INFORMATION BRIEF
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Subsidized Health Coverage through MNsure

MNsure, the state's health insurance exchange, was established by the 2013 Legislature as part of implementation of the Affordable Care Act (ACA). Individuals who are not eligible for Medical Assistance (MA) or MinnesotaCare, with incomes that do not exceed specified guidelines, may be eligible for premium tax credits and cost-sharing reductions to purchase health coverage on a subsidized basis through MNsure. This information brief describes eligibility, covered services, enrollee premiums and cost-sharing, and other aspects of subsidized coverage available through MNsure.

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Establishment and Role of MNsure

MNsure, the state's health insurance exchange, was established by the 2013 Legislature as part of implementation of the federal Affordable Care Act (ACA). MNsure was established as a state board and is governed by a seven-member board of directors (see Minn. Stat. § 62V.04).

The ACA requires health insurance exchanges to:

- facilitate access to individual and small group coverage through the offering of standard benefit and cost-sharing packages, referred to as qualified health plans;
- determine eligibility for premium tax credits and cost-sharing reductions; and
- determine eligibility for state public health care programs.

Plan Selection and Enrollment

Individuals may select and purchase a private sector health plan through MNsure or through a private sector insurance agent, and may also obtain assistance in selecting a plan from navigators and other assisters. Large group coverage is not currently available through MNsure. The ACA began to allow states to expand exchange coverage to include large employer groups in 2017.

For most individuals, coverage through MNsure is available only during an annual open enrollment period. The open enrollment period for coverage in 2019 will run from November 1, 2018, through January 13, 2019. Individuals and families who experience a qualifying life event, such as birth or adoption, marriage, or loss of health coverage (for reasons other than failing to pay premiums or turning down available coverage), are allowed to purchase coverage through MNsure outside of the open enrollment period and still receive premium tax credits and cost-sharing reductions, if eligible.

Qualified Health Plan Coverage

The ACA requires health coverage offered through an exchange to meet the standards of a qualified health plan, including standards related to covered benefits and cost-sharing. In addition, health coverage offered through an exchange must meet the regulatory requirements specified in state and federal law that apply to health coverage generally.

General Requirements

ACA standards for a qualified health plan include, but are not limited to:

- meeting certification standards established by the federal government, such as those relating to marketing practices, provider adequacy, quality measurement and improvement, and the use of standard forms;[1]
- providing the essential health benefits package (described below);
- being offered by health insurers that meet specified requirements;[2] and
- meeting any state-specific standards for certification as a qualified health plan.[3]

Essential Health Benefits

Qualified health plans must provide "essential health benefits" as required under the ACA. The ACA requires essential health benefits to include at least the following ten categories of items and services:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- mental health and substance use disorder services, including behavioral health treatment
- prescription drugs
- rehabilitative and habilitative services and devices

[1] See 42 U.S.C. § 18031 (c).

[2] For example, health insurers must be licensed by the state, offer at least one silver-level plan and one gold-level plan through the state exchange, and charge the same premiums for a plan inside and outside the exchange (42 U.S.C. § 18021 (a)(1)(c)).

[3] Minnesota law contains a number of provisions that are intended to comply with more general ACA directives and requirements related to health plan certification and insurance regulation. In addition, MNsure has the option to serve as an "active purchaser" by selecting qualified health plans for participation in the exchange. To date, MNsure has not implemented this active purchaser option.

- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care

The ACA allows each state to designate its essential health benefit package by choosing among four categories of benchmark plans, supplementing the benchmark plan as necessary to cover the ten categories of essential health benefits specified above.[4] Minnesota, by not choosing a specific benchmark plan, has opted for the federal essential health benefit default—the largest health plan by enrollment in the largest product in the state's small group market.

Cost-sharing

The ACA sets limits for cost-sharing under a qualified health plan. The ACA also prohibits health insurers from applying cost-sharing (e.g., copayments, coinsurance, or deductibles) to certain preventive services.[5] These requirements apply to individual and small group policies issued both inside and outside the exchange.

Annual out-of-pocket limits for a qualified plan cannot exceed federal limits that apply to health savings account-qualified, high-deductible health plans. For 2018, these limits are $7,350 for single coverage and $14,700 for family coverage (limits are adjusted annually).

Certain low-income individuals, and American Indians and Alaska Natives, qualify for health coverage through the exchange with reduced, or no, cost-sharing (see section on cost-sharing reductions).

Actuarial Value and Metal Levels

The ACA requires insurers in the individual and small group markets to align their coverage to conform to one or more "metal levels" that correspond to different actuarial values. Actuarial value (AV) is an estimate of the percentage of medical expenses incurred by a typical enrollee that will on average be paid by the insurer.

The ACA metal levels, and corresponding actuarial values, are as follows: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). As an example, the silver metal plan will pay 70 percent of the medical expenses of the typical enrollee; the remaining 30 percent would be the enrollee's share of the cost of coverage. Plans with higher actuarial values will on average charge higher premiums but require less enrollee cost-sharing, while plans with lower actuarial values will on average charge lower premiums, but require more enrollee cost-sharing.

[4] 45 C.F.R. part 156.100.

[5] Section 2713 of the ACA requires health insurers to provide coverage, without cost-sharing, for certain preventive services recommended by specified professional medical bodies, such as the U.S. Preventive Services Task Force and the Institute of Medicine.

Other Insurance Requirements

Qualified health plans must comply with other applicable federal and state health insurance requirements. The ACA, for example, requires plans to cover dependents up to age 26, requires guaranteed issue and renewal, sets loss ratios, and limits the extent to which plans can impose annual maximum dollar limits for coverage. These requirements apply uniformly to all health carriers and health plans in the individual and small group markets, whether the plan is offered through MNsure or directly by an insurer.

Subsidies for the Purchase of Qualified Health Plans

Individuals who are not eligible for MA, MinnesotaCare, or other specified types of health coverage, who have incomes[6] that are greater than 200 percent but do not exceed 400 percent of the federal poverty guidelines (FPG) for household size, may be eligible to receive premium tax credits to subsidize the purchase of health coverage through MNsure. Individuals with incomes greater than 200 percent but less than or equal to 250 percent of FPG may also be eligible to receive subsidies to reduce enrollee cost-sharing. The cost of providing premium tax credits is borne by the federal government.

Eligibility for Premium Tax Credits

In order to be eligible for a federal premium tax credit through MNsure, an individual must:

- be enrolled in coverage through MNsure;
- not be eligible for other specified health coverage;
- have an income greater than 200 percent but not exceeding 400 percent of FPG; and
- file a federal income tax return.

The premium tax credit is refundable—it is available to all who are eligible, even persons with little or no income tax liability. Refundable credits in excess of tax liability are paid as refunds.

Coverage through MNsure. In order to be eligible for a premium tax credit, an individual must be enrolled in individual health coverage through MNsure. This means that a person must meet the following eligibility criteria for purchasing a qualified health plan through MNsure, whether subsidized or unsubsidized:

- be lawfully present (a citizen or legal noncitizen)
- meet state residency standards

[6] Income eligibility for premium tax credits and cost-sharing subsidies is determined using modified adjusted gross income (MAGI). MAGI is defined as adjusted gross income increased by: (1) the foreign earned income exclusion; (2) tax-exempt interest; and (3) an amount equal to the value of Social Security benefits not subject to tax (I.R.C. § 36B).

- not be incarcerated

Not eligible for other health coverage. To be eligible for a premium tax credit, an individual must not be eligible for health coverage that is considered "minimum essential coverage" under the ACA. Minimum essential coverage includes, but is not limited to, coverage through Medicaid, Medicare or another government program, and employer-sponsored coverage, except that persons may be eligible for subsidies if they have: (i) coverage in the individual market; or (ii) employer-sponsored coverage that is unaffordable (premiums for the employee cost more than 9.86 percent of household income[7]) or does not provide minimum value (the plan covers less than 60 percent of total average health care costs).

Meet program income limit. In order to be eligible for premium tax credits, individuals must have an income that is greater than 200 percent but does not exceed 400 percent of FPG (see table 1 below for FPG dollar amounts for different household sizes). The ACA sets a floor of 100 percent of FPG for eligibility for premium tax credits, but also provides that persons eligible for minimum essential coverage or a basic health program (such as MinnesotaCare) are not eligible for premium tax credits. This means that in Minnesota, adults with incomes less than or equal to 200 percent of FPG are not eligible for premium tax credits because they are eligible for MA or MinnesotaCare.[8] Similarly, most children with incomes not exceeding 275 percent of FPG (ages 2 to 18) or 283 percent of FPG (children under age 2) are not eligible for premium tax credits because they are eligible for MA.

File a federal income tax return. Individuals must file a federal income tax return to qualify for a premium tax credit, since the tax credits are administered through the federal tax system.

[7] This percentage is indexed; the percentage specified is for 2019 (the percentage for 2018 is 9.56). The IRS final rule on eligibility for premium tax credits determines affordability for related individuals (i.e., family members) based on the cost of the employee premium for self-only coverage. If the affordability percentage is met for this employee self-only coverage, both the employee and family members are ineligible for premium tax credits, regardless of the cost of dependent or family health coverage (I.R.C. § 1.36B-2).

[8] The MA income limit for parents, caretakers, children 19 to 20, and adults without children is 133 percent of FPG. MinnesotaCare is available to persons with incomes greater than 133 percent of FPG but not exceeding 200 percent of FPG. Legal noncitizens who are not eligible for MA due to immigration status may be eligible for MinnesotaCare, and would then not be eligible for advanced premium tax credits and cost-sharing subsidies through MNsure.

Table 1
Income Limits for Premium Tax Credits
(Effective 1/1/18 to 12/31/18)

Family Size	> 200% FPG	≤ 400% FPG
1	$24,120	$48,240
2	32,480	64,960
3	40,840	81,680
4	49,200	98,400
5	57,560	115,120
6	65,920	131,840
7	74,280	148,560
8	82,640	165,280
Add'l	8,360	16,720

Source: Minnesota Department of Human Services

Amount of Premium Tax Credit

The amount of premium tax credit that an eligible person receives varies from person to person.

The maximum premium tax credit amount is equal to the difference between the premium cost of the enrollee's benchmark plan and the enrollee's expected premium contribution.

The *benchmark plan* is the second lowest cost silver plan available in the enrollee's geographic area for coverage of the enrollee and any dependents. A silver plan is one that has an actuarial value of 70 percent (i.e., covers on average at least 70 percent of medical expenses).[9] MNsure has designated nine geographic areas for purposes of setting insurance premium rates.

The *expected premium contribution* is the amount of income an individual or family is expected to contribute toward the cost of health coverage. The amount is determined by multiplying household income by a percentage that, for 2019 in Minnesota, varies from 6.54 percent to 9.86 percent based on a sliding scale.[10] This percentage is a measure of affordability—a maximum percentage of income that the ACA requires a household to spend on premiums before a premium tax credit is made available.

[9] Qualified health plans offered through the exchange must provide coverage at one of the following metal levels, which vary with the actuarial value of the benefits covered, as follows: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent).

[10] For 2018, the expected premium contribution ranges from 6.34 percent of income at 200 percent of FPG to 9.56 percent of income at 400 percent of FPG.

Table 2 specifies these percentages of income for different income levels, based on the federal poverty guidelines. Within each income range, the percentage of income (that must be spent on premiums before a premium tax credit is made available) increases based on a sliding scale.

Table 2
Sliding Scale for Premium Tax Credits

% FPG	Expected Premium Contribution, as % of Household Income –2019
At least 200 but less than 250	6.54 -8.36
At least 250 but less than 300	8.36 -9.86
At least 300 but not greater than 400	9.86
Note: The ACA sets expected premium contributions, ranging between 2.08 percent and 6.54 percent of income, for households with incomes at or below 200 percent of FPG. These contribution percentages do not apply in Minnesota, since persons at this income level are not eligible for premium tax credits through MNsure and instead are eligible for coverage through MA or MinnesotaCare.	

The *premium tax credit* is the difference between the cost of the second-lowest-cost silver plan (the benchmark plan) and the enrollee's expected premium contribution. If the premium cost of the benchmark plan is less than the dollar amount of the expected premium contribution, no premium credit is provided.

While the maximum amount of the premium tax credit is fixed based on the calculation relative to a specific benchmark plan, the premium tax credit is available to enrollees regardless of the cost or metal level of the plan chosen. Persons who choose a higher cost plan, relative to the benchmark plan, will pay higher premiums out-of-pocket, after application of the premium tax credit. Persons who choose a lower cost plan, relative to the benchmark plan, will pay lower premiums out of pocket, after application of the premium tax credit.

Administration and Reconciliation of Tax Credits

Individuals apply for premium tax credits and cost-sharing subsidies through MNsure. Persons eligible for the tax credit may claim the credit in advance or may obtain the credit when filing a federal income tax return for the tax year in which the credit applies. If a person claims the credit in advance, the federal government pays the estimated credit directly to the insurance company from whom the person receives coverage through a qualified health plan. The insurance company then reduces the premium by the amount of the credit, and the person must pay the balance of the premium to the insurance company.

The amount of premium tax credits received in advance is based on an estimate of income expected for the year. The final amount of premium tax credits is based on actual income as reported on the enrollee's tax return. This means that persons who receive advanced tax credits must "reconcile" the estimated and final amounts as part of the tax filing process. Persons whose actual income for the year is higher than estimated income may need to pay back some or all of

the advanced premium tax credits received (e.g., by having the amount subtracted from any tax refund, or by payment of the amount to the IRS if no refund is received). Persons whose actual income is lower than the estimated income may get a refund when filing taxes, or have the amount of taxes owed reduced by the amount of underpayment of the tax credit.

The amount of excess advanced premium tax credits that must be repaid by persons with incomes less than 400 percent of FPG is limited by a dollar cap that increases with income.[11] Persons with incomes equal to or greater than 400 percent of FPG must repay the full amount owed.

Cost-sharing Reductions

Individuals purchasing coverage through MNsure are subject to deductibles, copayments, and other cost-sharing requirements that vary with the actual health plan purchased, subject to an annual out-of-pocket limit. Persons who receive premium tax credits, with incomes greater than 200 percent but not exceeding 250 percent of FPG,[12] qualify for an enhanced silver health plan that provides reductions in enrollee cost-sharing sufficient to increase the plan's actuarial value to 73 percent (the actuarial value for a regular silver plan is 70 percent). A health insurer has flexibility in how it achieves this higher actuarial value of 73 percent—it may reduce the annual out-of-pocket limit, reduce deductibles, or reduce copayments or coinsurance, or implement any combination of these cost-sharing reductions.

Eligible individuals do not have to take action to receive a cost-sharing reduction; if they purchase coverage through MNsure and select a silver plan, they are simply enrolled in the enhanced silver plan that is linked to that regular silver plan. Cost-sharing reductions are only available to persons who select a silver plan.

American Indians and Alaska Natives with incomes that do not exceed 300 percent of FPG are exempt from cost-sharing altogether (they receive a 100 percent cost-sharing reduction plan at all metal level choices). American Indians and Alaska Natives with incomes greater than 300 percent of FPG are exempt from cost-sharing for services received at Indian Health Service facilities and tribal and urban Indian organization providers, or for essential health benefits received as a result of a referral from these providers.

In contrast to premium tax credits, eligibility for a cost-sharing reduction does not change to reflect differences in estimated and actual income, and there is no requirement for financial reconciliation at the end of a coverage year.

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[11] For married couples filing jointly, the dollar cap based on income as a percentage of FPG for repayment of premium tax credits received in 2017 is as follows: (1) less than 200 percent of FPG, $600; (2) at least 200 percent but less than 300 percent of FPG, $1,500; and (3) at least 300 percent but less than 400 percent of FPG, $2,550. The dollar cap for single tax filers is one-half of the amount that applies to joint filers. These dollar caps are adjusted to reflect changes in the Consumer Price Index. See 26 U.S.C. § 36B, subsection (f).

[12] The ACA also provides cost-sharing reductions to persons with incomes at or below 200 percent of FPG. These reductions do not apply in Minnesota, since persons at this income level are not eligible for subsidized coverage through MNsure and instead are eligible for coverage through MA or MinnesotaCare.

A federal district court ruled on May 12, 2016, that the U.S. Congress had not appropriated funding for cost-sharing reductions under the ACA, and that the use of unappropriated money to fund cost-sharing reductions would be enjoined (i.e., the federal government would be prohibited from funding cost-sharing reductions). However, the court also stayed (delayed implementing) this injunction pending any appeal, allowing the federal government to continue to pay cost-sharing reductions during an appeal.[13] The court further delayed its decision in March 2017 to allow for a nonjudicial resolution, such as legislative action. On October 13, 2017, the Trump administration notified the court that the Department of Health and Human Services had directed that cost-sharing reduction payments to insurers be stopped, beginning with the payment due October 18. Following this decision and a settlement reached by the parties, the case was remanded to district court. These actions eliminated federal funding for cost-sharing reductions, but did not eliminate the requirement that health insurers provide cost-sharing reductions to eligible persons. The elimination of federal funding is projected to increase insurance premiums and also federal expenditures for premium tax credits.[14]

Financing Subsidized Coverage

The cost of providing premium tax credits for the purchase of qualified health plans is borne by the federal government. Premium tax credit payments are made by the federal government directly to health insurers (if a recipient chooses to receive the payments in advance) or to the recipient through the tax filing process (if the recipient does not elect to receive the tax credit in advance).

Health insurers had been reimbursed by the federal government until October 2017 for any cost-sharing reductions provided. Health insurers submitted to the federal Department of Health and Human Services estimates of the amount of cost-sharing reductions they expect to provide for a coming year and received payments from the federal government based on these estimates. The estimated and actual amounts of cost-sharing reductions provided were periodically reconciled.

[13] *House of Representatives v. Burwell*, no. 14-1967 (RMC), 2016 WL 2750934 (D.D.C. May 12, 2016; now captioned as *House of Representatives v. Azar*).

[14] Levitt, Larry, et. al. "The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments" Kaiser Family Foundation, Issue Brief, April 2017; Congressional Budget Office, "The Effects of Terminating Payments for Cost-Sharing Reductions," August 2017.

Enrollment Statistics

As of June 17, 2018, 101,519 individuals were enrolled in a qualified health plan through MNsure. An additional 229,839 individuals were enrolled through MNsure in MA and an additional 52,364 in MinnesotaCare.[15]

Based on May 2018 enrollment data, 65 percent of qualified health plan enrollees received advanced premium tax credits, and 13 percent of qualified health plan enrollees received cost-sharing reductions.

Application Procedure

Individuals interested in applying for premium tax credits and cost-sharing reductions can contact MNsure at 1-855-366-7873 or www.mnsure.org. The MNsure website also has information on obtaining face-to-face enrollment assistance from a navigator or insurance agent.

For more information about health care programs, visit the health and human services area of our website, www.house.mn/hrd/.

[15] Statistics in this section are from MNsure Enrollment Dashboard, prepared for the MNsure Board of Directors meeting, June 20, 2018.