 11/20/15	Barriers Workgroup
Alicia Simon	Department of Health	12/21/15	Seamless Workgroup
Marie Zimmerman	Minnesota Department of Human Services	12/21/15	Seamless Workgroup

H. Appendix H – Voting Process and Structure

Step 1: Workgroup Responded to Survey about Recommendations

- Based on a Likert Scale; recommendations needed 51% of possible points to be included in the preliminary package.
- Results were made available to Members and the public on January 4th.
- Members were permitted to abstain from voting on recommendations.
- Survey was available from Monday, December 21st (following the Workgroup meeting) through Wednesday, December 23rd at 11:59 pm CT.

Step 2: Manatt Drafted Package with Input from Workgroup Leads

- Package included most salient pros and cons and identified where there were differing views among Members.
- Members received a preview of the package on January 4th and the package was posted online prior to January 11th.

Step 3: Workgroup Amended, as needed, and Voted on Package

- Workgroup Lead presented the package at meeting held on January 8th (Delivery Design and Barriers to Access) or January 11th (Seamless Coverage) for discussion and amendments.
- A vote to approve meant there was agreement with most (but not necessarily all) of the recommendations.
- Majority vote was needed to approve package to be sent to the Task Force.
- Amendments required a supermajority (3/5th) for approval; no new items were permitted to be added by amendment.
- Members were allowed to abstain from voting on Workgroup package.

Step 4: Task Force Amends, as needed, and Votes on Package

- Co-chairs presented the package on January 15th for discussion and amendments.
- A vote to approve meant there was agreement with most (but not necessarily all) of the recommendations.
- A supermajority vote (3/5th) was required for approval of the full package of recommendations.
- Amendments required a supermajority (3/5th) for approval; no new items were permitted to be added by amendment.
- Members were allowed to abstain from voting on final package.

I. Appendix I – Barriers to Access Framework

Access to care represents the degree of “fit” between health care consumers and the health care system, made up of the following dimensions⁴¹:

- **AVAILABILITY:** The volume and type of existing services available for the consumers’ volume and needs, including the adequacy of those services
- **ACCESSIBILITY:** The relationship between the location of services and the location of consumers including; transportation resources, distance, time, and cost
- **ACCOMMODATION:** The relationship between the organization of supply resources and the consumers ability to accept those factors (i.e. appointment systems)
- **AFFORDABILITY:** The relationship between prices of services and providers’ insurance to the consumer’s income, ability to pay, and health insurance coverage
- **ACCEPTABILITY:** The relationship between the consumer’s attitudes about personal and practice characteristics of providers to the actual characteristics of providers

⁴¹ R. Penchansky and J. Thomas. *The Concept of Access: Definition and Relationship to Consumer Satisfaction*. Medical Care (19)(2). Feb. 1981. pp. 127 – 140.

J. *Appendix J – List of Acronyms*

Acronyms Used	Meaning
ACA	Affordable Care Act
APTC	Advance Payments of the Premium Tax Credit
BHHS	Behavioral Health Homes
BHP	Basic Health Program
CSR	Cost-sharing Reductions
DHS	Minnesota Department of Human Services
EHR	Electronic Health Record
FFM	Federally-facilitated Marketplace
FPL	Federal Poverty Level
HCHs	Health Care Homes
HIE	Health Information Exchange
HIPAA	Health Insurance Portability and Accountability Act of 1996
IAP	Insurance Affordability Program
ICSP	Integrated Care System Partnerships
IHP	Integrated Health Partnerships
QHP	Qualified Health Plan
MDH	Minnesota Department of Health
MMB	Minnesota Management & Budget
MN.IT	State of Minnesota Information Technology
SBM	State Based Marketplace
SSBM	Supported State Based Marketplace

K. Appendix K – Workgroup Charters

Workgroup #1 – Health Care Delivery Design & Sustainability

WORKGROUP LEAD: Dr. Penny Wheeler

MEMBERS: Rep. Matt Dean, Sen. John Marty, Allison O’Toole, Rosemarie Roach, Larry Schulz, Jim Schowalter, Todd Stivland, and Dr. Penny Wheeler

WORKGROUP COORDINATOR: [Mat Spaan](#) (DHS), mathew.spaan@state.mn.us

AGENCY SUPPORT STAFF: Peter Brickwedde (COM); Kristin Kelly (MNSure); Ahna Minge (MMB); and Diane Rydrych (MDH)

Charge to the Workgroup

DELIVERY DESIGN & SUSTAINABILITY: The workgroup will identify innovative health care delivery system strategies to reduce costs and improve health outcomes. In developing these recommendations, the workgroup should assess the impact of these options on the sustainability of health programs, including the impact on the state budget, if any. This workgroup will also examine the impact of options on the health care workforce and delivery system in Minnesota, including, but not limited to, rural and safety-net providers, clinics, and hospitals.

As provided under Minn. Session Laws 2015, Chap. 71, Article 11, Section 62, these strategies may include, but are not limited to:

- Value-based direct contracting with providers and other entities to reward improved health outcomes and reduced costs, including selective contracting;
- Contracting to provide services to public programs and commercial products; and
- Payment models that support and reward coordination of care across the continuum of services and programs.
- Care model redesign efforts that decrease cost while maintaining or improving quality of care.

HEALTH DISPARITIES & TRIPLE AIM: The workgroup will describe how their recommendations impact health disparities in Minnesota—including disparities related to one’s geographical location, socioeconomic status, race/ethnicity, and/or disability—as well their impact on Minnesota’s efforts to meet the goals of the Triple Aim (improving patient experience and health outcomes, along with lowering health care costs).

Initial workgroup recommendations are due to the Task Force on November 13, 2015. Final Task Force recommendations are due on January 15, 2016.

Workgroup #2 – Seamless Coverage Continuum and Market Stability

WORKGROUP LEAD: Lynn Blewett

MEMBERS: Sen. Benson, Lynn Blewett, Danette Coleman, Phillip Cryan, Liz Doyle, Molly Jungbauer, Sheila Kiscaden, Sen. Lourey, Peter Nelson, Commissioner Mike Rothman, and Rep. Schultz.

WORKGROUP COORDINATOR: [Stacie Weeks](#) (DHS), stacie.weeks@state.mn.us

AGENCY SUPPORT STAFF: Darcy Miner (MDH); Kristin Kelly (MNSure); Katie Burns (MNSure); Peter Brickwedde (COM); Lindsay McLaughlin (COM); and Ahna Minge (MMB)

Charge to the Workgroup

SEAMLESS COVERAGE CONTINUUM RECOMMENDATIONS: The workgroup will examine opportunities for providing and financing a seamless, affordable and financially stable coverage continuum in Minnesota. As provided under *Minn. Session Laws* 2015, Chap. 71, Art. 11, Section 62, options may include, but are not limited to, the following:

- Alignment of eligibility and enrollment requirements;
- Smoothing consumer cost-sharing across programs;
- Alignment and alternatives to benefit sets;
- Alternatives to the individual mandate;
- Alternatives to the employer mandate and penalties;
- Alternatives to advanced premium tax credits; and
- Alternatives to qualified health plans.

MARKET STABILITY, INCLUDING GOVERNANCE & FINANCING RECOMMENDATIONS: The workgroup will assess options for aligning the financing and governance of operational and resource components for insurance affordability programs—including Medical Assistance, MinnesotaCare, and advanced premium tax credits used to buy an ACA-compliant commercial insurance product. The workgroup will consider the impact of recommendations on the ability of families to maintain adequate and affordable coverage as they move up the income ladder. Recommendations should take into consideration the transparency and accountability of programs.

HEALTH DISPARITIES & TRIPLE AIM: The workgroup will describe how their recommendations impact health disparities in Minnesota—including disparities related to one's geographical location, socioeconomic status, race/ethnicity, and/or disability—as well their impact on Minnesota's efforts to meet the goals of the Triple Aim (improving patient experience and health outcomes, along with lowering health care costs).

DEADLINES: Initial joint workgroup recommendations on a seamless coverage continuum and reducing financial barriers are due to the Task Force on October 23, 2015. Initial workgroup recommendations on (1) Financing a Seamless Coverage Continuum, (2) Ensuring a Stable Marketplace and Coverage Platform and, (3) Opportunities for Consolidation, Alignment and Innovation. are due to the Task Force on December 4, 2015. Final recommendations are due to the Task Force on January 15, 2016.

Workgroup #3 – Barriers to Access

WORKGROUP LEAD: Marilyn Peitso

MEMBERS: Commissioner Ed Ehlinger, Sen. Jeff Hayden, Monica Hurtado, Scott Keefer, Rep. Tara Mack, Marilyn Peitso, Sen. Kathy Sheran, and Chris Schneeman

WORKGROUP COORDINATOR: [Diogo Reis](#) (DHS); diogo.reis@state.mn.us

AGENCY SUPPORT STAFF: Jackie Edison (MNSure); Lindsay McLaughlin (DOC); Ahna Minge (MMB); ThaoMee Xiong (MDH)

Charge to the Workgroup

BARRIERS TO ACCESS: The workgroup will identify opportunities to reduce barriers to accessing quality care that will improve health outcomes in Minnesota. This includes options that address existing financial or structural barriers to care for special or harder to reach populations. Recommendations should include a state fiscal assessment, including any potential costs or savings to the state budget.

FINANCIAL BARRIERS: The workgroup will review and assess financial barriers or affordability gaps to accessing care and health insurance coverage, and identify options for addressing such barriers.

STRUCTURAL BARRIERS: The workgroup will review and assess structural barriers to care, and identify options for addressing such barriers. This includes geographical or cultural barriers to care.

HEALTH DISPARITIES & TRIPLE AIM: The workgroup will describe how their recommendations impact health disparities in Minnesota—including disparities related to one's geographical location, socioeconomic status, race/ethnicity, and/or disability—as well their impact on Minnesota's efforts to meet the goals of the Triple Aim (improving patient experience and health outcomes, along with lowering health care costs).

DEADLINES: Initial joint recommendations on a seamless coverage continuum and reducing financial barriers are due to the Task Force on October 23, 2015. Initial recommendations on reducing structural barriers and disparities are due to the Task Force on November 13, 2015. Final recommendations are due to the Task Force on January 15, 2016.

L. *Appendix L – Recommended Premium Affordability and AV Affordability Scales*

Recommended Premium Affordability Scale for 138 to 275% FPL

Income Level (FPL)	Recommended Scale (% of income)	Current Scale in Minnesota (% of income)	Reduction in Premiums under Recommended Scale as compared to Current Scale (% of income)
138% FPL	1.22%	1.22%	0%
150% FPL	2.51%	2.51%	0%
200% FPL	4.08%	4.08%	0%
201% FPL	4.40%	6.38%	1.98%
250% FPL	7.24%	8.05%	0.81%
275% FPL	8.83%	8.83%	0%

Recommended AV Affordability Scale for 200 to 275% FPL

Income Level (FPL)	Current AV for Silver Product in Minnesota (% of income)	Recommended AV Scale (% of income)
138% - 200%	94%	94%
201% - 250%	73%	87%
251% - 275%	70%	73%

M. Appendix M – Overview of Marketplace Models

Overview of Marketplace Models

- **State-Based Marketplace (SBM):** State retains MNsure, continuing to improve its functionality.
- **Supported State-Based Marketplace (SSBM):** The State would rely on Federally Facilitated Marketplace (FFM) for certain core functions, especially eligibility and enrollment determinations. Federal Marketplace would hand off Medicaid-eligible individuals to the State, and thus the State would need to maintain an IT system for Medicaid eligibility and enrollment and build account transfer functionality to accept application hand-offs of Medicaid-eligible individuals from healthcare.gov. The FFM cannot currently be customized to account for MinnesotaCare, and recent guidance on 1332 waivers clarifies that healthcare.gov will not be able to accommodate customized coverage programs for FFM and SSBM states. Under the SSBM model, the State would retain full responsibility for plan management functions within the IT constraints and certain other plan management conditions of the FFM. With respect to consumer assistance, the federal government's call center would handle questions about eligibility and enrollment, while the State would control and be responsible for funding consumer outreach and navigators. In its proposed payment notice for 2017, HHS has proposed that its fee for providing the federal platform would be a 3% carrier user fee. This fee is deemed as high by many states adopting or considering adopting this model; the State of Oregon, which transitioned to the SSBM model in 2015 has recently issued an RFP to transition again to the privatized Marketplace model.
- **Federally Facilitated Marketplace (FFM):** The State would replace MNsure with the FFM, which would handle all Marketplace functionality, including consumer assistance and plan management, though HHS has encouraged FFM states to handle plan management duties on an advisory basis. The State would continue to maintain a Medicaid eligibility and enrollment system, and it would need to build a new account transfer functionality to receive application handoffs of Medicaid-eligible individuals from healthcare.gov. As with the SSBM model, the FFM would not be able to accommodate MinnesotaCare, at least for the near future. The annual fee for the FFM is proposed to remain as 3.5% carrier user fee for 2017.
- **Privatized Marketplace:** Under this model, the State would contract with private vendors to provide much of the eligibility and enrollment functionality. The State could purchase either "off-the-shelf" products, customized solutions, or both, potentially enabling the State to achieve full functionality more quickly than if it retains MNsure. The private model, however, is largely untested and requires diligent ongoing state oversight to ensure proper implementation. The costs of the private model are unknown absent a procurement process.

N. Appendix N—Tool for Reform: Federal Waivers

Section 1332 of the Affordable Care Act

Beginning in 2017, 1332 waiver authority permits states to waive certain ACA provisions, such as the rules governing covered benefits and subsidies, the individual and employer mandates, and Marketplaces as the vehicle for determining eligibility and enrolling consumers in coverage.

To receive federal approval, the state's waiver request must meet the following four criteria:

1. Coverage must be least as “comprehensive” as coverage currently offered through the Marketplace
2. Coverage must be at least as “affordable” as coverage offered without the waiver
3. At least as many people are covered as would have been without a waiver
4. The waiver must not increase the federal deficit

In guidance released on December 11, 2015, the federal government provided additional information on the guardrails for 1332 proposals. Among the key takeaways: federal deficit neutrality is broadly defined and includes administrative cost to the federal government. The federal government also specifically excludes the possibility of states assessing budget neutrality across section 1115 and section 1332 waiver authorities. Finally, HHS clarifies that healthcare.gov will not be able to support state programs that vary from the standard ACA structure, making it more difficult for FFM states to pursue waivers that alter eligibility, enrollment or insurance product standards under the ACA.

Section 1115 of the Social Security Act

HHS may permit states to waive certain Medicaid requirements if doing so is “likely to assist in promoting the objectives” of the Medicaid program. States may use an 1115 waiver to modify eligibility or benefits, craft alternative models for Medicaid expansion, reform long-term care systems, and innovate within the health care system. CMS has broad discretion to grant 1115 waiver, though waivers must be “budget neutral” to the federal government, meaning federal Medicaid expenditures during the project must not be more than federal spending without the waiver.