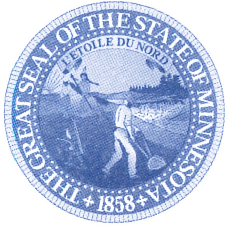

STATE OF MINNESOTA

Office of Governor Mark Dayton

130 State Capitol ♦ 75 Rev. Dr. Martin Luther King Jr. Boulevard ♦ Saint Paul, MN 55155

May 5, 2017

The Honorable Steven Mnuchin
Secretary
United States Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Thomas E. Price, M.D.
Secretary
United States Department of Health & Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Mnuchin and Secretary Price:

Thank you for the March 13, 2016 letter to governors regarding the 1332 State Innovation waiver process. We write to request your support for a swift review of Minnesota's application for a 1332 State Innovation Waiver to support our recently-enacted, state-based reinsurance program.

In March, the Minnesota Legislature passed legislation to establish a new state-based reinsurance program to help stabilize the individual market, which provides health insurance coverage to about 190,000 Minnesotans statewide. Individual market insurance rates increased significantly in 2017 and the Minnesota Premium Security Plan (MPSP) aims to strengthen the market with the following goals:

- Stabilizing individual market premiums, and reducing future rate increases to a level that encourages more Minnesotans to purchase health coverage;
- Encouraging consumer enrollment and ongoing participation by health insurers in Minnesota's individual market;
- Eliminating unintended financial consequences for Minnesota's Basic Health Plan (BHP), known as MinnesotaCare, and federal premium tax credits; and
- Creating a fiscally sustainable program that maximizes the positive impact of federal funding on the market.

During the legislative process, CMS staff advised us that in order to receive federal funding, the state law must require that implementation of the MPSP is contingent on receiving the federal 1332 Waiver. Thus, Minnesota must receive approval of the waiver before we can fully implement the MPSP. As you know, the amount of the federal funding will be based on the savings in Premium Tax Credits that the federal government would otherwise pay to Minnesotans without the MPSP. State funds will finance the remaining costs of the program.

A quick approval of Minnesota's waiver application is essential, because Minnesota's health plans will soon file their proposed 2018 individual market rates with the Minnesota Department of Commerce, and the MPSP is a critical factor in the rate-setting process. Therefore, we are hoping you will be able to provide an expeditious review and approval of Minnesota's application. Staff and leadership in the federal agencies have been very helpful in guiding Minnesota's application thus far. Given the short timeline and importance of the waiver, we welcome your attention to providing a swift federal review and approval of Minnesota's 1332 Waiver application.

Sincerely,

Voice: (651) 201-3400 or (800) 657-3717
Website: http://governor.state.mn.us

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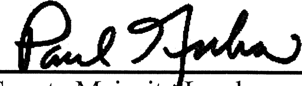
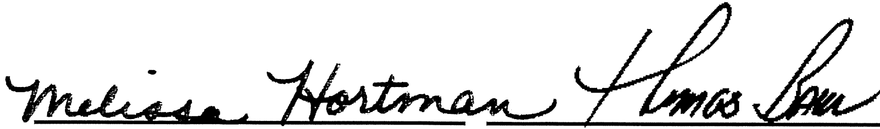
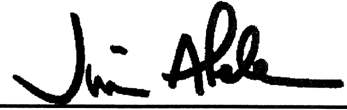


Governor Mark Dayton

House Speaker Kurt Daudt

Senate Majority Leader,
Paul Gazelka

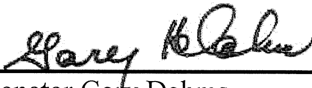
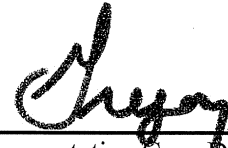




House Minority Leader,
Melissa Hortman

Senate Minority Leader,
Tom Bakk

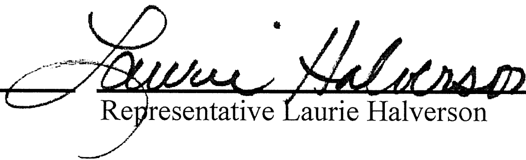
Senator Jim Abeler

Senator Michelle Benson

Senator Gary Dahms

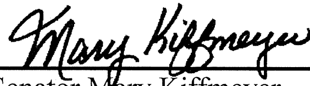
Representative Greg Davids

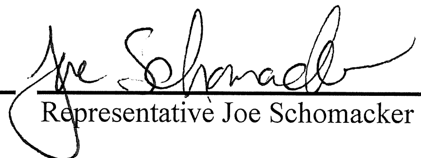


Representative Matt Dean

Representative Laurie Halverson

Representative Joe Hoppe





Senator Mary Kiffmeyer

Senator Tony Lourey

Representative Joe Schomacker

cc: Seema Verma, Administrator, Centers for Medicare and Medicaid Services
Jeff Wu, Acting Director, Center for Consumer Information and Insurance Oversight
Minnesota Congressional Delegation Members

Congress of the United States
Washington, DC 20515

May 16, 2017

The Honorable Steven Mnuchin
Secretary
U.S. Department of the Treasury
1500 Pennsylvania Avenue, NW
Washington, D.C. 20220

The Honorable Thomas E. Price, M.D.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Mnuchin and Secretary Price:

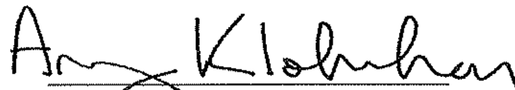
We write to request that the U.S. Department of the Treasury and the U.S. Department of Health and Human Services grant expedited consideration to Minnesota's application for a Section 1332 State Innovation Waiver. With your approval, Minnesota will be better positioned to fund and implement the Minnesota Premium Security Program (MPSP), a state-based reinsurance program designed to stabilize its individual health insurance market.

This year, the Minnesota Legislature voted to establish MPSP with bipartisan support from the Governor and Democratic and Republican Leadership to address premium increases in the individual market. This is particularly important to our rural and underserved areas, where it is critical that we reduce future rate increases, encourage consumer enrollment, preserve insurer participation, and expand access to affordable healthcare.

Minnesota's waiver application is increasingly time-sensitive as health plans prepare to propose individual market rates for 2018. On behalf of our constituents, we encourage you to consider and approve the application as soon as possible and keep our offices appraised of any developments.

Sincerely,

Collin C. Peterson
Member of Congress



Amy Klobuchar
U.S. Senator

Al Franken
U.S. Senator

Betty McCollum
Member of Congress

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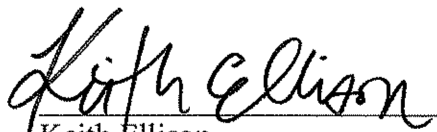
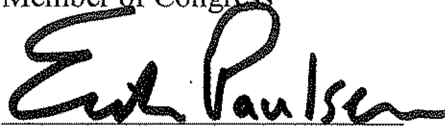
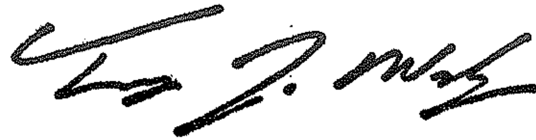
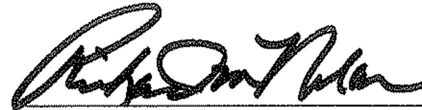
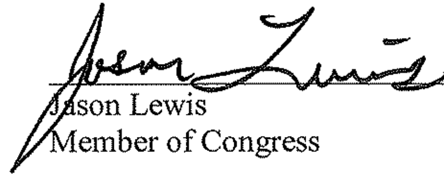

Keith Ellison
Member of Congress


Erik Paulsen
Member of Congress

Tom Emmer
Member of Congress


Tim Walz
Member of Congress


Richard M. Nolan
Member of Congress


Jason Lewis
Member of Congress

MINNESOTA

Minnesota 1332 Waiver Application

Minnesota Department of Commerce

May 30, 2017

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Minnesota 1332 Waiver Proposal

Affordable Care Act (ACA) Waiver for State Innovation

Executive Overview

The Minnesota Department of Commerce (Commerce) respectfully submits this 1332 State Innovation Waiver to the Center for Medicare and Medicaid Services (CMS), a division of the United States Health and Human Services (HHS), and the Department of Treasury in order to support and stabilize Minnesota's individual health insurance market.

Minnesota's enabling legislation (Attachment A) and this waiver application support a new state-based reinsurance program, the Minnesota Premium Security Plan (MPSP), for the individual market designed to address the following goals:

1. Stabilizing individual market premiums, and reducing future rate increases, to a level that encourages more Minnesotans to purchase health coverage;
2. Encouraging consumer enrollment and ongoing participation by health insurers in Minnesota's individual market;
3. Eliminating unintended consequences for Minnesota's Basic Health Plan (BHP), known as MinnesotaCare, and federal premium tax credits (PTC); and
4. Creating a fiscally sustainable program that maximizes the positive impact of federal funding on the market.

The MPSP's funding sources are, pending federal approval of Minnesota's 1332 waiver, (1) savings generated by PTC that the federal government would otherwise pay to Minnesotans without the MPSP; and (2) state appropriations from Minnesota's Health Care Access Fund and General Fund.

Federal PTC support is applied to monthly premium payments of low- and middle-income enrollees to help with affordability. Minnesota has structured the MPSP in a manner similar in structure to the temporary federal reinsurance program that was in place for plan years 2014 through 2016. Further, neither the MPSP nor this waiver request will negatively affect individuals who typically qualify and receive federal PTC support.

To achieve the goal of reduced monthly premium rates to stabilize the individual market, Minnesota's enabling legislation establishes a $271 million reinsurance program, partially funded with federal dollars resulting from an approved 1332 waiver. Commerce projects that this level of support will reduce the entire market's premiums by an average of over 20 percent from where rates would be absent the MPSP and that healthier Minnesotans will either remain in, or return to, the market. The MPSP will help stabilize the state's individual market because:

- It will have an immediate effect on premium affordability for consumers in 2018.
- It is a seamless and invisible program to enrollees and maintains access to carriers, networks, health savings accounts, and plan design choices.

- It meets the goal of maintaining preexisting condition prohibitions, a major accomplishment of the ACA.
- It fosters competition through reducing the risk of high-cost claims; this risk is a major barrier for issuers who may consider entry into this market.
- It uses a delivery structure similar to the federal reinsurance program, allowing for easy federal review and feedback. Quick dissemination and approval of the program is important, given that issuers are already making plans for 2018 participation in the individual market.
- It is budget neutral for the federal government. This approach ensures that the raw data used to verify the federal waiver remains intact. For example, CMS is able to audit the count and proportion of enrollees receiving PTCs at each carrier, ensuring no additional expenses for the federal budget.

Many Minnesotans purchased health insurance for the first time because of the ACA. The most recent survey estimates that the Minnesota uninsured rate reached 4.3 percent in 2015,[1] among the lowest in the country. Commerce predicts that the uninsured rate may increase in Minnesota due to extraordinary premium escalation in the individual market. Given the decrease in individual market enrollment since 2015, Minnesota's uninsured rate may grow to 5.5 percent in 2017.

Commerce estimates that the MPSP will attract at least 20,000 more Minnesotans to purchase individual market insurance in 2018 than would have otherwise purchased insurance in the absence of this program. This enrollment growth would help improve the uninsured rate.

In this application, Minnesota seeks to waive section 1312 (c)(1) of the Affordable Care Act. Federal funds will help support the MPSP and reduce each issuers' individual market rates.

In addition to seeking funding for reinsurance, Minnesota also seeks to secure receipt of funding equal to the amount of the forgone federal funds and assistance that would have been provided to Minnesotans without the waiver pursuant to the BHP funding formula as provided under 42 C.F.R. Part 600, Subpart G, also referred to as the pass-through funding under section 1332(a)(3) and subsequent guidance. Maintaining the same level of federal BHP funding that would have otherwise been available without the waiver is an essential component of this waiver request.

Minnesota proposes that this Section 1332 Waiver be effective starting January 1, 2018, and extend for a period of five years.

Description of the Minnesota Premium Security Plan

Minnesota's enabling legislation that created a state-based reinsurance program (MPSP) took effect on April 4, 2017. The MPSP is an attachment-point reinsurance model very similar in design to the temporary federal reinsurance program that was in place from 2014 through 2016. The parameters for 2018, set in state law, are an attachment point of $50,000, a coinsurance rate of 80 percent, and a reinsurance cap of $250,000. The legislation does not explicitly specify incentives for managing health-care cost or utilization.

[1] *Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey*, Feb 29, 2016, http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf.

Details on payments to carriers are provided in the actuarial report. See Attachment A for a copy of legislation.

Implementation of the MPSP

The MPSP enabling legislation repurposes the state's former high-risk pool, the Minnesota Comprehensive Health Association (MCHA) to administer the MPSP. Governed by a 13-member board, MCHA must establish operational processes and procedures subject to the approval of Commerce. MCHA will reimburse eligible health insurers for reinsurance-eligible expenses incurred during a plan year. Health insurers will remain responsible for ongoing enrollment, notice, administration, and claims handling responsibilities. MCHA staff and Commerce have already begun work on operational planning.

MCHA collects data to determine reinsurance payments and disburses reinsurance payments to each eligible health carrier. Reinsurance payments are calculated with respect to an eligible health insurers' incurred claims costs for an enrollee's covered benefits in a plan year. Once an enrollee's claims exceed the attachment point, reinsurance payments are calculated as the product of the coinsurance rate and the lesser of 1) the claims cost minus the attachment point, or 2) the reinsurance cap minus the attachment point. Reinsurance payments cannot exceed the total amount paid by a health insurer for an eligible claim. Health insurers must provide data to MCHA and maintain certain records in order to be eligible for the reinsurance program.

After plan year 2018, the MCHA board will propose the payment parameters each year, taking into account available funding, in order to ensure stabilized premiums, increased market participation, improved access to providers, and mitigation of the impact of high-risk individuals. [2] Commerce can approve or disapprove proposed parameters. For plan year 2019 and beyond, the attachment point may be no lower than $50,000; the coinsurance rate may be no higher than 80 percent; and the cap may be no higher than $250,000. Note that evaluations indicate that plan year 2018 parameters have been reasonably set to ensure that the MPSP will have sufficient funds in time to meet its obligations, an important consideration given the unknown cash flow timing of initial federal waiver support. A detailed timeline of MPSP implementation is included in Attachment C.

Additional State Responsibilities Related to the MPSP

Additional duties of the Commerce Commissioner and other state agencies are specified in the legislation. MPSP funds are annually appropriated to Commerce and then granted to MCHA for operational and administrative costs and reinsurance payments.

The MPSP enabling legislation also creates a legislative working group that will advise MCHA and the state on payment parameters for plan year 2019. The working group must review and monitor the effectiveness of Alaska's and other states' reinsurance programs as well as the effect of federal health reform legislation

[2] See Attachment A, Minnesota Laws 2017, Ch. 13, Article 1, Sec. 4.

on the MPSP.[3] The Commerce Department is required to provide technical assistance to the working group.

Related to each benefit year, the Commerce Commissioner will receive a report summarizing the plan operations and receive the results of a required audit. There are no federal responsibilities related to the operations of the MPSP.

Compliance

Minnesota's 1332 waiver intends to use federal dollars to partially fund the MPSP. State dollars will fund the balance.

The benefits of an approved waiver will be shared by the entire non-grandfathered individual health insurance market, without regard to enrollees' income, age, health condition, tobacco status, area of residence, race, carrier selection, network selection, or metal level selection.

Minnesota does not seek to waive any other aspect of the ACA. This waiver is designed to maintain access to comprehensive health insurance for all Minnesotans through more affordable rates. This waiver request does not contemplate any overall funding level changes to the state's basic health plan, MinnesotaCare, Medicaid, the state-based exchange (MNsure), federal grants, or any direct purchases. The State of Minnesota provides the following assurances:

- This waiver request meets the scope of coverage comparability requirements of Section 1332 (b)(1)(A) of the Affordable Care Act:
  - The Essential Health Benefit (EHB) coverage set (which dictates covered medical services, visit limits, and formulary) will be unaffected.
  - Coverage for vulnerable populations by health condition, age, income, geographic location, or any other demographic characteristic, will be unaffected by this waiver.
  - This waiver will not affect cost sharing parameters that could indirectly affect the scope of coverage.
- This waiver meets the affordability requirements of Section 1332 (b)(1)(B):
  - This waiver will not affect cost sharing parameters (deductible, coinsurance, copays, OOP Max, etc.), which will continue to rely on the federal Actuarial Value Calculator for annual calibration. Coverage and cost sharing protections (such as the self-only coverage limit) against excessive out-of-pocket spending will remain the same. There will be no increases in design or effective enrollee cost sharing, whether based on parameters or premiums, due to the approval or existence of this waiver.
  - EHB coverage will be unaffectedand thus have no indirect effect on cost sharing.
  - Cost sharing for vulnerable populations by health condition, age, income, geographic location, or any other demographic characteristic will be unaffected.
- This waiver request meets the affected number of individuals requirements of Section 1332 (b)(1)(C). The state expects more, not fewer, Minnesota residents will enroll in coverage if this

[3] During legislative debate, Commerce supported a conditions-based reinsurance program similar to Alaska's. There was also significant legislative interest in Alaska's model. Commerce expects that the state will strongly consider moving to a conditions-based model beginning in plan year 2019.

waiver is approved. Minnesota estimates that this waiver will result in at least 20,000 more Minnesota residents accessing health insurance and as many as 50,000, in comparison to the number expected in the absence of the MPSP.

- This waiver request meets the deficit neutrality requirement of Section 1332 (b)(1)(D). Any anticipated increase in federal spending, administrative costs or other expenses to the federal government, or reduction in federal income tax, payroll tax, excise tax, health insurance tax, PCORI assessments, or any other federal revenue is accounted for and explained in the economic and actuarial analysis.
- This waiver retains the existing scope of benefits, including requiring the provision for 10 EHB, matching the state's benchmark plan's covered service list and minimum visit limits. Waiver approval will not result in a decrease in the number of individuals with coverage that meets the EHB, nor will approval of this waiver affect health plan coverage offered through the state's basic health plan, MinnesotaCare, Medicaid, or employers.
- This waiver meets the requirements of Section 1332(a)(3). Minnesota proposes that the savings that the federal government would have otherwise spent on PTC be used instead for broader financial support of the individual market through the MPSP. It also seeks the pass through of funding of the federal assistance that, absent this waiver, would have otherwise been spent on Minnesotans pursuant to the state's BHP, MinnesotaCare.
- This waiver requests no change or consideration of any kind to state-specific exchanges or the federal role in the exchange or Minnesota's BHP. As previously stated, this waiver requests both: (1) federal funds that, absent the waiver for the MPSP, would have otherwise been spent on Minnesotans pursuant to the BHP, be instead directed to the state to be treated as BHP trust funds for the purposes of 42 C.F.R. Part 600, Subpart H; and (2) federal PTC that would have otherwise been spent without the waiver be instead directed to the MPSP. It is estimated that federal staff would not need to be hired pursuant to this waiver, but existing staff time would be valued at $100,000 in the initial year and the fifth year, when an extension request needs review. For every other year, we estimated existing staff time would be valued at $50,000 per year. These numbers are show on Table E-13 in the Actuarial Analysis.
- This waiver request meets the requirements for public input and a coordinated approach under Section 1332 (a)(4) and (5). The proposed waiver is publicly posted and public hearings were held. Public comment was solicited in compliance with 31 § CFR 33.112 and additional public comment will be solicited in compliance with 45 § CFR 155.1312. Online materials meet national and Minnesota accessibility standards.

Summary of Proposal

Background

Minnesota's individual health insurance market experienced significant rate increases in 2017. In June 2016, Blue Cross Blue Shield of Minnesota, Minnesota's largest individual market insurer, announced that it would withdraw from the state's individual market in 2017. Following that action, most remaining health insurers also requested to leave the market. Ultimately, each health insurer (except Blue Cross) remained for 2017, although HealthPartners Insurance Company and Group Health Inc. (together, the second largest brand in Minnesota's individual market) restricted their service area to one geographic rating area in the state. In addition, all but one health insurer requested, and was granted, an enrollment capacity limit for 2017. As a result of rate increases, Minnesota's current rate increase trajectory exceeds that of most other states in the nation.

Minnesota's steep premium trajectory moved Minnesota from the lowest-cost state in 2014 to near the 60th percentile in 2017. The deterioration of affordability has led to lower enrollment levels with further consequences for Minnesota's premium levels and risk pool composition, causing morbidity to continue to increase at a faster rate than the rest of the nation's individual markets.

Goal of Waiver

Minnesota targets $271 million in individual market reinsurance payments for 2018, partially covered by federal dollars resulting from an approved 1332 waiver. This level of support will subsidize the entire market's premiums by over 20 percent, or in a range of $125 to $175 per person per month in 2018.

The benefits of an approved waiver would include:

- More Minnesotans would have insurance coverage than in the absence of an approved waiver.
- Allowing for reduced premium increases and more affordable premiums to Minnesota residents, targeting over 20 percent average premium reduction from where rates would otherwise be without the MPSP.
- No negative effect on plan offerings, cost sharing, and covered services.
- Potential increased health insurer participation and competition in the market.
- Promoting stability of the individual market risk pool.
- Reducing issuers' risk from high-cost claims, which reduces risk margins, which further reduces premiums.
- No increase in federal spending to support the individual market.
- No increase in federal spending to support MinnesotaCare, Minnesota's BHP.

Applicable Federal Regulations

Minnesota proposes to make alternative use of federal savings, as allowed under Section 1332 of the Affordable Care Act.

Federal funding will be deposited for use by the MPSP. The MPSP will reimburse certain high costs in Minnesota's individual market in a manner similar to the temporary federal reinsurance program that was in place between 2014 and 2016.

The MPSP will directly affect the price of the second lowest cost silver plan and thus the PTC available through the state's individual market, as well as federal funding for MinnesotaCare, the state's BHP. Therefore, Minnesota seeks to receive the funding equal to the amount of the forgone federal assistance that would have otherwise been spent on Minnesotans without this waiver pursuant to the BHP funding formula, under 42 C.F.R. Part 600, Subpart G, as a passthrough of funding under section 1332(a)(3) and subsequent guidance. Protecting the federal BHP funding that, without this waiver, would have otherwise been spent in support of MinnesotaCare, is an essential component of this waiver request.

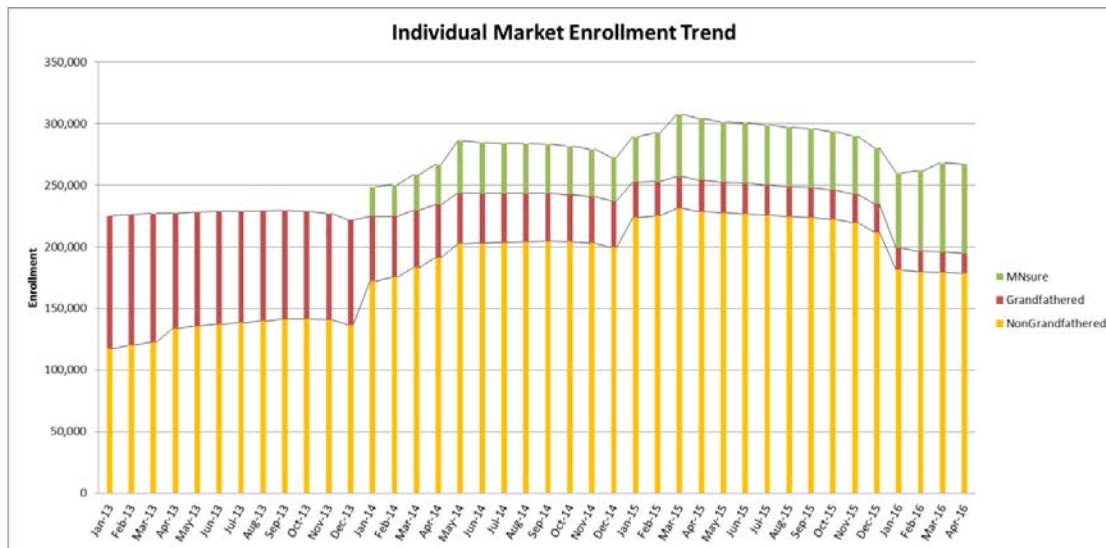
Background on Minnesota's Health Insurance Market

Minnesota has long been a national leader in health care reform and efforts to address the state's uninsured rate. Through Section 1115 demonstration waivers, Minnesota has a long history of expanding and supporting public programs to cover people in need. This includes MinnesotaCare, which operates

today as a Basic Health Plan under the ACA. Prior to the ACA's implementation in 2014, Minnesota had the second oldest and largest (with approximately 26,000 members in its last year of full operation) high-risk pool in the nation.

The ACA's guarantee issue requirements and preexisting condition prohibitions increased Minnesota's individual market enrollment in 2014 and 2015. This increase is somewhat understated when compared to other states, as Minnesota residents with incomes at or below 200 percent of the Federal Poverty Level (FPL) are enrolled in MinnesotaCare. Further expansion of Medicaid reduced Minnesota's uninsured rate to an all-time low (estimated at 4.3 percent) in 2015.[4]

At its highest point, the individual market covered just over 300,000 Minnesotans (2015), or approximately 5.5 percent of Minnesotans. Rate increases in 2017 (on top of those in 2016) have been significant, however, and individual market enrollment declined significantly in 2016 and 2017. The following graph shows Minnesota's individual market enrollment history, with a breakdown of MNsure, grandfathered, and non-grandfathered enrollment.



Based on rate review feedback, many people who purchase health insurance through Minnesota's individual market are self-employed, including contractors, entrepreneurs, realtors, insurance agents, farmers, and day care providers. The individual market also provides insurance for people working for very small employers who fail to provide health insurance. Market participants have identified premium affordability, access to providers and out-of-pocket expenses as critical issues driving enrollment declines.

[4] 4.3%, see *Health Insurance Coverage in Minnesota: Results from the 2015 Minnesota Health Access Survey*, Feb 29, 2016, http://www.health.state.mn.us/divs/hpsc/hep/publications/coverage/healthinscovmnhas2015brief.pdf

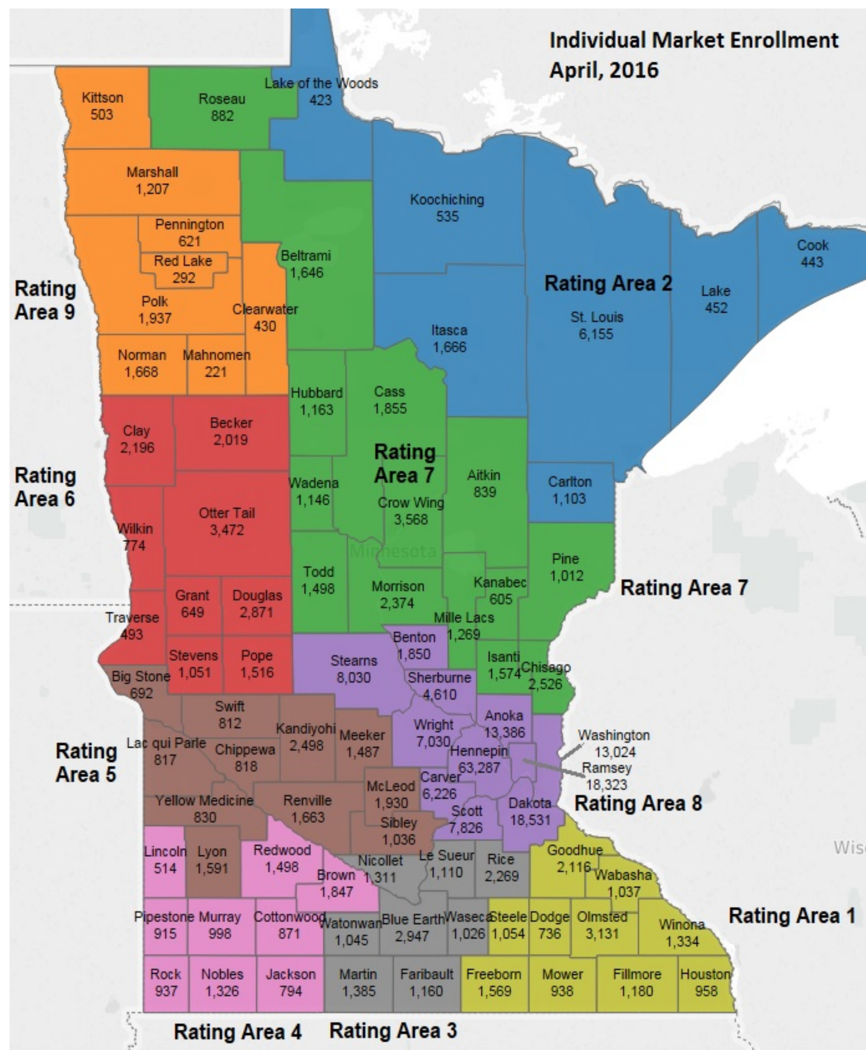
Many Minnesotans indicated that for 2017, they chose not to purchase health insurance at all. This significant decline is also evident through monitoring of enrollment, processed twice per week in order to monitor insurers' enrollment caps in place for 2017.

Enrollees in the individual market have also been critical of the value of the insurance purchased, given that many of the plans that they could afford (bronze) will not cover services until they hit a very high deductible (often nearly $7,000).

Market participants have also been very critical of the insurers' limited provider networks. Issuers have significantly reduced provider networks as a strategy to address affordability, sustainability, and stability, as well as their own risk management concerns.

Minnesota has nine rating areas, which are based on contiguous counties, as shown in the map below. In the Twin Cities metro area, the provider community is composed of several competitive integrated delivery systems. Many carriers have partnered with these systems to offer narrow networks in the individual market.

In Greater Minnesota, providers have more bargaining power and some charge significantly more for services than in the Twin Cities. Minnesota has some world-renowned providers, including the Mayo Clinic and the University of Minnesota. Individual market enrollment in each county in Minnesota is shown in the map below.

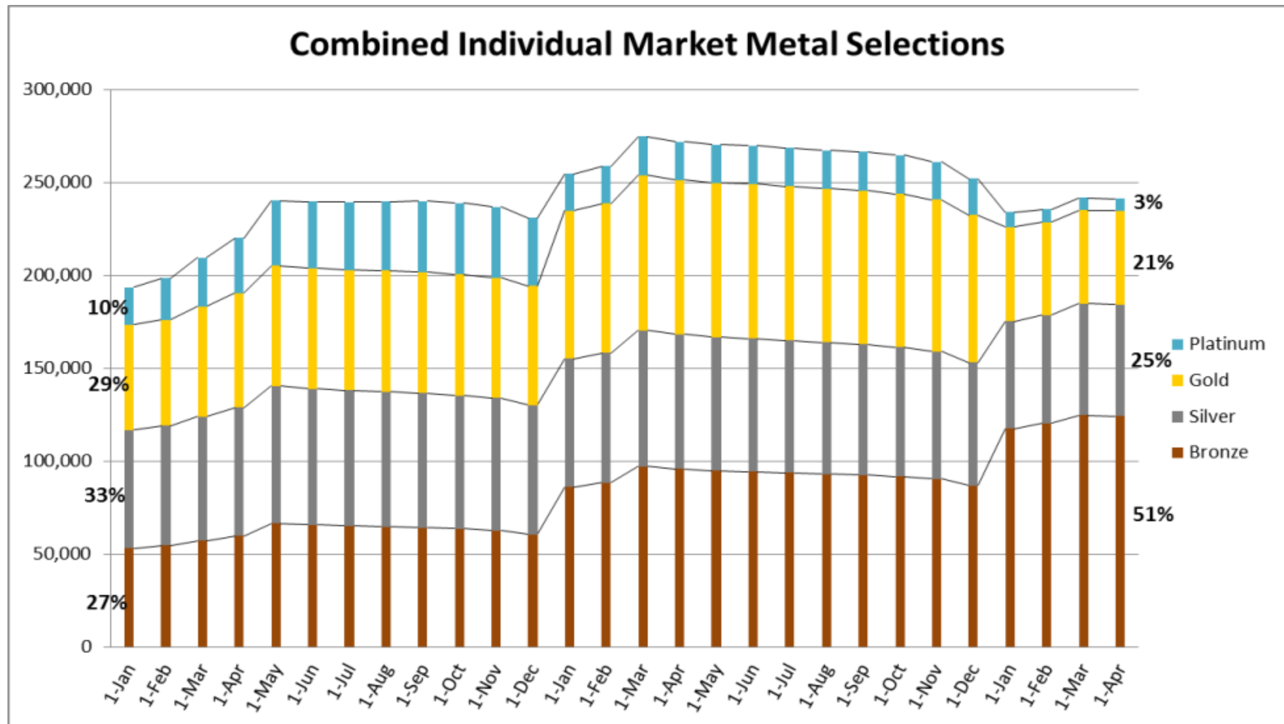


Individual market participants in rating area 1 (counties near Rochester, Minnesota, where the Mayo Clinic is headquartered) have had the highest rates in Minnesota, generally 20-35% higher than rates available elsewhere.

In general, the Twin Cities metro rating area (rating area 8) has the most competitive rates in Minnesota. Enrollment in the Twin Cities metro area tends to make up about 60 percent of the Minnesota individual marketplace.

Minnesota elected not to allow for transition plans in the individual or small group markets.

Based on data collected from issuers in April 2016 and subsequent reductions in plan availability, Commerce expects that by 2018 there will only be several hundred people enrolled in grandfathered individual plans. For modeling purposes and conservatism, Commerce has included grandfathered counts in the financial modelling supporting this request, despite grandfathered individual enrollees playing no role in the actual waiver process.



As the chart above indicates, most individual market members have migrated to bronze and silver plans due to rate increases. By 2016, over 75 percent of Minnesotans had purchased those tiers of plans. This migration to bronze and silver plans has occurred generally uniformly at all ages.

High-cost claimants are the predominant issue affecting affordability. About 50 percent of the aggregate claims in 2015 were a result of high-cost cases. While this dynamic is not atypical in comparison to the group market, the group market has far more subsidies from employers in place to stabilize the curve to this general shape over time.

Waiver Proposal: Use of Savings

As provided by Section 1332 of the ACA, Minnesota proposes to use federal savings that, without the MPSP, would have been paid as premium tax credits due to higher premium levels. The MPSP will reduce the cost of the applicable second lowest cost silver plan.

Due to the MPSP's reinsurance support for Minnesota's individual market, all premiums (including second-lowest silver premiums) will be less than they would have been without the MPSP. Health insurers' actuaries will be asked to certify the premium reduction amount attributable to the MPSP when developing and submitting proposed premium rates to Minnesota state regulators during the rate review process.

Minnesota proposes to receive federal savings as described in federal guidance issued on December 11, 2015.[5] Federal waiver funding will contribute to reducing each issuer's individual market health insurance rates.

As discussed above, Minnesota also seeks to receive the federal savings attributed to the impact of lowering the second lowest silver plan on the federal BHP funding formula, as a passthrough of funding under section 1332(a)(3). These federal savings will be treated by the state as federal BHP trust funds under 42 C.F.R. 600, Subpart H, and, therefore, only available to the state for the support of the state's BHP, MinnesotaCare. Currently, MinnesotaCare is federally supported by a formula relating to the federal premium tax credits and cost sharing reduction subsidies, as provided under 42 C.F.R. Part 600, Subpart G. That funding value is the difference between the federal BHP funding with and without the 1332 waiver to support the MPSP. As illustrated in the actuarial report, the impact of the 1332 waiver to support the MPSP in conjunction with a passthrough of federal savings associated with the BHP formula to the state would be budget neutral to the federal deficit over the next 10 years.

Minnesota will provide the Federal government with all information necessary to administer the Federal waiver. This includes annual data on premium tax credits provided to Minnesotans, the second-lowest cost silver premiums, overall premiums, and enrollment.

Waiver Funding Proposal Financial Effects

As shown in the actuarial report, under the waiver scenario, the federal government would save approximately $138-$167 million in premium tax credits during 2018. The required 10-year projection (see actuarial report) shows the federal government would not expect deficits in any future years if this waiver is approved.

Minnesota has an above-national-average percentage of individual market enrollees who do not qualify for federal premium tax credits. The projected federal savings take into account both those who are eligible for premium tax credits and those who are not eligible. The MPSP will directly allow more people to afford coverage but also indirectly allow for lower rates by attracting a healthier risk pool (that is, as rates decrease, healthier individuals are more likely to see value in purchasing insurance). The final premium rates will generally remain about the same as without the MPSP for Minnesotans receiving premium tax credits with family incomes between 200-300 percent FPL, as well as older enrollees between 300-400 percent. Premium rates will decrease proportionally in comparison to rates without the MPSP for Minnesotans not eligible for any premium tax credits as well as for those who are younger with family incomes between 300-400 percent FPL.

[5] https://www.federalregister.gov/documents/2015/12/16/2015-31563/waivers-for-state-innovation

Description of Post-Waiver Marketplace

Individual Health Insurance Market

Approval of this waiver will not affect the existing functions of the individual market, nor its consumer experience, other than to have reduced rates available to consumers. Individuals and families can continue to apply to MNsure, where eligibility for Medicaid, MinnesotaCare, tax credits, and cost-sharing reduction plan variations are determined. In many cases, there are also individual market plans available directly through issuers' websites and insurance brokers. Assistance with plan selection is unchanged by this waiver and may be provided by an agent, broker, navigator, or other in-person assister. Individual rates will be reduced by every issuer, whether or not the issuer sells plans through MNsure.

Small and Large Employers

This waiver does not affect health insurance available to Minnesota residents through small and large employers. Employers using the individual market as the provider of health insurance for their early-retirement plans often provide service-based subsidies to premiums and will be aided by improved stability in this market. Based on the typical employer strategy to subsidize a fixed amount of an early retiree's premium, the proposed waiver could help early retirees (versus the employer) in such employer early-retirement plans.

Medicare

This waiver does not affect health insurance available to Minnesota residents through Medicare, including Medicare Cost plans and Medicare Advantage plans. This waiver has no effect on Medicare Supplement coverage ("Medigap") offered from commercial carriers.

Medical Assistance, Minnesota's Medicaid Program

This waiver does not affect health insurance available to Minnesota residents through Medicaid.

MinnesotaCare

Approval of this waiver, in conjunction with the passthrough of savings to the state attributable to the BHP formula, will not affect the state's existing BHP program, MinnesotaCare, nor its consumer experience. MinnesotaCare-eligible individuals and families will continue to apply through MNsure where eligibility is determined. Assistance with plan selection is unchanged by this waiver.

Number of Employers Offering Coverage Pre/Post Waiver

This waiver will not affect the number of employers offering health insurance coverage in Minnesota.

Impact on Insurance Coverage in the State

Minnesota's proposed 1332 waiver requests premium tax-credit savings from the federal government, based on an amount determined by the federal government. This waiver does not affect any health insurance covered services in Minnesota. The MPSP does not affect cost sharing parameters or coverage of services for individual market health plans or MinnesotaCare. Other markets are unaffected by this waiver. The MPSP is intended to make the individual health insurance market more viable, more affordable, and more stable. Minnesota's proposal encourages competition. If additional issuers move into, or return to, the individual market, consumers may benefit from expanded choice of plans and competitive pressure on rates. For 2017, there are seven issuers offering individual health insurance, though six of the issuers operate with an approved enrollment cap in place. Modeling provided by the Commerce actuarial staff indicates that the MPSP will help reduce the rates for all issuers in the Minnesota individual market and thus the premium amounts charged to Minnesotans.

Minnesota's waiver does not request any modification to benefits or design parameters. Benefit packages will contain the same essential health benefits, remaining comprehensive, and will comply with standard national metal level requirements, including out-of-pocket limitations to protect in-network point of service cost sharing. Minnesota will report on any modifications to the EHBs on an annual basis.

Under this waiver, Minnesota's insurance coverage will continue to meet the requirements of federal law.

In addition, the waiver will not affect residents' ability to obtain health care services out of state because the only impact for enrollees will be lower premium rates. The state health plans provide coverage for emergency services out of state.

Administrative Burden

Minnesota expects that the MPSP will result in a small increase in health insurers' administrative burden. Health insurers' actuarial, claims, and finance departments will need to report and account for high-cost claims, and many of the issuers will continue their participation on the MCHA Board. Health insurers will continue to manage rate filing requests, plan design and benefit set-up, enrollment, marketing, and claims administration in the same manner as they would without a waiver. Participation in the MPSP will be mandatory to participation in the non-grandfathered individual market.
Commerce will monitor the governance, solvency, and administration of MCHA, as well as review the actuarial work relating to the MCHA credit in issuer's rate filings. Actuarial staff participated in drafting this waiver request and actuarial study and are available for future inquiries from issuers, MCHA, or the federal government.

The Department of Treasury and CMS staff will have a small increased burden in determining waiver funding values as related to the individual market. The waiver does not affect the calculation of PTC or the reconciliation of PTC in terms of tax filings. Minnesota's waiver does not require operational or financial changes for MNsure.

This waiver will have no administrative impact to individuals and families, even those whose conditions are reinsured by MCHA. All individuals will continue to purchase plans in the same manner available now, including through MNsure at www.mnsure.org or through a broker, agent, navigator, or through directly contacting issuers.

Waivers Requested

The Minnesota Department of Commerce seeks to waive Section 1312 (c)(1)[6] for the individual market single risk pool in connection with a Section 1332 waiver to implement a state-operated reinsurance program for 2018 and future years. Currently, Section 1312(c)(1) requires a health insurance issuer to consider "all enrollees in all health plans….offered by such issuer in the individual market…to be members of a single risk pool." To maximize the rate-lowering impact of the reinsurance program the state seeks to waive this single risk pool provision at 45 CFR 156.80 to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate. The state requests that with the waiver, the single risk pool still include: adjustment for the risk adjustment program, marketplace user-fee adjustment, and adjustment for the state based reinsurance program, Minnesota Premium Security plan.

The Department of Commerce will communicate with issuers participating on the Marketplace that issuers should include state-operated reinsurance dollars in rate setting. The reinsurance program will result in a reduction in premiums and premium tax credits which the state believes will result in pass-through funding that the state can use towards the reinsurance program. The implementation of this waiver will be straightforward, as claims for enrollees through the reinsurance program will still be collected and other programs such as MLR will be unaffected.

More on Minnesota Coverage of Services

All Minnesota individual market plans must include the 10 Essential Health Benefits (EHBs), listed below. These benefits will not change as a result of the proposed waiver.

Federally Required Essential Health Benefits (Non-grandfathered Individual and Small Group)
1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care

[6] 1312 (c)(1)Individual market--A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Minnesota's state-mandated benefits can be found at the following links:

https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Minnesota-Benchmark-Summary.pdf

https://downloads.cms.gov/cciio/State%20Required%20Benefits_MN.PDF

These state-mandated benefits are summarized below:

Benefit	Name of Required Benefit	Market Applicability	Statutory Authority
Outpatient Surgery Physician/Surgical Services	Outpatient medical & surgical services	Individual, Group, HMO	62A.153 4685.0100 Subp. 5 4685.0700, Subp. 2 62D.02, Subd. 7 (Citations individually apply to specific markets) (Citations individually apply to specific markets) 62D.02, Subd. 7

			(Citations individually apply to specific markets)
Mental/Behavioral Health Outpatient Services	Outpatient services	Qualified Plans, HMO	62E.06 Subd. 1(b)(2) 4685.0100 Subp. 5 4685.0700, Subp. 2 62D.02, Subd. 7 (Citations individually apply to specific markets)
Private-Duty Nursing	Private duty nurse	Individual, Group, HMO	62A.155 Subd. 2
Preventive Care/ Screening/ Immunization	Preventive health services	Individual, Group, HMO	62Q.46 62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Home Health Care Services	Home health services	Qualified Plans, HMO	62E.06 Subd. 1(b)(5)
Emergency Room Services	Emergency services	Individual, Group, HMO	62A.049 62Q.81 Subd. 4 (a) 62M.07 (b); 62Q.55

			4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Emergency Transportation/Ambulance	Ambulance services	All health plans	62E.06 Subd. 1(b)(14) 62J.48 4685.0100 subp. 5 62D.02, subd. 7 (Citations individually apply to specific markets)
Inpatient Hospital Services	Hospital services	Qualified Plans, HMO	62E.06 Subd. 1(b)(1) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Inpatient Hospital Services	Inpatient hospital services	Qualified Plans, HMO	62E.06 Subd. 1(b)(2) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply

			to specific markets)
Skilled Nursing Facility	Skilled nursing facility	Qualified Plans, HMO	62E.06 Subd. 1(b)(4)
Delivery and All Inpatient Services for Maternity Care	Maternity benefits	Individual, Group, HMO	62Q.81 Subd. 4(5) 62A.047 62A.041 62A.0411 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Prenatal and Postnatal Care	Pre-natal care	Individual, Group, HMO	62Q.81 Subd. 4(5) 62A.047 62A.041 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Delivery and All Inpatient Services for Maternity Care	Minimum maternity stay	Individual, Group, HMO	62A.0411

Emergency Transportation/Ambulance	Ambulatory mental health services	Individual, Group, HMO	62A.152 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Mental/Behavioral Health Inpatient Services	Inpatient mental health benefits	Individual, Group, HMO	62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Substance Abuse Disorder Outpatient Services Substance Abuse Disorder Inpatient Services	Treatment for alcoholism and chemical dependency	Individual, Group, HMO	62A.149 62Q.47 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations apply to specific markets)
Generic Drugs, Preferred Brand Drugs, Non-Preferred Brand Drugs, Specialty Drugs	Prescription drug coverage	Qualified Plans, HMO	62E.06 Subd. 1(b)(3) 4685.0700, subp. 3 4685.0700, subp. 3A

			(Citations individually apply to specific markets)
Mental/Behavioral Health Outpatient Services Mental/Behavioral Health Inpatient Services	Therapeutic services	Qualified Plans, HMO	62E.06 Subd. 1 (b)(3) 4685.0700 Subd. 2E 4685.0100 Subd. 5D (Citations individually apply to specific markets)
Durable Medical Equipment	Durable medical equipment	Individual, Group, HMO	62Q. 66 62E.06 Subd. 1(b)(10) 4685.0700, subp. 2 4685.0700, subp. 3B (Citations individually apply to specific markets)
Durable Medical Equipment	Scalp-hair prostheses for alopecia areata	Individual, Group, HMO	62A.28
Durable Medical Equipment	Durable medical equipment	Individual, Group, HMO	62Q. 66 62E.06 Subd. 1(b)(10) (Citations individually apply to specific markets)

Durable Medical Equipment	Prostheses	Qualified Plans	62E.06 Subd. 1(b)(9)
Hearing Aids	Hearing aids	Individual, Group, HMO	62Q.675
Outpatient Surgery Physician/Surgical Services	Professional services, outpatient services and hospital services	Qualified Plans, HMO	62E.06 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive Care/ Screening/ Immunization	Well-child visits, immunizations	Individual, Group, HMO	62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive Care/ Screening/ Immunization	Routine cancer screenings (mammograms, ovarian cancer screening for women at risk , pap smears)	Individual, Group, HMO	62A.30 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)

Preventive Care/ Screening/ Immunization	Prostate cancer screening	Individual, Group, HMO	62Q.50 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Preventive Care/ Screening/ Immunization	Preventive health services	Individual, Group, HMO	62Q.46 62A.047 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)
Routine Eye Exam (Adult) Routine Eye Exam for Children	Routine eye exams	HMO plans	4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7
Diagnostic Test (X-Ray and Lab Work)	Diagnostic testing	Qualified Plans, HMO	62E.06 Subd. 1(b)(11) 4685.0100 subp. 5 4685.0700, subp. 2 62D.02, subd. 7 (Citations individually apply to specific markets)

Radiation	Radiation therapy	Qualified Plans	62E.06 Subd. 1(b)(6)
Treatment for Temporomandibular Joint Disorders	Temporomandibular joint disorder (TMJ) and craniomandibular disorder (CMD)	Individual, Group, HMO	62A.043
Reconstructive Surgery	Reconstructive surgery	Individual, Group, HMO	62A.25
	Clinical trials	Individual, Group, HMO	62D.109, 62Q.526 (Citations individually apply to specific markets)
Diabetes Care Management	Coverage for diabetes	Individual, Group, HMO	62A.3093
Inherited Metabolic Disorder - PKU	PKU treatment	Individual, Group, HMO	62A.26
Off Label Prescription Drugs	Coverage for off-label drugs to treat cancer in certain circumstances	Individual, Group, HMO	62Q.525
Dental Anesthesia	Anesthesia and hospital charges for dental care	Individual, Group, HMO	62A.308
Diabetes Care Management	Coverage for chemical	Health plan that provides coverage	62Q.137

	dependency in corrections facilities	for chemical dependency	
Mental Health Other	Coverage for mental health medically necessary care	Individual, Group, HMO	62Q.53
Mental Health Other	Court-ordered mental health services	Individual, Group, HMO	62Q.535
Off Label Prescription Drugs	Nonformulary antipsychotic drugs	Individual, Group, HMO	62Q.527
Congenital Anomaly, including Cleft Lip/Palate	Cleft lip/cleft palate	Individual, Group, HMO	62A.042
Treatment of Lyme Disease	Lyme disease	Individual, Group, HMO	62A.265
Port-Wine Stain Removal	Port-wine stain removal	Individual, Group, HMO	62A.304
Residential Treatment for Children with Emotional Disabilities	Health insurance benefits for emotionally disabled children	All health plans	62A.151
Services to Ventilator-Dependent Persons	Coverage of services to ventilator-dependent persons	All health plans	62A.155
	Anesthetics	Qualified Plans	62E.06 Subd. 1(b)(8)
Mental/Behavioral Health Outpatient Services	Family therapy	HMO	62D.102

Outpatient Surgery Physician/Surgical Services	Oral surgery	Qualified Plans	62E.06 Subd. 1(b)(12)
	Oxygen	Qualified Plans	62E.06 Subd. 1(b)(7)
Substance Abuse Disorder Outpatient Services	Second opinions related to chemical dependency and mental health	HMO	62D.103
	Second surgical opinions	Qualified Plans	62E.06 Subd. 1(e)
Chemotherapy	Cancer Chemotherapy Treatment Coverage	All health Plans	62A.3075
	Benefits for DES Related Conditions	All health Plans	62A.154
	Conditions caused by Breast Implants	All health Plans	62A.285 Subd. 2

10-Year Waiver Budget (Budget Neutrality)

As discussed in the actuarial report, the proposed waiver will have no effect on reducing federal revenues or increasing federal spending.

Ensuring Compliance, Reducing Waste and Fraud

Commerce has the responsibility for regulating and ensuring the compliance and solvency of all issuers, performing market conduct analysis and examinations, investigations, and providing consumer outreach. The Minnesota Department of Health also regulates and ensures compliance for HMOs specifically, but monitors all issuers' accreditation, quality, and network adequacy.
The State of Minnesota, MCHA, and MinnesotaCare prepare financial statements and reports annually. Financial statements are audited annually, with the most recent audit completed for fiscal year ending

2016. The state's enabling legislation creates several new accounting, auditing, and reporting requirements for MCHA as part of its administration of the MPSP. The MPSP is also subject to audit by Minnesota's Legislative Auditor.

The State of Minnesota, MinnesotaCare, and MCHA are audited annually by Certified Public Accountants.

Federal staff are responsible for determining the savings calculations related to this waiver and ultimately ensuring that there are no increases to federal spending related to this waiver.

Implementation Timeline and Process

Minnesota expects implementation of the waiver can be accomplished in order to be in place for the plan year starting January 1, 2018.

An implementation timeline is included as Attachment C.

Reporting Responsibilities

As required under 45 CFR 155.1308(f)(4), Commerce will submit quarterly, annual, and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement.
In addition, Commerce proposes to include the following information in the reports:

- Evidence of compliance with public forum requirements (within six-months after waiver implementation and annually thereafter), including date, time, place, description of attendees, the substance of public comment and the state's response, if any.
- Information about any challenges the state may face in implementing and sustaining the waiver program and its plan to address the challenges.
- A description of any substantive changes in Minnesota's insurance market such as the number of insurers serving the individual market.
- Any other information consistent with the terms and conditions in the state's approved waiver.

Please see Attachment G for information related to scope, affordability, comprehensiveness, and deficit neutrality that Commerce proposes to provide on a quarterly, annual and cumulative basis, where appropriate. As required, Minnesota will hold public meetings six months after the proposed waiver is granted and annually thereafter. The date, time, and location of each forum will be posted on the Commerce website. Consumers and business organizations will also be notified using existing communication channels. Each meeting will be conducted at a site that allows both in-person and telephonic attendance to accommodate residents across the state.

Minnesota's enabling legislation requires MCHA to submit an annual public report summarizing plan operations for each benefit year by November 1 of the year following the applicable benefit year, or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

Minnesota will provide the Federal government with all information necessary to administer the Federal waiver. This includes annual data on advanced premium tax credits provided to Minnesotans, the second-

lowest cost silver premiums before and after the waiver as submitted by the carriers, overall premiums, and enrollment. See Attachment G for an outline of these reporting targets as well as Appendix 5 of the Actuarial Analysis.

Waiver Development Process

As required under Section 1332(a)(1)(B)(i), Minnesota's state legislature authorized submission and implementation of the proposed waiver. House File 5 became law on April 4, 2017. This bill language can be found in Attachment A. A copy of the revised Minnesota Statutes can be found in Attachment B.

As required in Section 1332 (a)(4)(B)(i), public hearings were held in accordance with 31 CFR 33.112 and 45 CFR 155.1312, to address the state public notice requirements. Public hearing notices and the written draft proposal were duly posted on the Commerce Department webpage on April 28, 2017. The public comment period was open through the close of business on May 30, 2017.

In addition, the state offered separate tribal consultation to Minnesota's Federally-Recognized Tribal Governments in compliance with federal requirements and Commerce and DHS's agency tribal consultation policies. Commerce and DHS presented on the waiver at a Tribal Health Directors Meeting on May 11, 2017. Commerce also presented on the waiver at the Minnesota Indian Affairs Council meeting on May 25, 2017.

The schedule of public hearings on the draft waiver application is indicated in the following table:

Date	Time	Place
May 8, 2017	10:00 am-12:00 pm	Public Safety Building, 2030 N. Arlington Ave., Duluth
May 9, 2017	11:30 am-1:30 pm	Rochester Public Library, 101 2nd St. SE, Rochester
May 10, 2017	12:00-2:00 pm	Moorhead Public Library, 118 5th St. S, Moorhead
May 12, 2017	11:00 am–1:30 pm	Rondo Community Outreach Library, 461 Dale St. N., St. Paul

The schedule of Tribal consultation and notification on the draft waiver application is indicated in the following table:

Date	Subject	Place
April 28, 2017	Tribal Notification Letters to all Federally Recognized Tribes	N/A
May 11, 2017	Tribal Health Directors Meeting Presentation	SMSC- Link Conference Center 2200 Trail of Dreams Prior Lake, MN 55372
May 25, 2017	Minnesota Indian Affairs Council Presentation	St. Cloud State University

A summary of comments received during the public meetings is included in Attachment D.

Attachment A: New Legislation - 2017 Session Law, Chapter 13, House File 5, Article 1

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

This Document can be made available in alternative formats upon request

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 5

01/05/2017	Authored by Davids, Hoppe, Gruenhagen, Halverson, Haley and others
	The bill was read for the first time and referred to the Committee on Commerce and Regulatory Reform
03/02/2017	Adoption of Report: Amended and re-referred to the Committee on Health and Human Services Finance
03/07/2017	Adoption of Report: Amended and re-referred to the Committee on Taxes
03/08/2017	Adoption of Report: Amended and re-referred to the Committee on Ways and Means
03/09/2017	Adoption of Report: Placed on the General Register as Amended
	Read for the Second Time
03/13/2017	Calendar for the Day
	Read for the Third Time
	Passed by the House and transmitted to the Senate
03/20/2017	Returned to the House as Amended by the Senate
	Refused to concur and a Conference Committee was appointed
03/30/2017	Conference Committee Report Adopted
	Read Third Time as Amended by Conference and repassed by the House
	Read Third Time as Amended by Conference and repassed by the Senate
	Presented to Governor
04/03/2017	Became law without the Governor's signature

1.1 A bill for an act

1.2 relating to insurance; health; creating the Minnesota premium security plan;

1.3 providing funding; establishing a legislative working group; regulating health care

1.4 provider system access; modifying premium subsidy program provisions;

1.5 appropriating money; amending Minnesota Statutes 2016, sections 62E.10,

1.6 subdivision 2; 62K.10, by adding a subdivision; Laws 2013, chapter 9, section 15;

1.7 Laws 2017, chapter 2, article 1, sections 1, subdivision 3; 2, subdivision 4, by

1.8 adding a subdivision; 3; article 2, section 13; proposing coding for new law in

1.9 Minnesota Statutes, chapter 62E.

1.10 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

1.11 ARTICLE 1

1.12 MINNESOTA PREMIUM SECURITY PLAN

1.13 Section 1. Minnesota Statutes 2016, section 62E.10, subdivision 2, is amended to read:

1.14 Subd. 2. Board of directors; organization. The board of directors of the association

1.15 shall be made up of eleven 13 members as follows: six directors selected by contributing

1.16 members, subject to approval by the commissioner, one of which must be a health actuary;

1.17 two directors selected by the commissioner of human services, one of whom must represent

1.18 hospitals and one of whom must represent health care providers; five public directorsselected

1.19 by the commissioner, at least two of whom must be plan enrollees, two of whom are covered

1.20 under an individual plan subject to assessment under section 62E.11 or group plan offered

1.21 by an employer subject to assessment under section 62E.11, enrollees in the individual

1.22 market and one of whom must be a licensed insurance agent. At least two of the public

1.23 directors must reside outside of the seven-county metropolitan area. In determining voting

1.24 rights at members' meetings, each member shall be entitled to vote in person or proxy. The

1.25 vote shall be a weighted vote based upon the member's cost of self-insurance, accident and

State of Minnesota This Document can be made available

in alternative formats upon request

HOUSE OF REPRESENTATIVES

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03/09/2017 Adoption of Report: Placed on the General Register as Amended

Read for the Second Time

03/13/2017 Calendar for the Day

Read for the Third Time

Passed by the House and transmitted to the Senate

03/20/2017 Returned to the House as Amended by the Senate

Refused to concur and a Conference Committee was appointed

03/30/2017 Conference Committee Report Adopted

Read Third Time as Amended by Conference and repassed by the House

Read Third Time as Amended by Conference and repassed by the Senate

Presented to Governor

04/03/2017 Became law without the Governor's signature

2.1 health insurance premium,subscriber contract charges, health maintenance contract payment,

2.2 or community integrated service network payment derived from or on behalf of Minnesota

2.3 residents in the previous calendar year, as determined by the commissioner. In approving

2.4 directors of the board, the commissioner shall consider, among other things, whether all

2.5 types of members are fairly represented. Directors selected by contributing members may

2.6 be reimbursed from the money of the association for expensesincurred by them as directors,

2.7 but shall not otherwise be compensated by the association for their services. The costs of

2.8 conducting meetings of the association and its board of directorsshall be borne by members

2.9 of the association.

2.10 Sec. 2. [62E.21] DEFINITIONS.

2.11 Subdivision 1. Application. For the purposes of sections 62E.21 to 62E.25, the terms

2.12 defined in this section have the meanings given them.

2.13 Subd. 2. Affordable Care Act. "Affordable Care Act" means the federal act as defined

2.14 in section 62A.011, subdivision 1a.

2.15 Subd. 3. Attachment point. "Attachment point" means an amount as provided in section

2.16 62E.23, subdivision 2, paragraph (b).

2.17 Subd. 4. Benefit year. "Benefit year" means the calendar year for which an eligible

2.18 health carrier provides coverage through an individual health plan.

2.19 Subd. 5. Board. "Board" means the board of directors of the Minnesota Comprehensive

2.20 Health Association created under section 62E.10.

2.21 Subd. 6. Coinsurance rate. "Coinsurance rate" means the rate as provided in section

2.22 62E.23, subdivision 2, paragraph (c).

2.23 Subd. 7. Commissioner. "Commissioner" means the commissioner of commerce.

2.24 Subd. 8. Eligible health carrier. "Eligible health carrier" means all of the following

2.25 that offer individual health plans and incur claims costs for an individual enrollee's covered

2.26 benefits in the applicable benefit year:

2.27 (1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of

2.28 accident and sickness insurance as defined in section 62A.01;

2.29 (2) a nonprofit health service plan corporation operating under chapter 62C; or

2.30 (3) a health maintenance organization operating under chapter 62D.

3.1 Subd. 9.Individual health plan. "Individual health plan" means a health plan as defined

3.2 in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section

3.3 62A.011, subdivision 1b.

3.4 Subd. 10. Individual market. "Individual market" has the meaning given in section

3.5 62A.011, subdivision 5.

3.6 Subd. 11. Minnesota Comprehensive Health Association or association. "Minnesota

3.7 Comprehensive Health Association" or "association" has the meaning given in section

3.8 62E.02, subdivision 14.

3.9 Subd. 12. Minnesota premium security plan or plan. "Minnesota premium security

3.10 plan" or "plan" meansthe state-based reinsurance program authorized undersection 62E.23.

3.11 Subd. 13. Payment parameters. "Payment parameters" means the attachment point,

3.12 reinsurance cap, and coinsurance rate for the plan.

3.13 Subd. 14. Reinsurance cap. "Reinsurance cap" meansthe threshold amount as provided

3.14 in section 62E.23, subdivision 2, paragraph (d).

3.15 Subd. 15. Reinsurance payments. "Reinsurance payments" means an amount paid by

3.16 the association to an eligible health carrier under the plan.

3.17 Sec. 3. [62E.22] DUTIES OF COMMISSIONER.

3.18 The commissioner shall require eligible health carriers to calculate the premium amount

3.19 the eligible health carrier would have charged for the benefit year if the Minnesota premium

3.20 security plan had not been established. The eligible health carrier must submit this

3.21 information as part of its rate filing. The commissioner must consider this information as

3.22 part of the rate review.

3.23 Sec. 4. [62E.23] MINNESOTA PREMIUM SECURITY PLAN.

3.24 Subdivision 1. Administration of plan. (a) The association is Minnesota's reinsurance

3.25 entity to administer the state-based reinsurance program referred to asthe Minnesota premium

3.26 security plan.

3.27 (b) The association may apply for any available federal funding for the plan. All funds

3.28 received by or appropriated to the association shall be deposited in the premium security

3.29 plan account in section 62E.25, subdivision 1. The association shall notify the chairs and

3.30 ranking minority members of the legislative committees with jurisdiction over health and

3.31 human services and insurance within ten days of receiving any federal funds.

4.1 (c) The association must collect or access data from an eligible health carrier that are

4.2 necessary to determine reinsurance payments, according to the data requirements under

4.3 subdivision 5, paragraph (c).

4.4 (d) The board must not use any funds allocated to the plan for staff retreats, promotional

4.5 giveaways, excessive executive compensation, or promotion of federal or state legislative

4.6 or regulatory changes.

4.7 (e) For each applicable benefit year, the association must notify eligible health carriers

4.8 of reinsurance payments to be made for the applicable benefit year no later than June 30 of

4.9 the year following the applicable benefit year.

4.10 (f) On a quarterly basis during the applicable benefit year, the association must provide

4.11 each eligible health carrier with the calculation of total reinsurance payment requests.

4.12 (g) By August 15 of the year following the applicable benefit year, the association must

4.13 disburse all applicable reinsurance payments to an eligible health carrier.

4.14 Subd. 2. Payment parameters. (a) The board must design and adjust the payment

4.15 parameters to ensure the payment parameters:

4.16 (1) will stabilize or reduce premium rates in the individual market;

4.17 (2) will increase participation in the individual market;

4.18 (3) will improve access to health care providers and services for those in the individual

4.19 market;

4.20 (4) mitigate the impact high-risk individuals have on premium rates in the individual

4.21 market;

4.22 (5) take into account any federal funding available for the plan; and

4.23 (6) take into account the total amount available to fund the plan.

4.24 (b) The attachment point for the plan is the threshold amount for claims costs incurred

4.25 by an eligible health carrier for an enrolled individual's covered benefits in a benefit year,

4.26 beyond which the claims costs for benefits are eligible for reinsurance payments. The

4.27 attachment point shall be set by the board at $50,000 or more, but not exceeding the

4.28 reinsurance cap.

4.29 (c) The coinsurance rate for the plan is the rate at which the association will reimburse

4.30 an eligible health carrier for claims incurred for an enrolled individual's covered benefits

4.31 in a benefit year above the attachment point and below the reinsurance cap. The coinsurance

4.32 rate shall be set by the board at a rate between 50 and 80 percent.

5.1 (d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible

5.2 health carrier for an enrolled individual's covered benefits, after which the claims costs for

5.3 benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set

5.4 by the board at $250,000 or less.

5.5 (e) The board may adjust the payment parameters to the extent necessary to secure

5.6 federal approval of the state innovation waiver request in article 1, section 8.

5.7 Subd. 3. Operation. (a) The board shall propose to the commissioner the payment

5.8 parameters for the next benefit year by January 15 of the year before the applicable benefit

5.9 year. The commissioner shall approve or reject the payment parameters no later than 14

5.10 days following the board's proposal. If the commissioner fails to approve or reject the

5.11 payment parameters within 14 days following the board's proposal, the proposed payment

5.12 parameters are final and effective.

5.13 (b) If the amount in the premium security plan account in section 62E.25, subdivision

5.14 1, is not anticipated to be adequate to fully fund the approved payment parameters as of

5.15 July 1 of the year before the applicable benefit year, the board, in consultation with the

5.16 commissioner and the commissioner of management and budget, shall propose payment

5.17 parameters within the available appropriations. The commissioner must permit an eligible

5.18 health carrier to revise an applicable rate filing based on the final payment parameters for

5.19 the next benefit year.

5.20 Subd. 4. Calculation of reinsurance payments. (a) Each reinsurance payment must be

5.21 calculated with respect to an eligible health carrier's incurred claims costs for an individual

5.22 enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed

5.23 the attachment point, the reinsurance payment is $0. If the claims costs exceed the attachment

5.24 point, the reinsurance payment shall be calculated as the product of the coinsurance rate

5.25 and the lesser of:

5.26 (1) the claims costs minus the attachment point; or

5.27 (2) the reinsurance cap minus the attachment point.

5.28 (b) The board must ensure that reinsurance payments made to eligible health carriers do

5.29 not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total

5.30 amount paid of an eligible claim" meansthe amount paid by the eligible health carrier based

5.31 upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time

5.32 the data are submitted or made accessible under subdivision 5, paragraph (c).

6.1 Subd. 5. Eligible carrier requests for reinsurance payments. (a) An eligible health

6.2 carrier may request reinsurance payments from the association when the eligible health

6.3 carrier meets the requirements of this subdivision and subdivision 4.

6.4 (b) An eligible health carrier must make requestsfor reinsurance paymentsin accordance

6.5 with any requirements established by the board.

6.6 (c) An eligible health carrier must provide the association with access to the data within

6.7 the dedicated data environment established by the eligible health carrier under the federal

6.8 risk adjustment program under United States Code, title 42, section 18063. Eligible health

6.9 carriers must submit an attestation to the board asserting compliance with the dedicated

6.10 data environments, data requirements, establishment and usage of masked enrollee

6.11 identification numbers, and data submission deadlines.

6.12 (d) An eligible health carrier must provide the access described in paragraph (c) for the

6.13 applicable benefit year by April 30 of each year of the year following the end of the

6.14 applicable benefit year.

6.15 (e) An eligible health carrier must maintain documents and records, whether paper,

6.16 electronic, or in other media, sufficient to substantiate the requests for reinsurance payments

6.17 made pursuant to this section for a period of at least six years. An eligible health carrier

6.18 must also make those documents and records available upon request from the commissioner

6.19 for purposes of verification, investigation, audit, or other review of reinsurance payment

6.20 requests.

6.21 (f) An eligible health carrier may follow the appeals procedure under section 62E.10,

6.22 subdivision 2a.

6.23 (g) The association may have an eligible health carrier audited to assess the health

6.24 carrier's compliance with the requirements of this section. The eligible health carrier must

6.25 ensure that its contractors, subcontractors, or agents cooperate with any audit under this

6.26 section. If an audit resultsin a proposed finding of material weakness orsignificant deficiency

6.27 with respect to compliance with any requirement of this section, the eligible health carrier

6.28 may provide a response to the proposed finding within 30 days. Within 30 days of the

6.29 issuance of a final audit report that includes a finding of material weakness or significant

6.30 deficiency, the eligible health carrier must:

6.31 (1) provide a written corrective action plan to the association for approval;

6.32 (2) implement the approved plan; and

7.1 (3) provide the association with written documentation of the corrective action once

7.2 taken.

7.3 Subd. 6. Data. Government data of the association under this section are private data

7.4 on individuals, or nonpublic data, as defined under section 13.02, subdivisions 9 or 12.

7.5 Sec. 5. [62E.24] ACCOUNTING, REPORTS, AND AUDITS OF THE

7.6 ASSOCIATION.

7.7 Subdivision 1. Accounting. The board must keep an accounting for each benefit year

7.8 of all:

7.9 (1) funds appropriated for reinsurance payments and administrative and operational

7.10 expenses;

7.11 (2) requests for reinsurance payments received from eligible health carriers;

7.12 (3) reinsurance payments made to eligible health carriers; and

7.13 (4) administrative and operational expenses incurred for the plan.

7.14 Subd. 2. Reports. The board must submit to the commissioner and make available to

7.15 the public a report summarizing the plan operations for each benefit year by posting the

7.16 summary on the Minnesota Comprehensive Health Association Web site and making the

7.17 summary otherwise available by November 1 of the year following the applicable benefit

7.18 year or 60 calendar days following the final disbursement of reinsurance payments for the

7.19 applicable benefit year, whichever is later.

7.20 Subd. 3. Legislative auditor. The Minnesota premium security plan is subject to audit

7.21 by the legislative auditor. The board must ensure that its contractors, subcontractors, or

7.22 agents cooperate with the audit.

7.23 Subd. 4. Independent external audit. (a) The board must engage and cooperate with

7.24 an independent certified public accountant or CPA firm licensed or permitted under chapter

7.25 326A to perform an audit for each benefit year of the plan, in accordance with generally

7.26 accepted auditing standards. The audit must at a minimum:

7.27 (1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

7.28 (2) identify any material weaknesses or significant deficiencies and address manners in

7.29 which to correct any such material weaknesses or deficiencies.

7.30 (b) The board, after receiving the completed audit, must:

7.31 (1) provide the commissioner the results of the audit;

8.1 (2) identify to the commissioner any material weakness orsignificant deficiency identified

8.2 in the audit and address in writing to the commissioner how the board intends to correct

8.3 any such material weakness or significant deficiency in compliance with subdivision 5; and

8.4 (3) make public the results of the audit, to the extent the audit contains government data

8.5 that is public, including any material weakness or significant deficiency and how the board

8.6 intendsto correct the material weakness orsignificant deficiency, by posting the audit results

8.7 on the Minnesota Comprehensive Health Association Web site and making the audit results

8.8 otherwise available.

8.9 Subd. 5. Actions on audit findings. (a) If an audit results in a finding of material

8.10 weakness or significant deficiency with respect to compliance by the association with any

8.11 requirement under sections 62E.21 to 62E.25, the board must:

8.12 (1) provide a written corrective action plan to the commissioner for approval within 60

8.13 days of the completed audit;

8.14 (2) implement the corrective action plan; and

8.15 (3) provide the commissioner with written documentation of the corrective actionstaken.

8.16 (b) By December 1 of each year, the board must submit a report to the standing

8.17 committees of the legislature having jurisdiction over health and human services and

8.18 insurance regarding any finding of material weakness or significant deficiency found in an

8.19 audit.

8.20 Sec. 6. [62E.25] ACCOUNTS.

8.21 Subdivision 1. Premium security plan account. The premium security plan account is

8.22 created in the special revenue fund of the state treasury. Fundsin the account are appropriated

8.23 annually to the commissioner of commerce for grants to the Minnesota Comprehensive

8.24 Health Association for the operational and administrative costs and reinsurance payments

8.25 relating to the start-up and operation of the Minnesota premium security plan.

8.26 Notwithstanding section 11A.20, all investment income and all investment losses attributable

8.27 to the investment of the premium security plan account shall be credited to the premium

8.28 security plan account.

8.29 Subd. 2. Deposits. Except as provided in subdivision 3, funds received by the

8.30 commissioner of commerce or other state agency pursuant to the state innovation waiver

8.31 request in article 1, section 8, shall be deposited in the premium security plan account in

8.32 subdivision 1.

9.1 Subd. 3. Basic health plan trust account. Funds received by the commissioner of

9.2 commerce or other state agency pursuant to the state innovation waiver request in article 1,

9.3 section 8, that are attributable to the basic health program shall be deposited in the basic

9.4 health plan trust account in the federal fund.

9.5 Sec. 7. Laws 2013, chapter 9, section 15, is amended to read:

9.6 Sec. 15. MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

9.7 TERMINATION.

9.8 (a) The commissioner of commerce, in consultation with the board of directors of the

9.9 Minnesota Comprehensive Health Association, has the authority to develop and implement

9.10 the phase-out and eventual appropriate termination of coverage provided by the Minnesota

9.11 Comprehensive Health Association under Minnesota Statutes, chapter 62E. The phase-out

9.12 of coverage shall begin no sooner than January 1, 2014, or upon the effective date of the

9.13 operation of the Minnesota Insurance Marketplace and the ability to purchase qualified

9.14 health plans through the Minnesota Insurance Marketplace, whichever is later, and shall,

9.15 to the extent practicable, ensure the least amount of disruption to the enrollees' health care

9.16 coverage. The member assessments established under Minnesota Statutes, section 62E.11,

9.17 shall take into consideration any phase-out of coverage implemented under this section.

9.18 (b) Nothing in paragraph (a) applies to the Minnesota premium security plan, as defined

9.19 in Minnesota Statutes, section 62E.21, subdivision 12.

9.20 Sec. 8. STATE INNOVATION WAIVER.

9.21 Subdivision 1. Submission of waiver application. The commissioner of commerce

9.22 shall apply to the secretary of health and human services under United States Code, title

9.23 42, section 18052, for a state innovation waiver to implement the Minnesota premium

9.24 security plan for benefit years beginning January 1, 2018, and future years, to maximize

9.25 federal funding. The waiver application must clearly state that operation of the Minnesota

9.26 premium security plan is contingent on approval of the waiver request.

9.27 Subd. 2. Consultation. In developing the waiver application, the commissioner shall

9.28 consult with the commissioner of human services, the commissioner of health, and the

9.29 MNsure board.

9.30 Subd. 3. Application timelines; notification. The commissionershallsubmit the waiver

9.31 application to the secretary of health and human services on or before June 15, 2017. The

9.32 commissioner shall make a draft application available for public review and comment by

10.1 May 15, 2017. The commissioner shall notify the chairs and ranking minority members of

10.2 the legislative committees with jurisdiction over health and human services and insurance,

10.3 and the board of directors of the Minnesota Comprehensive Health Association of any

10.4 federal actions regarding the waiver request.

10.5 Sec. 9. COSTS RELATED TO IMPLEMENTATION OF THIS ACT.

10.6 A state agency that incurs administrative costs to implement any provision of this act

10.7 and does not receive an appropriation for administrative costs of this act must implement

10.8 the act within the limits of existing appropriations.

10.9 Sec. 10. PREMIUM SECURITY PLAN CONTINGENT ON FEDERAL WAIVER.

10.10 If the state innovation waiver request in article 1,section 8, is not approved, the Minnesota

10.11 Comprehensive Health Association and its board of directors shall not administer the

10.12 Minnesota premium security plan and provide reinsurance payments to eligible health

10.13 carriers.

10.14 Sec. 11. PAYMENT PARAMETERS FOR 2018.

10.15 (a) Notwithstanding Minnesota Statutes, section 62E.23, and subject to paragraph (b),

10.16 the Minnesota premium security plan payment parameters for benefit year 2018 are:

10.17 (1) an attachment point of $50,000;

10.18 (2) a coinsurance rate of 80 percent; and

10.19 (3) a reinsurance cap of $250,000.

10.20 (b) The board of directors of the Minnesota Comprehensive Health Association may

10.21 alter the payment parameters to the extent necessary to secure federal approval of the state

10.22 innovation waiver request in article 1, section 8.

10.23 Sec. 12. DEPOSIT OF FUNDS.

10.24 (a) Within ten days of the effective date of this section, the Minnesota Comprehensive

10.25 Health Association, as defined in Minnesota Statutes, section 62E.02, subdivision 14, shall

10.26 deposit all money, including monetary reserves, the association holds into the premium

10.27 security plan account in Minnesota Statutes, section 62E.25, subdivision 1.

10.28 (b) Notwithstanding paragraph (a), the Minnesota Comprehensive Health Association

10.29 may retain funds necessary to fulfill medical needs and contractual obligations in place for

10.30 former Minnesota Comprehensive Health Association enrollees until December 31, 2018.

11.1 Sec. 13. DISPOSITION AND SETTLEMENTS.

11.2 Notwithstanding Minnesota Statutes, section 62E.09, and any other law to the contrary,

11.3 the board of directors of the Minnesota Comprehensive Health Association, as defined in

11.4 Minnesota Statutes, section 62E.02, subdivision 14, shall have authority:

11.5 (1) over the disposition and settlement of all funds held by the association, including

11.6 prior assessments, to the extent funds have not been transferred pursuant to article 1,section

11.7 12; and

11.8 (2) to settle and make determinations regarding litigation pending on the effective date

11.9 of this act, including litigation that impacts funds held by the association.

11.10 Sec. 14. LEGISLATIVE WORKING GROUP.

11.11 A legislative working group is established consisting of the chairs and ranking minority

11.12 members of the senate committees with jurisdiction over commerce, health and human

11.13 services finance and policy, and human services reform finance and policy and the chairs

11.14 and ranking minority members of the house of representatives committees with jurisdiction

11.15 over commerce and regulatory reform, health and human services finance, and health and

11.16 human services reform. The purpose of the working group is to advise the board of the

11.17 Minnesota Comprehensive Health Association on the adoption of payment parameters and

11.18 other elements of a reinsurance plan for benefit year 2019. The commissioner of commerce

11.19 must provide technical assistance for the working group, and must review and monitor the

11.20 following to serve as a resource for the working group:

11.21 (1) the effectiveness of reinsurance models adopted in Alaska and other states in

11.22 stabilizing premiums in the individual market and the related costs thereof;

11.23 (2) the effect of federal health reform legislation on the Minnesota premium security

11.24 plan, including but not limited to funding for the plan; and

11.25 (3) the status of the health care access fund, and issues relating to its potential continued

11.26 use as a source of funding for the Minnesota premium security plan.

11.27 Sec. 15. MINNESOTA PREMIUM SECURITY PLAN FUNDING.

11.28 (a) The Minnesota Comprehensive Health Association shall fund the operational and

11.29 administrative costs and reinsurance payments of the Minnesota security plan and association

11.30 using the following amounts deposited in the premium security plan account in Minnesota

11.31 Statutes, section 62E.25, subdivision 1, in the following order:

12.1 (1) any federal funding available;

12.2 (2) funds deposited under article 1, sections 12 and 13;

12.3 (3) any state funds from the health care access fund; and

12.4 (4) any state funds from the general fund.

12.5 (b) The association shall transfer from the premium security plan account any general

12.6 fund amount not used for the Minnesota premium security plan by June 30, 2021, to the

12.7 commissioner of commerce. Any amount transferred to the commissioner of commerce

12.8 shall be deposited in the general fund.

12.9 (c) The association shall transfer from the premium security plan account any health

12.10 care access fund amount not used for the Minnesota premium security plan by June 30,

12.11 2021, to the commissioner of commerce. Any amount transferred to the commissioner of

12.12 commerce shall be deposited in the health care access fund in Minnesota Statutes, section

12.13 16A.724.

12.14 (d) The Minnesota Comprehensive Health Association may not spend more than

12.15 $271,000,000 for benefit year 2018 and not more than $271,000,000 for benefit year 2019

12.16 for the operational and administrative costs of, and reinsurance payments under, the

12.17 Minnesota premium security plan.

12.18 Sec. 16. TRANSFERS.

12.19 (a) The commissioner of management and budget shall transfer $200,000,000 in fiscal

12.20 year 2018 and $200,000,000 in fiscal year 2019 from the health care access fund to the

12.21 premium security plan account in Minnesota Statutes, section 62E.25, subdivision 1. This

12.22 is a onetime transfer.

12.23 (b) The commissioner of management and budget shall transfer $71,000,000 in fiscal

12.24 year 2018 and $71,000,000 in fiscal year 2019 from the general fund to the premium security

12.25 plan account in Minnesota Statutes,section 62E.25,subdivision 1. Thisis a onetime transfer.

12.26 EFFECTIVE DATE. This section is effective upon federal approval of the state

12.27 innovation request in article 1, section 8. The commissioner of commerce shall inform the

12.28 revisor of statutes when federal approval is obtained.

13.1 Sec. 17. TRANSFER; 2018.

13.2 The commissioner of management and budgetshall transfer $750,000 in fiscal year 2018

13.3 from the health care accessfund to the premium security plan account in Minnesota Statutes,

13.4 section 62E.25, subdivision 1. This is a onetime transfer.

13.5 Sec. 18. APPROPRIATION.

13.6 $155,000 in fiscal year 2018 is appropriated from the general fund to the commissioner

13.7 of commerce to prepare and submit the state innovation waiver in article 1, section 8.

13.8 Sec. 19. EFFECTIVE DATE.

13.9 Sections 1 to 15, 17, and 18 are effective the day following final enactment.

13.10 ARTICLE 2

13.11 HEALTH POLICY

13.12 Section 1. Minnesota Statutes 2016, section 62K.10, is amended by adding a subdivision

13.13 to read:

13.14 Subd. 1a. Health care provider system access. For those counties in which a health

13.15 carrier actively markets an individual health plan, the health carrier must offer, in those

13.16 same counties, at least one individual health plan with a provider network that includes

13.17 in-network access to more than a single health care provider system. This subdivision is

13.18 applicable only for the year in which the health carrier actively markets an individual health

13.19 plan.

13.20 EFFECTIVE DATE. Thissection is effective January 1, 2018, and appliesto individual

13.21 health plans offered, issued, or renewed on or after that date.

13.22 Sec. 2. Laws 2017, chapter 2, article 1, section 1, subdivision 3, is amended to read:

13.23 Subd. 3. Eligible individual. "Eligible individual" means a Minnesota resident who:

13.24 (1) is not receiving a an advance premium tax credit under Code of Federal Regulations,

13.25 title 26, section 1.36B-2, as of the date in a month in which their coverage is effectuated

13.26 effective;

13.27 (2) is not enrolled in public program coverage under Minnesota Statutes, section

13.28 256B.055, or 256L.04; and

13.29 (3) purchased an individual health plan from a health carrier in the individual market.

14.1 EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

14.2 Sec. 3. Laws 2017, chapter 2, article 1, section 2, subdivision 4, is amended to read:

14.3 Subd. 4. Data practices. (a) The definitions in Minnesota Statutes, section 13.02, apply

14.4 to this subdivision.

14.5 (b) Government data on an enrollee or health carrier under this section are private data

14.6 on individuals or nonpublic data, except that the total reimbursement requested by a health

14.7 carrier and the total state payment to the health carrier are public data.

14.8 (c) Notwithstanding Minnesota Statutes, section 138.17, not public government data on

14.9 an enrollee or health carrier under this section must be destroyed by June 30, 2018, or upon

14.10 completion by the legislative auditor of the audits required by section 3, whichever is later.

14.11 This paragraph does not apply to data maintained by the legislative auditor.

14.12 EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

14.13 Sec. 4. Laws 2017, chapter 2, article 1, section 2, is amended by adding a subdivision to

14.14 read:

14.15 Subd. 5. Data sharing. (a) Notwithstanding any law to the contrary, government entities

14.16 are permitted to share or disseminate data as follows:

14.17 (1) the commissioner of human services and the board of directors of MNsure must

14.18 share data on public program enrollment under Minnesota Statutes, sections 256B.055 and

14.19 256L.04, as well as data on an enrollee's receipt of a premium tax credit under Code of

14.20 Federal Regulations, title 26, section 1.36B-2, with the commissioner of management and

14.21 budget; and

14.22 (2) the commissioner of management and budget must disseminate data on an enrollee's

14.23 public program coverage enrollment under Minnesota Statutes, sections 256B.055 and

14.24 256L.04, to health carriers to the extent the commissioner determines is necessary for

14.25 determining the enrollee's eligibility for the premium subsidy program authorized by this

14.26 act.

14.27 (b) Data shared under this subdivision may be collected, stored, or used only for the

14.28 purposes of administration of the premium subsidy program authorized by this act and may

14.29 not be further shared or disseminated except as otherwise provided by law.

14.30 (c) By June 30, 2018, a health carrier must destroy any data it received pursuant to this

14.31 subdivision.

15.1 EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

15.2 Sec. 5. Laws 2017, chapter 2, article 1, section 3, is amended to read:

15.3 Sec. 3. AUDITS.

15.4 (a) The legislative auditor shall conduct audits of the health carriers' supporting data, as

15.5 prescribed by the commissioner, to determine whether payments align with criteria

15.6 established in sections 1 and 2. The commissioner of human services shall provide data as

15.7 necessary to the legislative auditor to complete the audit. The commissioner shall withhold

15.8 or charge back payments to the health carriers to the extent they do not align with the criteria

15.9 established in sections 1 and 2, as determined by the audit.

15.10 (b) The legislative auditorshall audit the extent to which health carriers provided premium

15.11 subsidies to persons meeting the residency and other eligibility requirements specified in

15.12 section 1,subdivision 3. The legislative auditorshall report to the commissioner the amount

15.13 of premium subsidies provided by each health carrier to persons not eligible for a premium

15.14 subsidy. The commissioner, in consultation with the commissioners of commerce and health

15.15 human services, shall develop and implement a process to recover from health carriers the

15.16 amount of premium subsidiesreceived for enrollees determined to be ineligible for premium

15.17 subsidies by the legislative auditor. The legislative auditor, when conducting the required

15.18 audit, and the commissioner, when determining the amount of premium subsidy to be

15.19 recovered, may take into account the extent to which a health carrier makes use of the

15.20 Minnesota eligibility system, as defined in Minnesota Statutes,section 62V.055,subdivision

15.21 1.

15.22 EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

15.23 Sec. 6. Laws 2017, chapter 2, article 2, section 13, the effective date, is amended to read:

15.24 EFFECTIVE DATE. Thissection is effective 90 daysfollowing final enactmentJanuary

15.25 1, 2018, and applies to provider services provided on or after that date.

15.26 EFFECTIVE DATE. This section is effective retroactively from January 27, 2017.

Attachment B: Existing Law - Minnesota Statutes Chapter 62E – Minnesota Comprehensive Health Association (MCHA)

CHAPTER 62E

COMPREHENSIVE HEALTH INSURANCE

62E.01 ….62E.08 [Not applicable to the reinsurance program.

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

(a) formulate general policies to advance the purposes of sections 62E.01 to 62E.19;

(b) supervise the creation of the Minnesota Comprehensive Health Association within the limits described in section 62E.10;

(c) approve the selection of the writing carrier by the association, approve the association's contract with the writing carrier, and approve the state plan coverage;

(d) appoint advisory committees;

(e) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;

(f) contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;

(g) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.15, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;

(h) contract with insurers and others for administrative services; and

(i) adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.19.

62E.091 [Not applicable to the reinsurance program.

These sections discuss another subject on special Minnesota-specific disclosers pre-dating the ACA.]

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.§

Subdivision 1.Creation; tax exemption. There is established a Comprehensive Health Association to promote the public health and welfare of the state of Minnesota with membership consisting of all insurers; self-insurers; fraternals; joint self-insurance plans regulated under chapter 62H; the Minnesota employees insurance program established in section 43A.317, effective July 1, 1993; health maintenance organizations; and community integrated service networks licensed or authorized to do business in this

state. The Comprehensive Health Association is exempt from the taxes imposed under chapter 297I and any other laws of this state and all property owned by the association is exempt from taxation.

§ Subd. 2. Board of directors; organization. The board of directors of the association shall be made up of 13 members as follows: six directors selected by contributing members, subject to approval by the commissioner, one of which must be a health actuary; two directors selected by the commissioner of human services, one of whom must represent hospitals and one of whom must represent health care providers; five public directors selected by the commissioner, at least two of whom must be enrollees in the individual market and one of whom must be a licensed insurance agent. At least two of the public directors must reside outside of the seven-county metropolitan area. In determining voting rights at members' meetings, each member shall be entitled to vote in person or proxy. In approving directors of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Directors selected by contributing members may be reimbursed from the money of the association for expenses incurred by them as directors, but shall not otherwise be compensated by the association for their services. §

Subd. 2a.Appeals. A person may appeal to the commissioner within 30 days after notice of an action, ruling, or decision by the board.

A final action or order of the commissioner under this subdivision is subject to judicial review in the manner provided by chapter 14.

In lieu of the appeal to the commissioner, a person may seek judicial review of the board's action.§

Subd. 3.Mandatory membership. All members shall maintain their membership in the association as a condition of doing accident and health insurance, self-insurance, health maintenance organization, or community integrated service network business in this state. The association shall submit its articles, bylaws and operating rules to the commissioner for approval; provided that the adoption and amendment of articles, bylaws and operating rules by the association and the approval by the commissioner thereof shall be exempt from the provisions of sections 14.001 to 14.69.§

Subd. 4.Open meetings. All meetings of the association, its board, and any committees of the association shall comply with the provisions of chapter 13D, except that during any portion of a meeting during which an enrollee's appeal of an action of the writing carrier is being heard, that portion of the meeting must be closed at the enrollee's request.§

Subd. 5. [Repealed]§

Subd. 6.Antitrust exemption. In the performance of their duties as members of the association, the members shall be exempt from the provisions of sections 325D.49 to 325D.66.§

Subd. 7.General powers. The association may:

(a) Exercise the powers granted to insurers under the laws of this state;

(b) Sue or be sued;

(c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);

(d) Establish administrative and accounting procedures for the operation of the association;

(e) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by section 62E.04 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are:

(1) individual qualified plans, excluding group conversions;

(2) group conversions;

(3) group qualified plans with fewer than 50 employees or members; and

(4) major medical coverage.

A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. A member electing to reinsure risks of a category of coverage shall enter into a contract with the association establishing a reinsurance plan for the risks. This contract may include provision for the pooling of members' risks reinsured through the association and it may provide for assessment of each member reinsuring risks for losses and operating and administrative expenses incurred, or estimated to be incurred in the operation of the reinsurance plan. This reinsurance plan shall be approved by the commissioner before it is effective. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than 110 percent of the total anticipated expenses incurred by the association for the reinsurance; and

(f) Provide for the administration by the association of policies which are reinsured pursuant to clause (e). Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than 110 percent of the total anticipated expenses incurred by the association for the administration.§

Subd. 8.Department of state exemption. The association is exempt from the Administrative Procedure Act but, to the extent authorized by law to adopt rules, the association may use the provisions of section 14.386, paragraph (a), clauses (1) and (3). Section 14.386, paragraph (b), does not apply to these rules.§

Subd. 9.Experimental delivery method. The association may petition the commissioner of commerce for a waiver to allow the experimental use of alternative means of health care delivery. The commissioner may approve the use of the alternative means the commissioner considers appropriate. The commissioner may waive any of the requirements of this chapter and chapters 60A, 62A, and 62D in granting the waiver. The commissioner may also grant to the association any additional powers as are necessary to facilitate the specific waiver, including the power to implement a provider payment schedule.§

Subd. 10.Cost containment goals. (a) By July 1, 2001, the association shall investigate managed care delivery systems, and if cost effective, enter into contracts with third-party entities as provided in section 62E.101.

(b) By July 1, 2001, the association shall establish a system to annually identify individuals insured by the Minnesota Comprehensive Health Association who may be eligible for private health care coverage,

medical assistance, state drug programs, or other state or federal programs and notify them about their eligibility for these programs.

(c) The association shall endeavor to reduce health care costs using additional methods consistent with effective patient care. At a minimum, by July 1, 2001, the association shall:

(1) develop a focused chronic disease management and case management program;

(2) develop a comprehensive program of preventive care; and

(3) implement a total drug formulary program.

The association may establish an enrollee incentive based on enrollee participation in the chronic disease management and case management program developed under this section.

62E.101-19 [Not applicable to the reinsurance program.

These sections discuss another subject on special Minnesota-specific disclosers pre-dating the ACA.]

62E.21 DEFINITIONS.

Subdivision 1. Application. For the purposes of sections 62E.21 to 62E.25, the terms defined in this section have the meanings given them.

Subd. 2. Affordable Care Act. "Affordable Care Act" means the federal act as defined in section 62A.011, subdivision 1a.

Subd. 3. Attachment point. "Attachment point" means an amount as provided in section 62E.23, subdivision 2, paragraph (b).

Subd. 4. Benefit year. "Benefit year" means the calendar year for which an eligible health carrier provides coverage through an individual health plan.

Subd. 5. Board. "Board" means the board of directors of the Minnesota Comprehensive Health Association created under section 62E.10.

Subd. 6. Coinsurance rate. "Coinsurance rate" means the rate as provided in section 62E.23, subdivision 2, paragraph (c).

Subd. 7. Commissioner. "Commissioner" means the commissioner of commerce.

Subd. 8. Eligible health carrier. "Eligible health carrier" means all of the following that offer individual health plans and incur claims costs for an individual enrollee's covered benefits in the applicable benefit year:

(1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;

(2) a nonprofit health service plan corporation operating under chapter 62C; or

(3) a health maintenance organization operating under chapter 62D.

Subd. 9. Individual health plan. "Individual health plan" means a health plan as defined in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section 62A.011, subdivision 1b.

Subd. 10. Individual market. "Individual market" has the meaning given in section 62A.011, subdivision 5.

Subd. 11. Minnesota Comprehensive Health Association or association. "Minnesota Comprehensive Health Association" or "association" has the meaning given in section 62E.02, subdivision 14.

Subd. 12. Minnesota premium security plan or plan. "Minnesota premium security plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

Subd. 13. Payment parameters. "Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the plan.

Subd. 14. Reinsurance cap. "Reinsurance cap" means the threshold amount as provided in section 62E.23, subdivision 2, paragraph (d).

Subd. 15. Reinsurance payments. "Reinsurance payments" means an amount paid by the association to an eligible health carrier under the plan.

62E.22 DUTIES OF COMMISSIONER.

The commissioner shall require eligible health carriers to calculate the premium amount the eligible health carrier would have charged for the benefit year if the Minnesota premium security plan had not been established. The eligible health carrier must submit this information as part of its rate filing. The commissioner must consider this information as part of the rate review.

62E.23 MINNESOTA PREMIUM SECURITY PLAN.

Subdivision 1. Administration of plan. (a) The association is Minnesota's reinsurance entity to administer the state-based reinsurance program referred to as the Minnesota premium security plan.

(b) The association may apply for any available federal funding for the plan. All funds received by or appropriated to the association shall be deposited in the premium security plan account in section 62E.25, subdivision 1. The association shall notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services and insurance within ten days of receiving any federal funds.

(c) The association must collect or access data from an eligible health carrier that are necessary to determine reinsurance payments, according to the data requirements under subdivision 5, paragraph (c).

(d) The board must not use any funds allocated to the plan for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative or regulatory changes.

(e) For each applicable benefit year, the association must notify eligible health carriers of reinsurance payments to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year.

(f) On a quarterly basis during the applicable benefit year, the association must provide each eligible health carrier with the calculation of total reinsurance payment requests.

(g) By August 15 of the year following the applicable benefit year, the association must disburse all applicable reinsurance payments to an eligible health carrier.

Subd. 2. Payment parameters. (a) The board must design and adjust the payment parameters to ensure the payment parameters:

(1) will stabilize or reduce premium rates in the individual market;

(2) will increase participation in the individual market;

(3) will improve access to health care providers and services for those in the individual market;

(4) mitigate the impact high-risk individuals have on premium rates in the individual market;

(5) take into account any federal funding available for the plan; and

(6) take into account the total amount available to fund the plan.

(b) The attachment point for the plan is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments. The attachment point shall be set by the board at $50,000 or more, but not exceeding the reinsurance cap.

(c) The coinsurance rate for the plan is the rate at which the association will reimburse an eligible health carrier for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap. The coinsurance rate shall be set by the board at a rate between 50 and 80 percent.

(d) The reinsurance cap is the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits, after which the claims costs for benefits are no longer eligible for reinsurance payments. The reinsurance cap shall be set by the board at $250,000 or less.

(e) The board may adjust the payment parameters to the extent necessary to secure federal approval of the state innovation waiver request in article 1, section 8.

Subd. 3. Operation. (a) The board shall propose to the commissioner the payment parameters for the next benefit year by January 15 of the year before the applicable benefit year. The commissioner shall approve or reject the payment parameters no later than 14 days following the board's proposal. If the commissioner fails to approve or reject the payment parameters within 14 days following the board's proposal, the proposed payment parameters are final and effective.

(b) If the amount in the premium security plan account in section 62E.25, subdivision 1, is not anticipated to be adequate to fully fund the approved payment parameters as of July 1 of the year before the applicable benefit year, the board, in consultation with the commissioner and the commissioner of management and budget, shall propose payment parameters within the available appropriations. The commissioner must permit an eligible health carrier to revise an applicable rate filing based on the final payment parameters for the next benefit year.

Subd. 4. Calculation of reinsurance payments. (a) Each reinsurance payment must be calculated with respect to an eligible health carrier's incurred claims costs for an individual enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed the attachment point, the reinsurance

payment is $0. If the claims costs exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of:

(1) the claims costs minus the attachment point; or

(2) the reinsurance cap minus the attachment point.

(b) The board must ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total amount paid of an eligible claim" means the amount paid by the eligible health carrier based upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time the data are submitted or made accessible under subdivision 5, paragraph (c).

Subd. 5. Eligible carrier requests for reinsurance payments. (a) An eligible health carrier may request reinsurance payments from the association when the eligible health carrier meets the requirements of this subdivision and subdivision 4.

(b) An eligible health carrier must make requests for reinsurance payments in accordance with any requirements established by the board.

(c) An eligible health carrier must provide the association with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under United States Code, title 42, section 18063. Eligible health carriers must submit an attestation to the board asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

(d) An eligible health carrier must provide the access described in paragraph (c) for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

(e) An eligible health carrier must maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this section for a period of at least six years. An eligible health carrier must also make those documents and records available upon request from the commissioner for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

(f) An eligible health carrier may follow the appeals procedure under section 62E.10, subdivision 2a.

(g) The association may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this section. The eligible health carrier must ensure that its contractors, subcontractors, or agents cooperate with any audit under this section. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this section, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier must:

(1) provide a written corrective action plan to the association for approval;

(2) implement the approved plan; and

(3) provide the association with written documentation of the corrective action once taken.

Subd. 6. Data. Government data of the association under this section are private data on individuals, or nonpublic data, as defined under section 13.02, subdivisions 9 or 12.

62E.24 ACCOUNTING, REPORTS, AND AUDITS OF THE ASSOCIATION.

Subdivision 1. Accounting. The board must keep an accounting for each benefit year of all:

(1) funds appropriated for reinsurance payments and administrative and operational expenses;

(2) requests for reinsurance payments received from eligible health carriers;

(3) reinsurance payments made to eligible health carriers; and

(4) administrative and operational expenses incurred for the plan.

Subd. 2. Reports. The board must submit to the commissioner and make available to the public a report summarizing the plan operations for each benefit year by posting the summary on the Minnesota Comprehensive Health Association Web site and making the summary otherwise available by November 1 of the year following the applicable benefit year or 60 calendar days following the final disbursement of reinsurance payments for the applicable benefit year, whichever is later.

Subd. 3. Legislative auditor. The Minnesota premium security plan is subject to audit by the legislative auditor. The board must ensure that its contractors, subcontractors, or agents cooperate with the audit.

Subd. 4. Independent external audit. (a) The board must engage and cooperate with an independent certified public accountant or CPA firm licensed or permitted under chapter 326A to perform an audit for each benefit year of the plan, in accordance with generally accepted auditing standards. The audit must at a minimum:

(1) assess compliance with the requirements of sections 62E.21 to 62E.25; and

(2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.

(b) The board, after receiving the completed audit, must:

(1) provide the commissioner the results of the audit;

(2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and

(3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association Web site and making the audit results otherwise available.

Subd. 5. Actions on audit findings.

(a) If an audit results in a finding of material weakness or significant deficiency with respect to compliance by the association with any requirement under sections 62E.21 to 62E.25, the board must:

(1) provide a written corrective action plan to the commissioner for approval within 60 days of the completed audit;

(2) implement the corrective action plan; and

(3) provide the commissioner with written documentation of the corrective actions taken.

(b) By December 1 of each year, the board must submit a report to the standing committees of the legislature having jurisdiction over health and human services and insurance regarding any finding of material weakness or significant deficiency found in an audit.

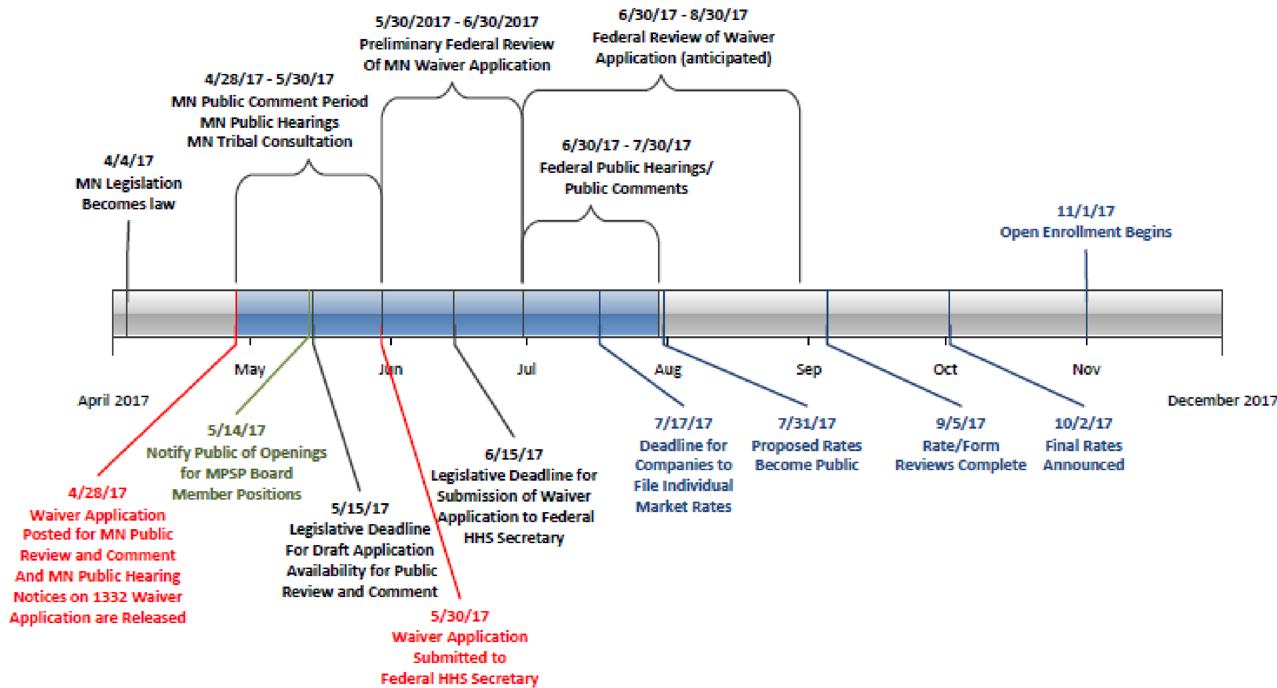
62E.25 ACCOUNTS.

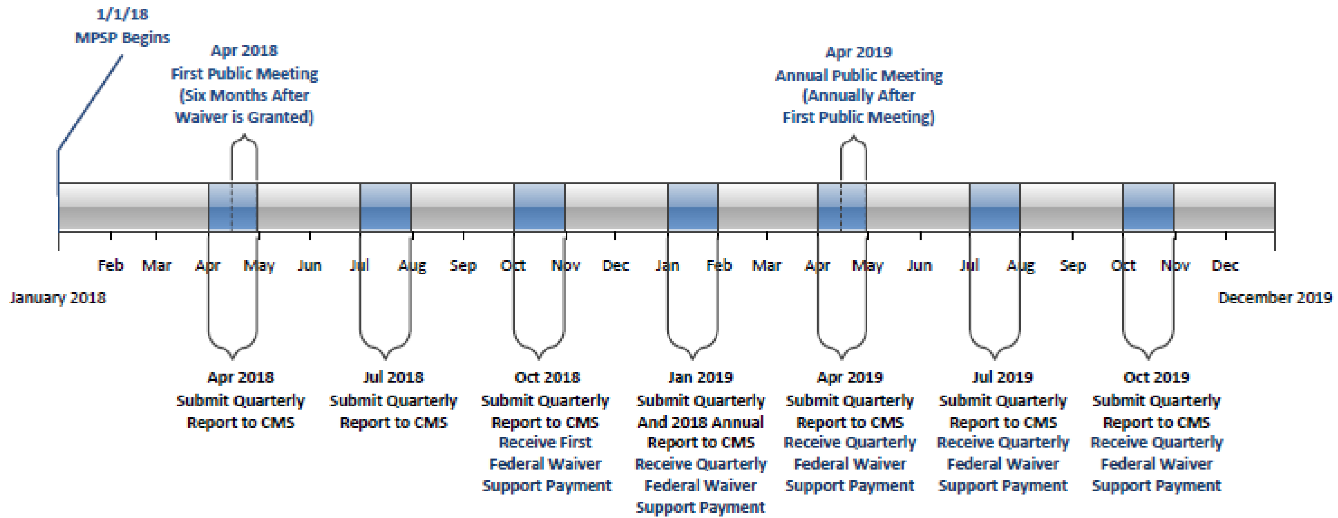
Subdivision 1. Premium security plan account. The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational and administrative costs and reinsurance payments relating to the start-up and operation of the Minnesota premium security plan. Notwithstanding section 11A.20, all investment income and all investment losses attributable to the investment of the premium security plan account shall be credited to the premium security plan account.

Subd. 2. Deposits. Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

Subd. 3. Basic health plan trust account. Funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, that are attributable to the basic health program shall be deposited in the basic health plan trust account in the federal fund.

Attachment C: Timeline




1/1/18
MPSP Begins
Apr 2018
First Public Meeting
(Six Months After
Waiver is Granted)
Apr 2019
Annual Public Meeting
(Annually After
First Public Meeting)
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Jul
Aug
Sep
Oct
Nov
Dec
January 2018
December 2019
Apr 2018
Submit Quarterly
Report to CMS
Jul 2018
Submit Quarterly
Report to CMS
Oct 2018
Submit Quarterly
Report to CMS
Receive First
Federal Waiver
Support Payment
Jan 2019
Submit Quarterly
And 2018 Annual
Report to CMS
Receive Quarterly
Federal Waiver
Support Payment
Apr 2019
Submit Quarterly
Report to CMS
Receive Quarterly
Federal Waiver
Support Payment
Jul 2019
Submit Quarterly
Report to CMS
Receive Quarterly
Federal Waiver
Support Payment
Oct 2019
Submit Quarterly
Report to CMS
Receive Quarterly
Federal Waiver
Support Payment

Attachment D: Public Comments

Several public comments were generated at the public hearing and tribal consultation sites. The notice of these public comments can be found in Attachment F and a notice for tribal consultation opportunity for input is included in Attachment H. Commerce posted notice of the comment period, public meetings, and waiver documents on the Department webpage. These can be found at https://mn.gov/commerce/industries/insurance/reinsurance/. The notice of public forums was distributed and is included in Attachment F. Additionally, the public comment period opened on April 28, 2017 and was open until May 30, 2017. Commerce received written comments, which are appended in Attachment I.

Comments were provided during and following the presentation included as Attachment E. The slides were presented by the Deputy Commissioner of Insurance and the Assistant Commissioner of Government Affairs from the Department of Commerce, as well as the Director of Federal Relations from the Department of Human Services (Minnesota's Basic Health Plan regulator).

Public forum and tribal consultation participants' questions and comments were on health care delivery more generally and were not focused on the waiver process. They included:

- Multiple commenters had questions on federal legislation, including the AHCA, Medicaid funding and Medicare changes.
- Commenters raised concerns regarding rural providers and narrowing provider networks for rural enrollees.
- Commenters had questions on the state funding source that would be dedicated to the MPSP, namely the Health Care Access Fund (HCAF).
- Commenters mentioned that they view the MPSP as bailing out profitable insurance companies.
- Multiple commenters had questions on why the state did not get guarantees from insurers that they would either lower or stabilize premiums or provide service in all rating areas.
- Multiple commenters pointed out that the reinsurance program is a temporary solution to the problem of rising premiums.
- One commenter had a question on the program mechanisms and how the reinsurance money would lead to premium relief.
- Another commenter asked why there cannot just be one risk pool in Minnesota.
- One commenter asked whether the individual mandate penalty will still be in effect following the implementation of the reinsurance bill.
- Another commenter asked if Minnesota can have one rating area instead of nine different rating areas.
- Multiple commenters asked how network coverage would be impacted by the reinsurance program.
- One commenter asked how the possibility of going to the federal exchange could be impacted by the reinsurance program.
- One commenter mentioned that the metal level values widened and pointed out that this change may reduce the level price for 2018 and beyond (i.e. sliver changing from 68-72% to 66-72%).

- Another commenter asked whether BHP members are a part of the individual market.
- Multiple commenters asked about the feasibility of the timeline for the reinsurance program for the 2018 plan year.

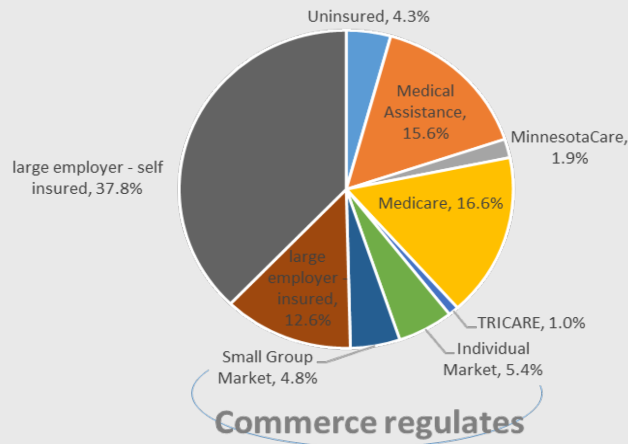
Comments received in person were responded to during public forums. Those that warranted mention and consideration were incorporated into this narrative and the Actuarial Analysis.

Attachment E: Slides From Public Hearings

Section 1332 Innovation Waiver
Public Meeting Presentation

Minnesotans access health insurance in many ways

Minnesota Health Insurance by Market (2015)



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Minnesotans who buy their own insurance need help

- About five percent of Minnesotans get healthcare coverage through the individual market
  - Minnesotans without access to coverage through an employer, MinnesotaCare, Medicare, Medicaid
  - Contractors, farmers, realtors, daycare providers
- Premiums increased dramatically in 2016 and 2017

Rising costs have destabilized Minnesota's individual market

- The rate of premium increases has been dramatic
  - Driven by high-cost claims and healthy people leaving the market
  - In 2015, claim costs exceeded premiums collected by 38%
  - 50% of individual market claim amounts have been incurred by 2.2% of enrollees
  - Costs are passed on to all individual market enrollees in the form of higher premium rates

National events also affected Minnesota's individual market

- Federal programs provided stabilizing assistance but not in amounts originally promised and are are no longer in effect
- Minnesota insurance companies reacted with rate increases, narrower provider networks and market exit
- Minnesota isn't unique - Similar issues occurring in other states

In 2017, Minnesota passed new laws aimed at helping consumers who buy their own insurance

- Short-term
  - January 2017: 25% discount on premiums for Minnesotans who don’t qualify for assistance
- Long-term:
  - April 2017: State-based reinsurance program called the Minnesota Premium Security Plan (MPSP)
  - Designed to alleviate the impact of high-cost claims
  - Translates to lower premium rates for consumers from what they would be absent the program, starting in 2018

Minnesota is seeking a 1332 waiver

- Minnesota’s waiver seeks to:
  - maximize federal funding to reduce individual market premiums
  - Capture federal funds that would otherwise already come to Minnesota
  - Stabilize the individual market
  - Not affect other state programs

The Federal government gives states the opportunity to innovate

- Section 1332 of the Affordable Care Act (ACA) permits states to apply for a State Innovation Waiver
- A successful waiver must ensure that the state's innovation results in:
  - Health care at least as comprehensive as prior to the waiver
  - Health care is at least as affordable as prior to the waiver
  - Coverage is provided to at least a comparable number of residents as would be expected without the waiver
  - No increase of the federal deficit

The MPSP will use Federal money to fund the reinsurance program

- Because reinsurance will lower premiums, it also will lower federal tax credits Minnesotans use to make their insurance more affordable
  - Higher premiums = higher federal tax credits; lower premiums = lower Federal tax credits
- Minnesota's waiver seeks to retain the foregone federal tax credits use those federal funds to support the MPSP
  - Budget neutral for the federal government
  - Using money that would otherwise come to Minnesota if the reinsurance program didn't exist

Establishment of Minnesota's reinsurance program is contingent on approval of the state's 1332 waiver

- For the MPSP to work, Minnesota needs an approved waiver
- With an approved waiver, the MPSP will:
  - Decrease premiums from what they otherwise would be absent the program
  - Not change employer-based insurance, Medicare, or Medicaid
  - Have no impact on MinnesotaCare

The amount of federal funding for the MPSP could be significant

- The federal government can be expected to pay $139 million - $167 million less in premium tax credits with the MPSP than without the MPSP in 2018
  - Based on analysis performed by MN Department of Commerce Actuaries
  - The amount could grow over time

Impact on federal funding for MinnesotaCare

- State law requires that the waiver seek necessary authority to hold MinnesotaCare's federal funding stream harmless
- MinnesotaCare is basic health plan under the ACA
- Federal funds are based on premium levels in the marketplace
- 'Pass through of funding' request in draft application

Minnesota is currently seeking public comment and input to improve the state's waiver

- 4/4/17: State legislation directs Commerce to seek 1332 waiver
- 4/28/17: Draft waiver and actuarial analysis posted publicly on Commerce website
- Comments accepted through May, 26

Timeline

- Four public meetings this week
  - Duluth, Rochester, Moorhead, St. Paul
  - Parallel consultation with Minnesota's Federally-Recognized Tribal Governments
- Commerce required by law to submit final application to federal regulators by June 15
- Federal government will then perform review, conduct its public comment period, and make a decision on approving the waiver

Questions?

- Questions or comments?

Attachment F: Copy of Notice of Public Hearings

April 28, 2017

Notice of Public Comment Period and Information Meetings

Draft Application for a State Innovation Waiver to Stabilize Minnesota's Individual Health Insurance Market and Reduce Premiums for Consumers

PLEASE TAKE NOTICE that the Minnesota Department of Commerce will conduct public information meetings and accept public comments on the draft application for a Section 1332 State Innovation Waiver to the U.S. Department of Health and Human Services to implement the Minnesota Premium Security Plan.

Background

Section 1332 of the Affordable Care Act permits a state to apply for a State Innovation Waiver to pursue innovative strategies to provide its residents with access to high-quality, affordable health insurance. Earlier this year, the Minnesota Legislature enacted a law that creates the Minnesota Premium Security Plan, a state-based reinsurance program designed to stabilize premiums in Minnesota's individual health insurance market. The new state law calls for the Commerce Department to submit a Section 1332 State Innovation Waiver application and, as required by federal regulations, make the draft application available for public review and comment.

If granted, the State Innovation Waiver would allow Minnesota to secure partial federal funding for the Minnesota Premium Security Plan, while preventing a loss of federal funding that helps support the MinnesotaCare public health insurance program.

Draft Waiver Application

The draft application may be viewed and downloaded at the Commerce Department website:

https://mn.gov/commerce/industries/insurance/reinsurance/index.jsp

Copies of the draft application will also be available at the public information meetings.

85 7th Place East, Suite 280, Saint Paul, MN 55101

Public Comment

Comments may be submitted in writing or presented orally at the public information meetings. Written comments (which will be available for public review) will be accepted until the close of business on May 30, 2017. Please submit comments via mail or email to:

Minnesota Department of Commerce
Attn: 1332 Waiver Draft Application
85 7th Place East, Suite 280
Saint Paul, MN 55101
WaiverComment@state.mn.us

Public Information Meetings

The Commerce Department will convene several public information meetings about the draft waiver application. Each meeting will include a presentation about the draft application, followed by time for questions and comments. The meeting dates, times and locations are listed below.

Date	Location	Time
Monday, May 8	Duluth Public Safety Building 2030 N. Arlington Ave. Duluth	10 AM - Noon
Tuesday, May 9	Rochester Public Library 101 2nd St. SE Rochester	11:30 - 1:30 PM
Wednesday, May 10	Moorhead Public Library 118 5th St. S. Moorhead	Noon - 2 PM
Friday, May 12	Rondo Community Outreach Library 461 Dale St. N. Saint Paul	11 AM - 1:30 PM

Persons with disabilities who require reasonable accommodations to participate in a meeting should contact Jen Fox at 651-539-1458 or jennifer.fox@state.mn.us at least five days in advance of the meeting to make appropriate arrangements. Documents can be made available in alternative formats (e.g., large print or audio) by calling 651-539-1458. Persons with hearing loss or speech disabilities may call through their preferred Telecommunications Relay Service.

Attachment G: Reporting Targets

Scope of Coverage/Comparability

Minnesota waiver is not expected to affect eligibility on individual enrollment or on coverage for vulnerable residents, who are more likely to be enrolled in Medicaid or Medicare. Minnesota's waiver will help stabilize participation and will increase in the number of Minnesota residents covered by individual health insurance. The waiver is not expected to have an impact on employer-sponsored insurance.

Total Individual Market Enrollment on and off Marketplace					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	173,000	171,000	169,000	167,000	170,000
2018 Actual					
2019 Projected	173,000	171,000	169,000	167,000	170,000
2019 Actual					
2020 Projected	173,000	171,000	169,000	167,000	170,000
2020 Actual					
2021 Projected	173,000	171,000	169,000	167,000	170,000
2021 Actual					
2022 Projected	173,000	171,000	169,000	167,000	170,000
2022 Actual					

Actual statistics will be monitored through an existing annual survey of carrier individual market enrollment.

Total MinnesotaCare Enrollment					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	83,179	83,179	83,179	83,179	83,179
2018 Actual					
2019 Projected	82,068	82,068	82,068	82,068	82,068
2019 Actual					
2020 Projected	82,427	82,427	82,427	82,427	82,427
2020 Actual					
2021 Projected	83,092	83,092	83,092	83,092	83,092
2021 Actual					
2022 Projected	83,923	83,923	83,923	83,923	83,923
2022 Actual					

Actual statistics will be monitored by a quarterly report supplied by MinnesotaCare.

Small Group Employer Insured Market Enrollment					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	260,000	260,000	260,000	260,000	260,000
2018 Actual					
2019 Projected	260,000	260,000	260,000	260,000	260,000
2019 Actual					
2020 Projected	260,000	260,000	260,000	260,000	260,000
2020 Actual					
2021 Projected	260,000	260,000	260,000	260,000	260,000
2021 Actual					
2022 Projected	260,000	260,000	260,000	260,000	260,000
2022 Actual					

Actual statistics will be monitored through NAIC financial statement data, known as the Supplemental Health Care Exhibit (SHCE) – annual.

Insurance Companies' Government Enrollment (Medicare Advantage, Medicaid/CHIP, Dual Eligibles, MinnesotaCare)					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	1,500,000	1,500,000	1,500,000	1,500,000	1,500,000
2018 Actual					
2019 Projected	1,515,000	1,515,000	1,515,000	1,515,000	1,515,000
2019 Actual					
2020 Projected	1,530,000	1,530,000	1,530,000	1,530,000	1,530,000
2020 Actual					
2021 Projected	1,545,000	1,545,000	1,545,000	1,545,000	1,545,000
2021 Actual					
2022 Projected	1,560,000	1,560,000	1,560,000	1,560,000	1,560,000
2022 Actual					

Actual statistics will be monitored by annual NAIC financial statement data, known as the Supplemental Health Care Exhibit (SHCE), with quarterly interpolations determined by annual enrollment growth.

Affordability

Minnesota's waiver is not expected to affect affordability of coverage in the individual market.

Average Individual Market Premium Contribution Per Member					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	$1,111	$1,111	$1,111	$1,111	$4,443
2018 Actual					
2019 Projected	$1,171	$1,171	$1,171	$1,171	$4,682
2019 Actual					
2020 Projected	$1,233	$1,233	$1,233	$1,233	$4,932
2020 Actual					
2021 Projected	$1,298	$1,298	$1,298	$1,298	$5,192
2021 Actual					
2022 Projected	$1,366	$1,366	$1,366	$1,366	$5,464
2022 Actual					

Actual statistics will be monitored by a new quarterly report supplied by the exchange (MNsure) on premiums after the Advanced Premium Tax Credit (APTC) for those eligible for APTC. Minnesota will not have access to final, reconciled actual PTC data, which is based on personal income tax filings. The data will be enhanced as information from NAIC financial statement data, known as the Supplemental Health Care Exhibit (SHCE) is submitted.

Average Individual Market Premiums Contributions Per Member + Cost Sharing (Total Out-of-Pocket) Per Member					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	$1,226	$1,341	$1,456	$1,571	$5,594
2018 Actual					
2019 Projected	$1,291	$1,411	$1,531	$1,651	$5,883
2019 Actual					
2020 Projected	$1,358	$1,483	$1,608	$1,733	$6,180
2020 Actual					
2021 Projected	$1,428	$1,558	$1,688	$1,818	$6,493
2021 Actual					
2022 Projected	$1,501	$1,636	$1,771	$1,906	$6,846
2022 Actual					

Data source for monitoring actual statistics will be provided by a new quarterly report supplied by the exchange (MNsure) on premiums after the Advanced Premium Tax Credit (APTC) for those eligible for

APTC. Minnesota will not have access to final, reconciled actual PTC data, which is based on personal income tax filings. Gross premium data will be enhanced as information from NAIC financial statement data, known as the Supplemental Health Care Exhibit (SHCE) is submitted. Small group issuers' Unified Rate Review Templates (URRTs) will further inform us on members' out-of-pocket costs and average gross premiums.

Average Small Group Market Premiums Contribution Per Member					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	$316	$322	$328	$334	$1,300
2018 Actual					
2019 Projected	$341	$347	$353	$359	$1,400
2019 Actual					
2020 Projected	$366	$372	$378	$384	$1,500
2020 Actual					
2021 Projected	$391	$397	$403	$409	$1,600
2021 Actual					
2022 Projected	$416	$422	$428	$434	$1,700
2022 Actual					

Data source for monitoring total (employer plus employee) premium actual statistics will be provided from NAIC financial statement data, known as the Supplemental Health Care Exhibit (SHCE) – annual. Based on national survey data, we assume that employees pay for 25 percent of premium in the small employer market.[7] We will apply that statistic to total premium data in order to infer the employee's share of premium costs.

Average Small Group Market Premiums Contribution Per Member + Cost Sharing (Total Out-of-Pocket) Per Member					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	$474	$553	$622	$702	$2,350
2018 Actual					
2019 Projected	$506	$589	$661	$744	$2,500
2019 Actual					
2020 Projected	$539	$625	$700	$787	$2,650
2020 Actual					
2021 Projected	$571	$661	$739	$829	$2,800
2021 Actual					

[7] Kaiser Family Foundation estimates that small employers' employees pay only 15 percent for single coverage but 36 percent for family coverage. See http://kff.org/report-section/ehbs-2015-summary-of-findings/

2022 Projected	$604	$697	$778	$872	$2,950
2022 Actual					

As with the table above, the data source for monitoring actual premium statistics will be provided from NAIC financial statement data, known as the Supplemental Health Care Exhibit (SHCE) – annual. That data will be enhanced as information from small group carriers' Unified Rate Review Templates (URRTs) becomes available, which will annually inform us on members' out-of-pocket costs.

Comprehensiveness

Minnesota is not proposing to waive or amend any aspects of the ACA that pertain to comprehensiveness of benefits.

Proposed Report

Every quarter throughout the waiver period, Minnesota will report on prospective and retrospective changes to federal and state law that affect federal budgetary projections and/or inform emerging experience. This report will also provide a marketplace update (such as enrollment updates, issuer participation, and reinsurance program financial summary).

Deficit Neutrality

Minnesota's waiver is expected to produce substantial savings to the Federal Government.

Federal APTC Spending in Minnesota, With Waiver					
	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Annual
2018 Projected	$80,658,000	$80,658,000	$80,658,000	$80,658,000	$322,600,000
2018 Actual					
2019 Projected	$88,016,000	$88,016,000	$88,016,000	$88,016,000	$352,100,000
2019 Actual					
2020 Projected	$96,064,000	$96,064,000	$96,064,000	$96,064,000	$384,300,000
2020 Actual					
2021 Projected	$104,868,000	$104,868,000	$104,868,000	$104,868,000	$419,500,000
2021 Actual					
2022 Projected	$115,500,000	$115,500,000	$115,500,000	$115,500,000	$458,000,000
2022 Actual					

Actual statistics will be monitored by a new quarterly report supplied by the exchange (MNsure). Minnesota will not have access to final, reconciled actual PTC data, which is based on personal income tax filings.

Federal APTC Spending in Minnesota, With Waiver (By Rating Area)										
Rating Area	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6	Area 7	Area 8	Area 9	Total Annual
2018 Projected	$48,390,000	$32,260,000	$22,582,000	$16,130,000	$19,356,000	$19,356,000	$35,486,000	$122,588,000	$6,452,000	$322,600,000
2018 Actual										
2019 Projected	$52,815,000	$35,210,000	$24,647,000	$17,605,000	$21,126,000	$21,126,000	$38,731,000	$133,798,000	$7,042,000	$352,100,000
2019 Actual										
2020 Projected	$57,645,000	$38,430,000	$26,901,000	$19,215,000	$23,058,000	$23,058,000	$42,273,000	$146,034,000	$7,686,000	$384,300,000
2020 Actual										
2021 Projected	$62,925,000	$41,950,000	$29,365,000	$20,975,000	$25,170,000	$25,170,000	$46,145,000	$159,410,000	$8,390,000	$419,500,000
2021 Actual										
2022 Projected	$68,700,000	$45,800,000	$32,060,000	$22,900,000	$27,480,000	$27,480,000	$50,380,000	$174,040,000	$9,160,000	$458,000,000
2022 Actual										

Actual statistics will be monitored by a new quarterly report supplied by the exchange (MNsure). Minnesota will not have access to final, reconciled actual PTC data, which is based on personal income tax filings.

Supporting information on reporting targets are provided in Appendix 5 of the Actuarial Analysis.

Attachment H: Notice for Tribal Consultation Opportunity for Input

85 7TH PLACE EAST, SUITE 280
SAINT PAUL, MINNESOTA 55101-2198
MN.GOV/COMMERCE
651.539.1500 FAX: 651.539.1547
AN EQUAL OPPORTUNITY EMPLOYER

April 28, 2017

RE: Minnesota 1332 Waiver Request

Dear Tribal Leader:

My name is Danielle Oxendine Molliver and I am the new Tribal Liaison with the Department of Commerce. The state of Minnesota is currently working on a federal 1332 waiver for certain provisions of the Affordable Care Act (ACA.). DHS and Commerce are coordinating outreach efforts, as part of the application process, to tribal communities.

On April 4, Minnesota Laws 2017 Chapter 13 became effective authorizing the creation of a new state-based reinsurance program, the Minnesota Premium Security Plan (MPSP). The goal of the MPSP is to stabilize the state's individual health insurance market and lower premium rates for individual market consumers. The 1332 waiver (attached) requests that the Federal government provide Minnesota with federal funds and assistance normally provided to Minnesotans absent the existence of the reinsurance program.

The ACA requires that states provide opportunities for Tribal Consultation and input as part of the application process. Moreover, Commerce and DHS are committed to their respective Tribal Consultation policies and therefore we request the opportunity, to get your input on the best next steps to meaningfully engage and outreach to your community if applicable.

States have the option to seek a State Innovation Waiver under Section 1332 of the Affordable Care Act to pursue innovative strategies to provide high quality, affordable health care coverage while retaining the statute's basic protections. The U.S. Department of Health and Human Services (HHS) and the U.S. Department of the Treasury are responsible for reviewing waiver applications.

Prior to submitting a State Innovation Waiver application to HHS for review and consideration, a state must provide public notice and a comment period sufficient to ensure a meaningful level of public input on the application. During the public comment period, the state must conduct public hearings regarding the state's application.

Section 1332 does not change existing waiver authority for provisions in other Federal health programs such as Medicaid or Medicare (including waiver authorities under section 3021 specific to the Center on Medicare and Medicaid Innovation or under section 1115 related to Medicaid and CHIP.) However, states may apply for such waivers as part of the Secretary's coordinated application

Commerce will have materials on its website to which you can direct members to as well as public notices of meetings. As part of our tribal outreach, in coordination with DHS, there will be a brief presentation to the Tribal Health Director's at their regularly scheduled meeting. There will also be a webinar available, and there will be a brief presentation at the Minnesota Indian Affairs Council (MIAC) meeting May 25, 2017.

If you would like to discuss, have questions/concerns please do not hesitate to contact me. If you believe we need to provide more tailored information for your leadership and/or members, we are happy to do so through coordination and/or consultation.

Sincerely,

Danielle Oxendine Molliver

Department of Commerce, Tribal Liaison

Attachment I: Written Response to Open Comment Period

COURT INTERNATIONAL BUILDING
2550 UNIVERSITY AVENUE WEST
SUITE 255 SOUTH
ST. PAUL, MINNESOTA 55114
651-645-0099 FAX 651-645-0098

May 24, 2017

Commissioner Mike Rothman
Minnesota Department of Commerce
Attn: 1332 Waiver Draft Application
85 7th Place East, Suite 280
St. Paul, MN 55101

RE: Section 1332 State Innovation Waiver

Dear Commissioner Rothman:

On behalf of the members of the Minnesota Council of Health Plans, thank you for the work you and your staff have done preparing the Section 1332 State Innovation Waiver application. We offer three comments on the draft application.

First, the Minnesota Council of Health Plans strongly supports the Minnesota Premium Security Plan ("MPSP") to provide a state reinsurance program. We strongly support the Section 1332 State Innovation Waiver request that will be submitted to allow Minnesota to implement a reinsurance program without negatively affecting federal funding for the state Basic Health Plan, MinnesotaCare.

Second, we note that the Department seeks a waiver to ACA section 1312(c)(1) "to maximize the rate-lowering impact of the reinsurance program . . . to the extent it would otherwise require excluding total expected state reinsurance payments when establishing the market wide index rate." The Council speculates that the intent of this waiver is to include the MPSP as an allowable adjustment for the calculation of the market adjusted index rate in the Unified Rate Review Template. The Unified Rate Review Template included the temporary reinsurance program administered by CMS for plan years 2014 through 2016 as an allowable adjustment, but the current federal rating rules do not allow for an adjustment. We support the goal for this request and recommend the draft waiver application be amended to clarify that the request to waive the limitations of what is a permitted market-wide adjustment in calculating the Market Adjusted Index Rate to include the MPSP as an allowable market-wide adjustment.

If this is not the intent of this request, the Council questions the need to waive the single risk pool requirement and requests more information on the rationale and the desired impact of the request. The single risk pool requirement remains an important requirement for market stabilization, and the Council recommends seeking only the waiver that is necessary for the MPSP to impact rates to the fullest extent under the program.

Blue Cross and Blue Shield/Blue Plus of Minnesota ■ HealthPartners ■ Medica
Hennepin Health ■ PreferredOne ■ Sanford Health Plan of Minnesota ■ UCare

Third, under ACA section 1332(e), the state is permitted to seek waiver authority for a full five-year period. We believe it would be prudent to seek the waiver for the full five-year period. This would provide the ongoing flexibility to the state necessary to return stabilization to the market. The Department will always have the ability to seek amendments to the waiver in the future, as needed.

Again, thank you for the opportunity to comment on the waiver application. The Council stands prepared to assist in gaining the necessary federal approval in a timely manner to ensure the Minnesota Premium Security Plan is fully in place for the 2018 plan year.

Sincerely,

Jim Schowalter
President

Blue Cross and Blue Shield of Minnesota
and Blue Plus
P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-8000 / (800) 382-2000

May 24, 2017

Commissioner Mike Rothman
Minnesota Department of Commerce
85 7th Place East, Suite 280
Saint Paul, MN 55101
Submitted via electronic mail to WaiverComments@state.mn.us

Re: 1332 Waiver Draft Application

Dear Commissioner Rothman:

Blue Cross and Blue Shield of Minnesota and Blue Plus (Blue Cross) strongly supports Minnesota's 1332 Waiver Application.

The Minnesota Premium Security Plan (MPSP) is a critical to supporting Minnesotans with individual insurance coverage and helping stabilize the market. By tying funding to those Minnesotans with high-cost medical individual (non-group) claims, the reinsurance structure of the MPSP will provide up to $542 million in funding to mitigate rates for both 2018 and 2019 plan years. If approved, the MPSP is expected to support premium stability year over year, stemming the continued declining enrollment of our individual market. Additionally, given that federal funding for the Basic Health Plan (BHP) is based upon the Advance Premium Tax Credits, this waiver is critical to maintaining current funding for MinnesotaCare, our version of the BHP.

This requested 1332 Waiver – similar to the Alaska waiver request – would permit the federal government's savings in reduced Premium Tax Credits to be passed through to the MPSP. Accordingly, the state would be held harmless from solely providing its own dollars to support the reinsurance program and help stabilize the market for Minnesotans. As you know, time is of the essence given that 2018 rates must be filed by July 17th. Thank you for your work to gain timely federal approval in order for the reinsurance program to impact 2018 rate filings.

Blue Cross identified one area of concern and clarification: the request to waive the single risk pool requirement under the draft 1332 waiver application. The single risk pool requirement under Section 1312(c)(1) is the bedrock of consumer and market protections under federal health care reform. Blue Cross recognizes that federal guidance limits the ability for the full application of the MPSP as it impacts rates, thus necessitating a change to the single risk pool requirement. Therefore, we recommend that the draft 1332 Waiver application be amended to narrowly tailor the request to instead waive the limitations under 45 CFR 156.80(d)(1) for the calculation of the Market Adjusted Index Rate to allow the MPSP to be a permitted market-wide adjustment to the Index Rate, thus maintaining the broader protections under the single

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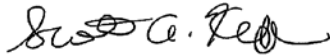
risk pool requirement. The state should specifically seek a waiver to permit the market-wide adjustments to the Index Rate to include (suggested new language underlined below):

- Adjustment for the Risk Adjustment program
- Marketplace user fee adjustment, and
- Adjustment for the state-based reinsurance program, Minnesota Premium Security Plan.

We hope this suggestion is helpful to deriving full benefit of the intended financial support from the waiver, while maintaining the integrity of the single risk pool. Blue Cross appreciates the opportunity to provide input and stands ready to assist your team and the state to gain the required approval in time to impact 2018 premium rates. Please do not hesitate to contact me directly at Scott.Keefer@bluecrossmn.com or 651-662-8786.

Sincerely,



Scott Keefer
Vice President, Public Affairs
Blue Cross and Blue Shield of Minnesota

HealthPartners
8170 33rd Avenue South
Bloomington, MN 55425

healthpartners.com

Mailing Address:
PO Box 1309
Minneapolis, MN 55440-1309

May 30, 2017

Commissioner Mike Rothman
Minnesota Department of Commerce
Attn: 1332 Waiver Draft Application
85 7th Place East, Suite 280
St. Paul, MN 55101

RE: Section 1332 State Innovation Waiver

Dear Commissioner Rothman:

On behalf of HealthPartners, we appreciate the fast and thorough work that your department has done in preparing the Section 1332 State Innovation Waiver application.

We strongly support the Minnesota Premium Security Plan, the state reinsurance program, recently passed by the Legislature. We also support the Section 1332 State Innovation Waiver request that will be submitted to allow Minnesota to implement a reinsurance program without negatively affecting federal funding for the Basic Health Plan, MinnesotaCare.

I would like to share two observations that may impact the program's effectiveness and overall equity:

- **Acknowledge and /or adjust program to reflect varying provider payment rates or regional unit cost differentials**
  "Using a dollar threshold approach to reimburse plans for high-cost enrollees can cause some inequities among insurers. .... Insurers in low-cost areas may benefit less from this approach than insurers in high-cost areas." American Academy of Actuaries Issue Brief, Using High-Risk Pools to Cover High-risk Enrollees", February 2017.

  In a reinsurance program, a dollar threshold approach can cause inequities among insurers and areas, which can be exacerbated when carriers compete in varying parts of the state. While the draft actuarial analysis uses the entire state as its unit of analysis which is reasonable for the purposes of a federal waiver, it sets an unrealistic expectation that the impact of reinsurance will be uniform across the state.

  Providers' negotiated reimbursement varies widely around the state. Unit prices in the Twin Cities' rating area are much lower than in certain other rating areas. As a result, the favorable effects of reinsurance will be much smaller in the Twin Cities than elsewhere. **The 1332 Waiver Application's narrative should make clear that the effects of reinsurance will vary dramatically across the state of Minnesota.**

One mechanism to mitigate this effect would be to cap claims at 150% (or other) of Medicare fees before submitting for reinsurance. Calculating reinsurance reimbursement using standardized claim

payment amounts could help avoid market distortions related to fee schedules. Health plans could adjust claims to a common fee schedule, such as a defined percentage of Medicare. This idea could be included for 2018 or for 2019, based on 2018 rate experience.

- **To mitigate the interaction between reinsurance and risk adjustment, use claims net of revenue received.**
  "If a high-risk pool program is in place, it should be coordinated with the risk adjustment program, otherwise insurers would be compensated twice for the same risk." American Academy of Actuaries Issue Brief, How Changes to Health Insurance Market Rules Would Affect Risk Adjustment, May 2017

  The reinsurance program, as designed, creates incentives that could distort the market due to the interaction with the risk adjustment program. The draft waiver application recognizes this fact in a footnote on page 30. Moving to a state specific risk adjustment program is an overly expensive approach that will further raise individual premiums. State administration of risk adjustment *"would require significant resources ....economies of scale would be lost." American Academy of Actuaries Issue Brief, How Changes to Health Insurance Market Rules Would Affect Risk Adjustment, May 2017.*

  Simply reducing claims by revenues received would reduce the market distortion without significant resource expense. If the state were to base reinsurance reimbursement on claims net of revenues received (i.e., claims minus premiums minus member specific risk adjustment transfer), that would help address this issue. **Base the reinsurance program on claims net of revenues for 2018 or by 2019.**

In addition, we suggest that the Minnesota Comprehensive Health Association consider changes to the attachment points in future years. If one goal of the program is to stabilize the market by protecting health plans from high claims, the lower and upper attachment points should be set significantly higher. This would also reduce the interaction with the risk adjustment program.

Thank you for the opportunity to comment on the waiver application. We are available to assist or advise on the impact of the reinsurance program on the individual market going forward. We hope timely approval of Minnesota's 1332 Waiver Application to ensure the Minnesota Premium Security Plan is fully in place for the 2018 plan year.

Sincerely,

Donna Zimmerman
Sr. Vice President, Government & Community Relations
HealthPartners

MINNESOTA

Actuarial Analysis and Certification for the Minnesota Section 1332 Waiver Application

Minnesota Department of Commerce

Division of Insurance

May 30, 2017

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Introduction

This actuarial report supplements the related 1332 waiver application seeking federal funding for Minnesota's individual market. The report also illustrates the impact of this waiver on federal funding to Minnesota's Basic Health Plan (BHP) as neutral to the federal deficit. The report also demonstrates that over a range of reasonable scenarios, projected federal spending net of federal revenues under the waiver will be equal to or lower than projected federal spending net of federal revenues in the absence of the waiver.

This actuarial report is designed to be read in concert with the waiver application.

Targets and Modeling Overview

The main goals of Minnesota's reinsurance program are to reduce premium rates from where they would be without the program and to encourage healthy people to participate in the individual market. The state legislation that created Minnesota's reinsurance program, the Minnesota Premium Security Plan (MPSP), establishes 2018 payment parameters that will provide health insurers with 80 percent coinsurance at an attachment point of $50,000 and a reinsurance cap of $250,000 for plan year 2018.

The resulting lower premium rates will save the federal government money through lower individual market premium tax credits (PTCs). These savings are modeled to be approximately $138 million to $167 million in 2018 under a wide range of scenarios (see Tables A-3 and A-5), reflecting reasonable ranges of premium levels, enrollment, inflation, morbidity, and second-lowest silver premiums.

Decreases to federal revenues or increases to federal spending are also modeled. The most material factors are reduction in individual shared responsibility payment revenue and reduction in health insurance providers' fee revenue. These losses are estimated to be approximately 4 to 7 percent of the federal premium tax credit savings over the 10-year budget projection period.

Commerce evaluated extensive data sources in order to model how the MPSP will affect the premium tax credits. Commerce also modeled the likely premium support delivered and the progression of the major funding sources over the required 10-year budget forecast period at level state financing amounts and resulting premium subsidy scenarios. Commerce modeled a range of reasonable enrollment and inflation scenarios. The MPSP modeling shows that Minnesota will derive a portion of financial support from the new state funding source and a portion from the federal government reflecting the difference in premium tax credits[1] with and without the MPSP.

[1] Section 36B of the Internal Revenue Code (IRC) describes premium tax credits.

In addition, Minnesota has a BHP, MinnesotaCare. The BHP funding formula is tied to the second-lowest silver plan in the market, meaning that federal funding for the program would be directly affected by the existence of the MPSP. However, as modeled in this report, the impact of this waiver to support the MPSP is neutral to both state and federal budgets.

Values modeled in this report are illustrative only; the formula to be used is not publicly known and is not an element that is possible to be requested as part of the waiver application.

The following analyses and actuarial certification demonstrate that the proposed waiver will comply with the uninsured rate and the federal deficit requirements of Section 1332 of the Affordable Care Act (ACA). The results section is broken into the following subjects:

- A discussion of the major assumptions affecting the state's strategy and federal savings.
- Documentation for the selected distribution model for the subsidy, which is similar to the temporary federal reinsurance program that was in place from 2014 through 2016.
- Scenario modeling of the individual market subsidy appropriations, subsidy pool (including from state and federal waiver sources), federal total savings for the individual market, and the final second-lowest silver and average premiums with the subsidy applied. Multiple scenarios are modeled in order to provide a 10-year budget outlook and summary and to ensure requirements are met over a range of reasonably likely scenarios.
- Major findings based on the modeled scenarios.

Scenario Modeling Approach and Major Assumptions

Calculating the difference between federal premium tax credits with and without the waiver requires estimates of the number of enrollees receiving premium tax credits with and without the waiver and estimates of the average second-lowest silver premium rate with and without the waiver.

These factors or inputs (such as age/rating area mix, medical trend, health of enrollees) are unknown for 2018 and beyond. For this reason, Commerce utilized a scenario modeling approach as an effective manner for modeling federal savings over the required 10-year period because there are many reasonably likely scenarios over such a period. A scenario modeling approach also aids in coupling assumptions that tend to correlate, either positively or negatively, to one another. For example, a high premium level is correlated to lower enrollment. The state modeled 18 reasonably likely scenarios based on a reasonable range of possibilities regarding the most critical factors.

Assumptions Used in Model

Here is a description of the input factors that were modeled: (L – low but reasonable, M – mid estimate, and H – high but reasonable):

- **2018 second-lowest silver premium with/without any waiver or state legislation**: Because enrollment in 2017 decreased significantly, Commerce modeled the 2018 average premiums (across all metal levels, ages, and rating areas) from the 2017 estimated value of $560 to a range of three values: $668.00 (L-Prm), $688.00 (M-Prm), and $708.00 (H-Prm). The corresponding average second-lowest silver premiums were modeled from the 2017 estimated value of $540.65 to a range of six values. These values start with the 2017 relationship between average second-lowest silver premium and average premium (97 percent). However with the new de minimis variation rules that will likely reduce the relativity, the 2018 best estimate for this relationship is 94%. Three of the values modeled use a 94 percent relationship, and these values are: $628 (L-Prm), $647 (M-Prm), and $666 (H-Prm). The other three values are based on a 98 percent relationship between average second-lowest silver premium and average premium, which assumes greater acceleration of the marketwide shift from higher-value metal level plans to bronze plans. For 2018, these values are: $655 (L-Prm), $674 (M-Prm), and $694 (H-Prm).
    - The second-lowest silver premium before and after the waiver has a direct impact on the premium tax credit savings. The basis for this relational assumption is discussed in detail in the Data Sources section of this report.

- **Individual market premium inflation**: The state modeled that premiums on the individual market after 2018 could take different paths of inflation. Assuming that the market would be stable after 2018, Commerce assumed the following average inflation levels: 5 percent (L-inf), 6.5 percent (M-inf), and 10 percent (H-inf). The cost of the MPSP is assumed to increase at a rate 3.5 percent higher than market premium inflation under each of the three inflation scenarios. The reinsurance program trend rate is assumed to be higher than the premium inflation trend rate because the trend is more highly leveraged.

- **2018-2027 individual market enrollment with/without the waiver**: The state modeled the following scenarios for enrollment with/without the waiver: 160,000/140,000 (L-En), 170,000/150,000 (M-En), and 190,000/160,000 (H-En). These levels are low in comparison to peak enrollment numbers in 2015. These scenarios acknowledge that, even with the MPSP, some people may not return to the individual market at the subsidized premium rates due to past experiences, newly-found insurance alternatives, or the likelihood that premium rates will still rise from year to year even with the MPSP. If enrollment returns to prior levels, federal savings would be greater than what is modeled in this report because morbidity savings would be even larger than modeled. Because healthy enrollees are more likely than sick enrollees to forego insurance and pay the individual shared responsibility payment, the L-En / H-Prem scenario is modeled to reflect this negative correlation.

- **Premium tax credit-eligible enrollee count**: Based on the respective eligibility scenario described above, the following numbers of premium-tax-credit-eligible enrollees were modeled: 75,000 (L), 77,000 (M) and 85,000 (H). Note that the range of members is relatively small because these enrollees are price

insensitive, given that the federal government subsidizes the rate increases under the various inflationary scenarios. The range is included because Minnesota has historically had an atypically low level of both subsidized enrollees and proportional use of the exchange. The proportion of premium tax credit eligible enrollees as compared to the entire individual enrollee count has a direct impact on the premium tax credit savings.

- **Risk margin**: Health insurers' risk margin on MPSP impacts is estimated to be 10 percent. It is assumed that only 90 percent of the aggregate subsidy will be passed on to policyholders due to carriers' uncertainty related to acute claims in excess of $50,000.

Distributions from Minnesota Premium Security Plan to Health Insurers

The MPSP is very similar in design to the temporary federal reinsurance program that was in place from 2014 through 2016. The parameters for 2018, set in law, are:

Attachment Point: $50,000

Coinsurance Rate: 80%

Reinsurance Cap: $250,000

As an example of the payments to carriers, if a person has $60,000 of claims in 2018, the reimbursement to the carrier would be:

$8,000 = [80% * (60,000 - 50,000)]

If a person has $600,000 of claims in 2018, the reimbursement to the carrier would be:

$160,000 = [80% * (250,000 – 50,000)]

The Minnesota Comprehensive Health Association (MCHA) will administer the MPSP, collect data to determine reinsurance payments, and disburse reinsurance payments to each eligible health carrier. After plan year 2018, the MCHA Board will determine the payment parameters each year, taking into account available funding, to ensure stabilized premiums, increased market participation, improved access to providers, and mitigation of the impact of high-risk individuals.[2]

The studies performed to verify the cost of aggregate subsidy provided by the MPSP are provided in the Appendices.

[2] MPSP program operations are discussed in greater detail in the 1332 waiver application.

Calculation of Second-Lowest Silver Premiums Before and After the Waiver

The second-lowest silver premiums are calculated in the manner described below, using the "mid scenario" of each varying assumption in order to illustrate the calculation:

- The subsidy to the individual market ($271 million in 2018) is divided by the post-waiver enrollment (170,000 in 2018). See Appendix 1 for development of the $271 million subsidy amount from the 2018 parameters.
- This figure is multiplied by 90 percent to reflect the possibility that carriers may, on average, apply a 10 percent risk margin on MPSP impacts; i.e., it is assumed only 90 percent of the aggregate subsidy will be passed on to policyholders.
- This figure is divided by 12, which leads to a per member per month average discounted premium ($119.56 in 2018). The proportional amount of discount applicable to the average premium applies across all ages, metal levels, and rating areas.[3]
- Because the MPSP improves the risk pool's morbidity (subsidized premiums attract additional healthier enrollees to participate), a price elasticity assumption was developed. The state estimates that for each $1 change in average monthly premium, the Minnesota individual market will change by 500 enrollees. More detail on the price elasticity assumption is provided in the "Effect on Minnesotans with Insurance" section of this report.
- The assumed 2018 average premium prior to the waiver and prior to accounting for price elasticity is $688. Assuming 20,000 more people would enroll in 2018 with the waiver than without the waiver, the assumed 2018 average premium after accounting for price elasticity of demand is $648.
- The estimated 2018 average premium after the waiver is $648.00 – 119.56 = $528.44.
- Applying a 94 percent ratio of average second-lowest silver premium to average market-wide premium, the assumed 2018 average second-lowest silver premium prior to the waiver and prior to accounting for elasticity of demand is $646.72.
- Based on a 94 percent between the average second-lowest silver premium and estimated average marketwide premium, the 2018 average second-lowest silver premium after the waiver is $609.12 - $112.39 = $496.73.[4]
- Therefore, the comparison of federal tax credits is based on a pre-waiver second-lowest silver premium of $646.72 and a post-waiver second-lowest silver premium of $496.73.
- The difference is multiplied by 77,000 enrollees expected to receive Federal tax credits, for total Federal savings related to lower tax credits of $138.6 million.

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[3] Although issuers have varied premium levels, risk margins, and MPSP valuations, the risk adjustment program has the effect of converging premiums to a large degree.

[4] Note that the second-lowest silver premiums are available to all individual market enrollees: those who receive premium tax credits and those who do not. In other words, this is another reason why the model should reflect that everyone in the risk pool plays a role in determining the federal savings, not just those who receive premium tax credits.

- An affordability adjustment, “income factor”, of 0.2 percent is made to recognize that a portion of the individual market population that will receive a full premium tax credit without the waiver will not receive it with the waiver (see Appendix 3). The resulting total Federal savings related to lower tax credits is $138.3 million.

10-Year Forecast: Mid-Scenario Results

Focusing on the "mid" estimates for each modeled assumption, the following tables provide detail on how all of the 18 scenario calculations shown later were developed.

Mid estimate assumptions:

Individual market premium inflation: **6.5%**
Subsidy inflation: **10%**

2018-2027 Enrollment with/without waiver: **170,000/150,000**
Premium tax credit eligible enrollee count: **77,000**

2018 Carrier Premium without waiver[5]: **$688.00 (average)**
2018 Carrier Premium without waiver: **$646.72 (average second-lowest silver)**

Income Factor[6] **0.2 percent**

Table A-1

Year	Enrollment without Waiver	Enrollment with Waiver	Modeled Second Lowest Silver (without waiver)	Modeled Second Lowest Silver (with waiver and reflects waiver)	Federal Premium Tax Credit Savings	Subsidy to Individual Market Inflated with leveraged trend
2016	267,000	267,000		90%	99.8%	10%
2017	170,000	170,000		issuer reinsurance risk margin	Adjustment for Income Factor	leveraged trend (reinsurance)
2018	150,000	170,000	$ 646.72	$ 496.73	$ 138,309,239	$ 271,000,000
2019	150,000	170,000	$ 688.76	$ 525.09	$ 150,926,611	$ 298,100,000
2020	150,000	170,000	$ 733.53	$ 554.89	$ 164,726,839	$ 327,910,000
2021	150,000	170,000	$ 781.21	$ 586.20	$ 179,823,082	$ 360,701,000
2022	150,000	170,000	$ 831.98	$ 619.07	$ 196,339,480	$ 396,771,100
2023	150,000	170,000	$ 886.06	$ 653.55	$ 214,412,234	$ 436,448,210
2024	150,000	170,000	$ 943.66	$ 689.70	$ 234,190,786	$ 480,093,031
2025	150,000	170,000	$ 1,004.99	$ 727.56	$ 255,839,120	$ 528,102,334
2026	150,000	170,000	$ 1,070.32	$ 767.18	$ 279,537,188	$ 580,912,568
2027	150,000	170,000	$ 1,139.89	$ 808.62	$ 305,482,484	$ 639,003,824

Consideration of BHP pass through with the waiver is described in a separate section of this report. Considerations of economic factors increasing federal net costs, including reduction in shared responsibility payments, reduction in health insurer providers' fees, and administrative fees are described in the Economic Analysis section near the end of this report.

[5] Per Minnesota Statutes section 62E.22, health carriers must submit as part of their rate filings the premium amount the carrier would have charged without the MPSP. This data could be used by federal staff to verify savings.
[6] A small portion of individual market enrollees who would otherwise be eligible for premium tax credits will not receive them due to post-waiver premiums falling below certain percentage of household income levels. See Appendix 3.

The 20,000 additional people who are estimated and assumed to be in the market who would not be in the market without the MPSP are assumed to be ineligible for premium tax credits and cost sharing reduction (CSR) subsidies because premium escalations that caused the disenrollment from the individual market did not financially affect those with federal subsidies. The MPSP has no affordability impact for those who qualify for such subsidies.

Scenario Results / Various Second-Lowest Silver Rates

The first nine scenarios modeled and shown below illustrate various premium/subsidy inflation levels and enrollment/premium scenarios. The model assumes that the second-lowest silver rate will be 94 percent of the average market premium, which starts with the mathematical relationship estimated to occur in plan year 2017 based on the most current data sources and includes an adjustment in consideration of the new de minimis variation rules. The connection of the second-lowest silver to the risk pool average is discussed at length later in this report.

Table A-2

Inflation (Premium, Subsidy)	Enrollment/ Premium	Total Subsidy Pool (millions) for sample years				State Portion of Subsidy Pool	Modeled 2018 Second Lowest Silver (94%)
		2018	2019	2023	2027	2018-2027	With Waiver Applied
Mid Estimate	M-En / M-Prm	$271	$298	$436	$639	49.0% - 52.2%	$497
Mid Estimate	L-En / H-Prm	$271	$298	$436	$639	48.0% - 51.1%	$509
Mid Estimate	H-En / L-Prm	$271	$298	$436	$639	41.0% - 46.4%	$471
Low/Reasonable	M-En / M-Prm	$271	$294	$407	$565	49.0% - 52.2%	$497
Low/Reasonable	L-En / H-Prm	$271	$294	$407	$565	48.0% - 51.1%	$509
Low/Reasonable	H-En / L-Prm	$271	$294	$407	$565	41.0% - 46.5%	$471
High/Reasonable	M-En / M-Prm	$271	$308	$510	$847	49.0% - 52.1%	$497
High/Reasonable	L-En / H-Prm	$271	$308	$510	$847	48.0% - 51.0%	$509
High/Reasonable	H-En / L-Prm	$271	$308	$510	$847	41.0% - 46.2%	$471

Table A-3

Inflation (Premium, Subsidy)	Enrollment/ Premium	IRC 36B Funding Section 1332 Waiver Request = Federal Savings (millions) (Individual Market)			
		2018	2019	2023	2027
Best Estimate	M-En / M-Prm	$138	$151	$214	$305
Best Estimate	L-En / H-Prm	$141	$154	$219	$312
Best Estimate	H-En / L-Prm	$160	$174	$244	$343
Low/Reasonable	M-En / M-Prm	$138	$149	$200	$270
Low/Reasonable	L-En / H-Prm	$141	$152	$204	$276
Low/Reasonable	H-En / L-Prm	$160	$171	$227	$302
High/Reasonable	M-En / M-Prm	$138	$156	$251	$406
High/Reasonable	L-En / H-Prm	$141	$159	$256	$415
High/Reasonable	H-En / L-Prm	$160	$179	$285	$455

The next nine scenarios modeled and shown below illustrate various premium/subsidy inflation levels and enrollment/premium scenarios. The model assumes that the second-lowest silver rate will be 98 percent of the average market premium. This relationship reflects a scenario where a higher-than-expected number of enrollees migrate from higher cost-sharing plans to bronze plans than expected in the scenarios shown above.

Table A-4

Inflation (Premium, Subsidy)	Enrollment/ Premium	Total Subsidy Pool (millions) for sample years				State Portion of Subsidy Pool	Modeled 2018 Second Lowest Silver (98%)
		2018	2019	2023	2027	2018-2027	With Waiver Applied
Mid Estimate	M-En / M-Prm	$271	$298	$436	$639	46.8% - 50.2%	$518
Mid Estimate	L-En / H-Prm	$271	$298	$436	$639	45.7% - 49.0%	$530
Mid Estimate	H-En / L-Prm	$271	$298	$436	$639	38.5% - 44.1%	$491
Low/Reasonable	M-En / M-Prm	$271	$294	$407	$565	46.8% - 50.2%	$518
Low/Reasonable	L-En / H-Prm	$271	$294	$407	$565	45.7% - 49.1%	$530
Low/Reasonable	H-En / L-Prm	$271	$294	$407	$565	38.5% - 44.2%	$491
High/Reasonable	M-En / M-Prm	$271	$308	$510	$847	46.8% - 50.1%	$518
High/Reasonable	L-En / H-Prm	$271	$308	$510	$847	45.7% - 48.9%	$530
High/Reasonable	H-En / L-Prm	$271	$308	$510	$847	38.5% - 44.0%	$491

Table A-5

Inflation (Premium, Subsidy)	Enrollment/ Premium	IRC 36B Funding Section 1332 Waiver Request = Federal Savings (millions) (Individual Market)			
		2018	2019	2023	2027
Best Estimate	M-En / M-Prm	$144	$157	$224	$318
Best Estimate	L-En / H-Prm	$147	$160	$228	$326
Best Estimate	H-En / L-Prm	$167	$181	$254	$357
Low/Reasonable	M-En / M-Prm	$144	$155	$209	$281
Low/Reasonable	L-En / H-Prm	$147	$158	$213	$288
Low/Reasonable	H-En / L-Prm	$167	$179	$237	$315
High/Reasonable	M-En / M-Prm	$144	$162	$262	$423
High/Reasonable	L-En / H-Prm	$147	$166	$267	$433
High/Reasonable	H-En / L-Prm	$167	$187	$297	$475

Additional considerations and background on these scenarios are provided in the "Assumptions and Methods Section" and the "Data Sources" sections of this report.

Effect on Minnesotans with Insurance

One of the key requirements of a Section 1332 waiver is that the overall strategy must support and demonstrate that more people will have health insurance due to the proposed waiver. Because the MPSP supports significantly lower premiums, more Minnesotans will be able to afford insurance or be willing to purchase the insurance as it will be more valuable (that is, the same comprehensive benefits will be available at a significantly lower price). Enrollment scenarios presented in the scenario model support this conclusion. Additional information on price elasticity assumptions is included in this section.

The level of overall enrollment shown in the scenarios recognizes that many people have left the individual market in 2016 and 2017. The association between enrollment and premium is based on the price elasticity estimated in the Minnesota individual marketplace. In order to model Minnesota's price elasticity, Commerce reviewed the 2015 premium and enrollment data from the issuers' Uniform Rate Review Template (URRT) and compared the data to the modeled average 2016 premiums as well as the enrollment level for 2016. Minnesota estimates that for each $1 change in average monthly premium, the Minnesota individual market is expected to change by 500 enrollees. The reasonableness of this relationship was verified by reviewing 2017 premiums and estimated 2017 enrollment. The state assumed that after 2018, enrollment will hold level regardless of health premium inflation in order to focus on the "with" versus "without" subsidy analysis. More detail regarding the price elasticity assumption is provided in the "Assumptions and Methods" section of this report.

Discussion of Findings

Neutral federal deficit impact is a reliable outcome of the MPSP under all future economic scenarios.

Overall, Commerce's modeling projects that the federal deficit will not increase under any modeled scenario, even after inclusion of funding to offset savings from the difference in premium tax credits before and after the MPSP.

Additional Details on Assumptions and Methods

2017 Average and Second-Lowest Silver Premiums

While 2017 premium rates are known, final enrollment totals, as well as a breakdown of plan enrollment within the individual market, is not yet publicly available. To develop average 2017 premium estimates for the starting basis of the model, Commerce used actual April 2016 enrollment proportional counts by metal level, age and rating area (see Data Sources and Table A-6 below), combined with actual premiums for 2017. Commerce assumed that within a metal level, people would select a plan that on average would be similar to the average of the lowest and average price point within a metal level. Based on actual Minnesota experience with a high degree of enrollment changes towards bronze and away from gold, Commerce modeled that bronze enrollment will increase by 3 percent, to the detriment of gold enrollment in the "mid" scenario. Although 2017 rate increases are proportional across ages, they have disparate dollar impact and thus affordability impact across age groups. As federal subsidy support is disproportionately directed towards older ages, distribution across age groups is assumed to be materially the same as in 2016.

Table A-6

In Force on 4/1/2016	TOTAL	Child (<18)	18-21	22-29	30-39	40-49	50-59	60-64	65+
Catastrophic	3.5%	0.7%	0.4%	2.4%	0.1%	0.0%	0.0%	0.0%	0.0%
Bronze	47.2%	7.4%	2.2%	3.0%	6.0%	6.6%	12.2%	9.7%	0.1%
Silver	24.4%	3.8%	1.2%	2.3%	3.6%	3.6%	5.6%	4.2%	0.1%
Gold	21.2%	4.2%	1.0%	2.1%	3.3%	3.4%	4.4%	2.8%	0.1%
Platinum	3.7%	0.6%	0.2%	0.4%	0.6%	0.7%	0.7%	0.4%	0.0%

Second-lowest silver 2017 premiums by county are shown in Table A-7 and an estimate of the average 2017 premium within a metal level is shown in Table A-8.

Table A-7

County	Actual 2016 Individual Market Enrollment by County as a Percentage of Total MN Individual Market Enrollment	Actual 2017 Second Lowest Silver Rate by County
Aitkin	0.31%	$ 560.54
Anoka	5.01%	$ 481.39
Becker	0.76%	$ 612.40
Beltrami	0.62%	$ 560.54
Benton	0.69%	$ 491.02
Big Stone	0.26%	$ 644.57
Blue Earth	1.10%	$ 646.34
Brown	0.69%	$ 730.46
Carlton	0.41%	$ 584.36
Carver	2.33%	$ 481.39
Cass	0.69%	$ 560.54
Chippewa	0.31%	$ 644.57
Chisago	0.95%	$ 552.67
Clay	0.82%	$ 612.40
Clearwater	0.16%	$ 620.89
Cook	0.17%	$ 584.36
Cottonwood	0.33%	$ 730.46
Crow Wing	1.34%	$ 560.54
Dakota	6.94%	$ 481.39
Dodge	0.28%	$ 730.52
Douglas	1.08%	$ 612.40
Faribault	0.43%	$ 646.34
Fillmore	0.44%	$ 730.52
Freeborn	0.59%	$ 730.52
Goodhue	0.79%	$ 730.52
Grant	0.24%	$ 612.40
Hennepin	23.71%	$ 481.39
Houston	0.36%	$ 730.52
Hubbard	0.44%	$ 560.54
Isanti	0.59%	$ 552.67
Itasca	0.62%	$ 584.36
Jackson	0.30%	$ 730.46
Kanabec	0.23%	$ 557.39
Kandiyohi	0.94%	$ 644.57
Kittson	0.19%	$ 558.79
Koochiching	0.20%	$ 584.36
Lac qui Parle	0.31%	$ 644.57
Lake	0.17%	$ 584.36
Lake of the Woods	0.16%	$ 607.74
Le Sueur	0.42%	$ 646.34
Lincoln	0.19%	$ 730.46
Lyon	0.60%	$ 644.57
Mahnomen	0.08%	$ 620.89
Marshall	0.45%	$ 558.79

Table A-7 Continued

County	Actual 2016 Individual Market Enrollment by County as a Percentage of Total MN Individual Market Enrollment	Actual 2017 Second Lowest Silver Rate by County
Martin	0.52%	$ 646.34
McLeod	0.72%	$ 642.95
Meeker	0.56%	$ 644.57
Mille Lacs	0.48%	$ 560.54
Morrison	0.89%	$ 560.54
Mower	0.35%	$ 730.52
Murray	0.37%	$ 730.46
Nicollet	0.49%	$ 628.42
Nobles	0.50%	$ 730.46
Norman	0.62%	$ 620.89
Olmsted	1.17%	$ 730.52
Otter Tail	1.30%	$ 612.40
Pennington	0.23%	$ 558.79
Pine	0.38%	$ 560.54
Pipestone	0.34%	$ 730.46
Polk	0.73%	$ 558.79
Pope	0.57%	$ 612.40
Ramsey	6.86%	$ 481.39
Red Lake	0.11%	$ 558.79
Redwood	0.56%	$ 730.46
Renville	0.62%	$ 644.57
Rice	0.85%	$ 646.34
Rock	0.35%	$ 730.46
Roseau	0.33%	$ 518.91
Scott	2.93%	$ 481.39
Sherburne	1.73%	$ 481.39
Sibley	0.39%	$ 642.95
St. Louis	2.31%	$ 584.36
Stearns	3.01%	$ 491.02
Steele	0.39%	$ 730.52
Stevens	0.39%	$ 612.40
Swift	0.30%	$ 644.57
Todd	0.56%	$ 560.54
Traverse	0.18%	$ 612.40
Wabasha	0.39%	$ 730.52
Wadena	0.43%	$ 560.54
Waseca	0.38%	$ 646.34
Washington	4.88%	$ 481.39
Watonwan	0.39%	$ 646.34
Wilkin	0.29%	$ 612.40
Winona	0.50%	$ 730.52
Wright	2.63%	$ 491.02
Yellow Medicine	0.31%	$ 644.57
Total	100%	$ 540.65

Table A-8

Metal Level	Average 2017 Premium All Ages Within Metal Level Statewide
Catastrophic	$239
Bronze	$497
Silver	$553
Gold	$631
Platinum	$755
Total	$560

For premium increases after 2018, scenarios are modeled at 5 percent, 6.5 percent and 10 percent inflation, with reinsurance inflation modeled at 3.5 percent higher in each scenario. The key considerations of the modeled average premiums are the influence on enrollment and the post-waiver average premium that addresses affordability.

The second-lowest silver price in each county plays an important role and more directly affects federal costs and waiver savings. The second-lowest silver premium in each county is known for 2017. In consideration of the trend toward bronze plans and away from gold and platinum plans, the ratio of the second-lowest silver premium to average premium across all metal levels has steadily increased since 2014, and Minnesota expects this trend to continue. The change in de minimis variation rules are reflected in the modeled ratios. To address uncertainty in future relationships between second-level silver premiums and overall average premiums, Commerce modeled two sets of scenarios: one assuming continuation of the estimated current relationship between second-lowest silver premiums and average premiums experienced for 2017, adjusted for the change in de minimis variation rules (a 94 percent ratio) and one assuming reasonable continuation of the trend towards bronze plans, adjusted for the change in de minimis variation rules (a 98 percent ratio).

Differential between Premiums at Different Levels of Enrollment (Price Elasticity)

In order to determine how enrollment and morbidity relate to one another, Commerce actuaries assessed price elasticity. It is estimated that for each additional $1 increase in average monthly premium, the state's individual market is expected to lose 500 enrollees. The development and considerations regarding this assumption are discussed in more detail below.

Because the size of Minnesota's individual market is structurally smaller than those in nearly all other states (due to the existence of the state's BHP), Minnesota has higher relative price elasticity compared to other states.

The 20,000 people who are assumed to be in the market who would not be in the market without the MPSP are assumed to be ineligible for premium tax credits and cost sharing reduction (CSR) subsidies because premium escalations that caused the disenrollment from the individual market did not financially affect those with federal

subsidies. The MPSP has no affordability impact for those who qualify for such subsidies, whether they are enrolled in the individual market or the BHP, MinnesotaCare.

The association between enrollment and premium is based on the price elasticity estimated directly from the Minnesota individual marketplace. In order to model Minnesota's price elasticity, Commerce reviewed the 2015 premium and enrollment data from the issuers' Uniform Rate Review Template (URRT, aggregated) and compared that data to the modeled average 2016 premium as well as the level of enrollment for 2016. This is the most recent data available.

489 enrollees per $1 = **66,000 enrollees leaving market from 2015 to 2016** / **$135 PMPM increase in average premiums 2015 to 2016**

To address uncertainty, this number is rounded to 500. Based on initial information, this function appears to be appropriate for 2017, as well.

Commerce also reviewed this modeled price elasticity relationship against 2015 claims experience (see Data Sources) and found that the price elasticity estimate is reasonable. In checking for reasonableness, Commerce held the top 5,700 high-cost cases steady along with the estimate of federally-subsidized enrollees, since the high-cost cases find value in health insurance even at high premiums while the federally-subsidized enrollees do not bear the financial effect of premium increases. Commerce actuaries modeled the morbidity changes assuming a proportional loss of all other 2015 members. The premium/enrollment scenarios from the price elasticity estimate fell within a reasonable range using this alternative approach. The modeled results also were reasonable in relation to expected 2018 values under a range of scenarios.

At lower levels of overall enrollment than modeled in this report, the price elasticity would decrease because there are about 77,000 price-insensitive persons with federal premium support who would hold on to their coverage regardless of non-subsidized premium levels. Thus, while price elasticity in the individual market is actually not linear, a linear model is used, as it produced reasonable values under the range of scenarios presented in this report.

Publicly available price elasticity studies are not helpful to this study, because they are generally outdated and are reflective of the heavily subsidized employer group market demographic. Individual market premiums would tend to be viewed as outliers in relation to generally available price elasticity studies. Further, even if recent individual market price elasticity estimates were available, these studies would not reflect the unique Minnesota situation (that is, the BHP's effect on price elasticity that is unique to Minnesota and perhaps New York). We assumed that after 2018, enrollment will hold level regardless of health premium inflation and its effect on price elasticity in order to focus on the "with" versus the "without" subsidy analysis.

Basic Health Plan (BHP) Impact

The BHP funding formula under 42 C.F.R. part 600, Subpart G was used to estimate the impact of this 1332 waiver on federal funding for MinnesotaCare. The funding formula is based on the second-lowest silver and

lowest bronze premium rate in each county for each specified age group broken out by tobacco and non-tobacco rates as outlined in the BHP funding methodology.

The state does not assume any changes to the methodology for the federal BHP funding formula, as described under 42 C.F.R. Part 600, Subpart G in determining the impact on federal BHP funding for MinnesotaCare.

As illustrated below, if approved, the impact of the MPSP 1332 waiver on the second-lowest silver together with the pass through of federal BHP funds under 1332(a)(3), would be budget neutral to the federal government.

Table A-9

Year	BHP Enrollment (with waiver)	BHP Enrollment (without waiver)	Modeled Second Lowest Silver (with waiver)	Modeled Second Lowest Silver (without waiver)	Federal BHP Funds (with waiver)	Federal BHP Funds (pass through amount with waiver)	**TOTAL Federal BHP Funds** (with waiver + pass through)	**TOTAL Federal BHP Funds** (without waiver)
2018	83,179	83,179	$496.73	$646.72	$493,034,730	$177,576,340	$670,611,070	$670,611,070
2019	82,068	82,068	$525.09	$688.76	$517,319,876	$191,187,671	$708,507,547	$708,507,547
2020	82,427	82,427	$554.89	$733.53	$552,234,945	$209,582,044	$761,816,989	$761,816,989
2021	83,092	83,092	$586.20	$781.21	$591,329,226	$230,634,813	$821,964,040	$821,964,040
2022	83,923	83,923	$619.07	$831.98	$636,504,448	$254,336,352	$890,840,800	$890,840,800
2023	84,762	84,762	$653.55	$886.06	$684,469,932	$280,525,107	$964,995,039	$964,995,039
2024	85,610	85,610	$689.70	$943.66	$735,360,374	$309,466,293	$1,044,826,667	$1,044,826,667
2025	86,466	86,466	$727.56	$1,004.99	$789,312,116	$341,453,740	$1,130,765,856	$1,130,765,856
2026	87,331	87,331	$767.18	$1,070.32	$846,462,315	$376,813,009	$1,223,275,325	$1,223,275,325
2027	88,204	88,204	$808.62	$1,139.89	$906,947,957	$415,904,848	$1,322,852,805	$1,322,852,805

Notes:

1. Federal BHP funding amounts in the table include both the APTC and CSR funding.
2. Modeled scenario:

   Medium premium level for overall average market premium

   Second-lowest cost silver is 94 percent of overall average market premium

   Medium trend in average market premiums is 6.5 percent

   Based on Minnesota's BHP funding model from the February 2017 State of Minnesota budget forecast.

Data Sources

Administrative Costs

Annual costs are estimated to be less than one percent of MPSP revenues. However, the state appropriation is sufficient to cover administrative costs. The model confirmed that MPSP administrative costs have no material impact.

Individual Market Enrollment

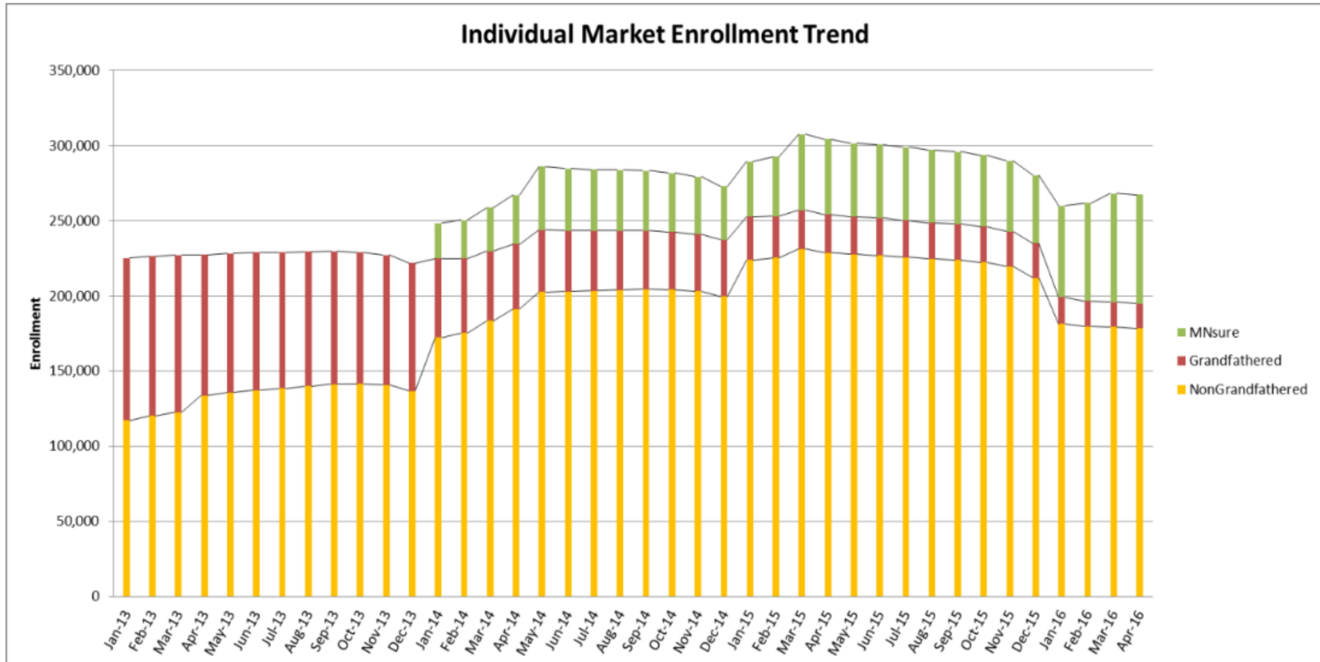
Data is available to place Minnesota individual market enrollees in groupings relevant to their decisions to buy insurance and buy certain metal levels. The following tables provide detail on age, metal level selection, and annual claims.

Minnesota's uninsured rate shrunk following ACA implementation. The most recent survey estimates that the Minnesota uninsured rate reached 4.3 percent in 2015, which is among the lowest in the country. Due to increasing premiums, Minnesota's uninsured rate may have increased since 2015.

Approximately 62,000 Minnesotans were eligible to receive federal tax premium credit support as of December 2016, but about 77,000 are eligible to receive credits as of January 2017.

For enrollment data, Commerce relied on past experience collected from individual market issuers in June 2016 including enrollment data through April 2016. Enrollment data shown on the following chart includes grandfathered plan enrollment, most of which was Blue Cross and Blue Shield of Minnesota, which announced that it would no longer sell individual market plans in 2017 (including grandfathered plans). Thus, Commerce expects a small number of grandfathered enrollees in 2017. Minnesota does not have transitional ("grandmothered") plans.

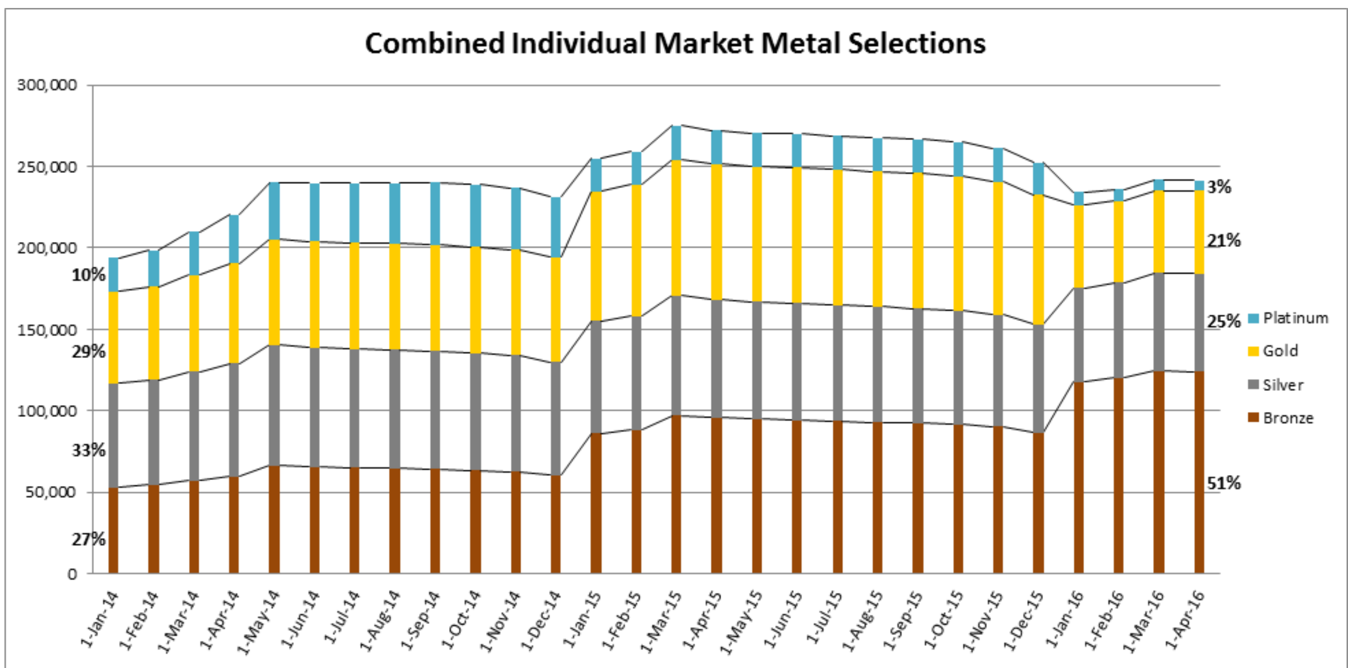
Table A-10



Source: Aggregated from annual issuer survey of individual market experience (Minnesota Department of Commerce).

Because prices increased effective January 1, 2017, the state assumes that there will be fewer enrollees in 2017. The drop in enrollment between 2015 and 2016 provides a point of reference used as the basis for the overall reasonable range on enrollment, considering the observations of price elasticity between 2015 and 2016. As prices in the individual market have escalated, there has also been a strong trend toward customers purchasing silver and bronze plans, as shown on the following chart (Table A-11). Not shown below are catastrophic plan enrollments, which were roughly 2 percent of 2015 enrollment and 3.5 percent of 2016 enrollment. Catastrophic plans are very similar in actuarial value to bronze plans.

Table A-11

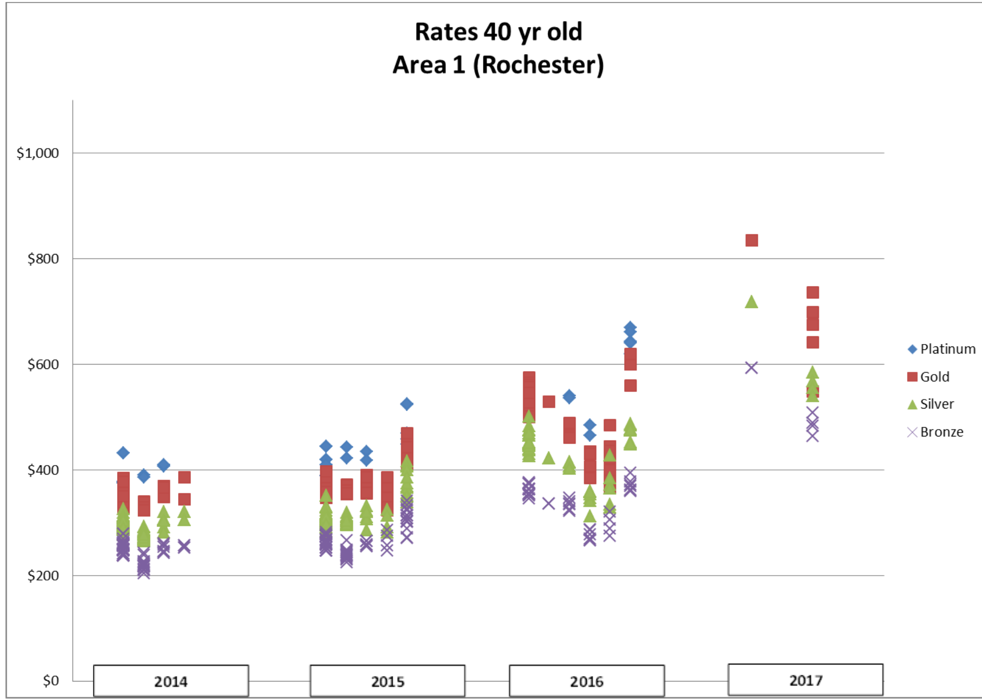


Source: Aggregated from annual issuer survey of individual market experience (Minnesota Department of Commerce).

Premiums

The following chart (Table A-12) shows how rates have increased significantly in Minnesota's most expensive rating area between 2014 and 2017. Each issuer's rates are represented by a column, with plan years grouped together. Rates by metal level are shown through the use of different shapes. Age 40 rates are shown, but all age rates are illustrated as well, since carrier and metal level positioning is consistent at all ages through the use of a fixed Minnesota age curve.

Table A-12



2017 rates and enrollment data were used as a starting point to model the reasonable range of average premiums and the second-lowest silver price point for 2018. Table A-13 shows how those rates vary by metal level and area. [7]

Table A-13

[7] Data Source: Issuer's Rate Data Templates, available at: https://filingaccess.serff.com/sfa/home/MN

Morbidity

It is difficult to determine exactly where the level of morbidity of the individual market will actually land or how it would be predicted by issuers' actuaries in advance of any given plan year. Therefore, Commerce did not make any assertive presumption of any particular scenario. Commerce developed a "mid estimate scenario" based on a scenario close to the median of reasonable ranges of likely future scenarios. This demonstrates that there is no addition to the federal deficit under a wide range of reasonably likely scenarios.

Data sources describing and referencing on the morbidity of Minnesota's individual market risk pool are provided in Appendix 2.

Benefit Design and Covered Services

This waiver includes no change to the scope of services covered. There will be no change to the Essential Health Benefit set due to this waiver. Thus, no changes in covered services were modeled. This waiver includes no change to the cost sharing parameters. Minnesota uses the same standard Actuarial Value Calculator that the rest of the nation uses to standardize the metal level targets of the designed plans. The mid estimate inflationary assumptions align with the actuarial value calculator (an annual trend of 6.5 percent), such that Commerce does not anticipate atypical deductible leveraging that would materially influence the premiums modeled. However, the change to widen the di minimis range that occurred based on April 2017 federal guidance and is applicable in Minnesota in plan years 2018 and beyond was considered.

Economic Analysis to Supplement Actuarial Analysis

By far, the most significant impact on the federal deficit will be from premium tax credit savings and BHP savings. Lesser impacts (4 to 7 percent of the savings) arise from lower individual shared responsibility payments, lower health insurance providers' fees, and higher administrative expenses. The analysis below estimates the offset to savings that is included as an "economic impact" column on the 10-year federal impact chart. This economic impact figure over the next 10 years is estimated in Table E-1:

Table E-1

Federal Reduction in Revenue from Minnesota

Year	Total Reduction in Federal Revenue
2018	$8,900,000
2019	$9,300,000
2020	$10,000,000
2021	$11,600,000
2022	$12,400,000
2023	$13,300,000
2024	$14,100,000
2025	$15,200,000
2026	$17,300,000
2027*	$18,600,000
Totals	$130,700,000

Individual Shared Responsibility Payment

With the implementation of a 1332 waiver, approximately 20,000 more individuals are anticipated to participate in the individual market than would be the case without a reinsurance program. It is reasonable to assume that the vast majority of the 20,000 additional people in the individual market would otherwise be uninsured, based on current and modeled premium differences between large group, small group, and individual market premiums. Those who have left the individual market for more affordable insurance alternatives (such as employment-based coverage) will be very likely to remain with those new alternatives because the reinsurance-supported individual market will still not compete with the affordability of employment-based coverage.

The 20,000 people who are assumed to be in the market because of the MPSP are assumed to be ineligible for federal premium tax credits and cost sharing reduction (CSR) subsidies because premium escalations that caused

the disenrollment from the individual market (from its high point of more than 300,000 participants in April 2015) did not financially affect those with premium tax credits (nor the very small subset of this population who are eligible for CSR subsidies[8]). The assumption that the new enrollees will come entirely from the uninsured also provides the most conservative estimate of the impact that a decrease in individual shared responsibility payments could have on the federal budget.

Because of the magnitude of premium rates expected in 2018 in Minnesota, many of the estimated 20,000 additional enrollees would not have been subject to the individual shared responsibility payments because the ratio of premiums to income would exceed the affordability limit (an IRS form and process which compares the lowest bronze premium to a threshold percentage of income slightly above 8 percent).[9] Congressional Budget Office (CBO) projections of national approximate penalty payments per uninsured individual were used. The March 2016 CBO report regarding federal subsidies for health insurance coverage forecasts the number of uninsured and the total responsibility payments projected for the years 2016 to 2026. From these numbers an approximate average individual responsibility payment was calculated. [10] See Table E-2.

Table E-2

Congressional Budget Office Projections of Individual Shared Responsibility Payments

National	Uninsured	Total Individual Shared Responsibility Payments	Approximate Average Individual Shared Responsibility Payment (Per Uninsured)
2018	26,000,000	$3,000,000,000	$115
2019	27,000,000	$3,000,000,000	$111
2020	27,000,000	$3,000,000,000	$111
2021	27,000,000	$4,000,000,000	$148
2022	27,000,000	$4,000,000,000	$148
2023	27,000,000	$4,000,000,000	$148
2024	28,000,000	$4,000,000,000	$143
2025	28,000,000	$4,000,000,000	$143
2026	28,000,000	$5,000,000,000	$179
2027*	28,000,000	$5,000,000,000	$179

[8] Because of MinnesotaCare (the state's BHP), only a small proportion of Minnesota's individual market has a CSR payment. Those who do qualify for CSR payments are only eligible for the 73 percent CSR variant.
[9] https://www.irs.gov/affordable-care-act/affordable-care-act-tax-provisions-for-individuals
[10] https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-healthinsurancebaselineonecol.pdf

Using the CBO approximation of the average individual shared responsibility payment per uninsured individual and the projected increase in enrollment, an approximate impact on the federal budget if the waiver is implemented is estimated. The difference in enrollment with and without waiver approval consists of 20,000 Minnesotans. The impact of this difference on the federal budget is modeled for all years when the waiver would be effective. See Table E-3.

Table E-3

Minnesota Modeled Impact of Reduction in Individual Shared Responsibility Payments

Minnesota	Projected Uninsured Migration to Individual Market	Approximate Average Individual Shared Responsibility Payment (Per Uninsured)	Approximate Impact to Federal Budget
2018	20,000	$115	$2,307,692
2019	20,000	$111	$2,222,222
2020	20,000	$111	$2,222,222
2021	20,000	$148	$2,962,963
2022	20,000	$148	$2,962,963
2023	20,000	$148	$2,962,963
2024	20,000	$143	$2,857,143
2025	20,000	$143	$2,857,143
2026	20,000	$179	$3,571,429
2027*	20,000	$179	$3,571,429

In addition to using this CBO projection, Commerce actuaries also modeled the financial effect of the individual shared responsibility payments based on Minnesota census data and the individual shared responsibility payment's design. The flat rate for 2016 is $695, and this amount is projected to conservatively inflate at three percent per year. Census data was used to determine approximate percentages of households composed of individuals, couples only, and families with children.[11] See Table E-4.

[11] https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_1YR_S0201&prodType=table

Table E-4

Family Size in Minnesota

Households	Minnesota Estimate
Family	60.00%
Couple	4.50%
Individual	35.50%

Census data was used to estimate the number of uninsured individuals per income range.[12] These numbers were compared with the modeled premiums for the years of the waiver to estimate the number of households nonexempt from shared responsibility payments. This, in conjunction with the census' estimated household size, and appropriate flat rate was used to determine the overall flat rate impact on the federal budget. See Table E-5.

Table E-5

Minnesota Reduction in Shared Responsibility Payments Based on Flat Rates

	Flat Rates (Inflated at 3% per Year)			Average Premium without waiver (annually)	Maximum Average Income for Exemption	Number of Non Exempt Households	Flat Rate Impact on Federal Budget
Year	Adult	Child	Family	From the model	Exempt if Premiums Greater than 8.13% of Income	Income Greater then Maximum Allowed for Exemption (Out of 20000)	Income Range based on Census Data
2016	$695	$348	$2,085				
2017	$716	$358	$2,148	$6,456			
2018	$737	$369	$2,212	$8,256	$101,550	2,660	$4,402,399
2019	$759	$380	$2,278	$8,793	$108,151	2,660	$4,534,471
2020	$782	$391	$2,347	$9,364	$115,180	2,660	$4,670,505
2021	$806	$403	$2,417	$9,973	$122,667	2,660	$4,810,620
2022	$830	$415	$2,490	$10,621	$130,640	2,660	$4,954,939
2023	$855	$427	$2,564	$11,311	$139,132	2,660	$5,103,587
2024	$880	$440	$2,641	$12,047	$148,176	2,660	$5,256,694
2025	$907	$453	$2,720	$12,830	$157,807	2,660	$5,414,395
2026	$934	$467	$2,802	$13,664	$168,065	2,660	$5,576,827
2027	$962	$481	$2,886	$14,552	$178,989	2,660	$5,744,132
							$50,468,568

The impact on the federal budget is also estimated based on a percentage of income. This percentage in 2016 was 2.5 percent of income and is assumed to remain constant over the timeframe of the waiver. Using the

12 https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_15_5YR_B27015&prodType=table

income census data and the same number of nonexempt households, a fee by percentage of income was estimated. See Tables E-6 and E-7.

Table E-6

Minnesota Population Income Breakdown

No Health Insurance Coverage (by Income)	Minnesota Estimate	Percentage	Estimate Income Used in Model
$74,999 or less	279,300	74.66%	-
$75,000 to $99,999:	45,036	12.04%	$87,500
$100,000 or more:	49,745	13.30%	$100,000

Table E-7

Minnesota Responsibility Payments Based on Income Breakdown

Year	Number of Non Exempt Households	Maximum Average Income for Exemption	Percentage Fee by Estimated Income
2018	2,660	$101,550	$6,648,961
2019	2,660	$108,151	$6,648,961
2020	2,660	$115,180	$6,648,961
2021	2,660	$122,667	$6,648,961
2022	2,660	$130,640	$6,648,961
2023	2,660	$139,132	$6,648,961
2024	2,660	$148,176	$6,648,961
2025	2,660	$157,807	$6,648,961
2026	2,660	$168,065	$6,648,961
2027	2,660	$178,989	$6,648,961
			$66,489,611

Table E-8

Comparison of Modeled Impact to Federal Budget

	Congressional Budget Office Model	Flat Rate Model	Percentage of Income Model	Best estimate, with margin added
2018	$2,307,692	$4,402,399	$6,648,961	$2,800,000
2019	$2,222,222	$4,534,471	$6,648,961	$2,700,000
2020	$2,222,222	$4,670,505	$6,648,961	$2,700,000
2021	$2,962,963	$4,810,620	$6,648,961	$3,600,000
2022	$2,962,963	$4,954,939	$6,648,961	$3,600,000
2023	$2,962,963	$5,103,587	$6,648,961	$3,600,000
2024	$2,857,143	$5,256,694	$6,648,961	$3,400,000
2025	$2,857,143	$5,414,395	$6,648,961	$3,400,000
2026	$3,571,429	$5,576,827	$6,648,961	$4,300,000
2027*	$3,571,429	$5,744,132	$6,648,961	$4,300,000
Totals	$28,498,168	$50,468,568	$66,489,611	$34,400,000

Of the estimates provided above in Table E-8, the percentage of income model is more appropriate than the flat rate model, since most people exposed to the flat rate payments are the same as those who are exempt from the tax due to affordability. However, the CBO estimate is likely the most accurate model, given that the CBO model takes into account the income and age demographics of the individual market purchasers, and more accurately addresses hardship, religious, and other important exemptions available. Minnesota's rates have recently risen to be just above the national average, and thus the CBO estimates are likely appropriate for this reason as well. However, for a conservative estimate, a 20 percent margin to the CBO model was added in part due to the fact that Minnesota tends to have higher incomes than the national average. In the model, Commerce actuaries also conservatively assumed that the January 20, 2017 executive order to allow for silent tax returns would not affect the financial consequences of the individual shared responsibility payment.

Health Insurance Providers' Fees

Section 9010 of the ACA imposes a fee on each covered entity engaged in the business of providing health insurance for United States health risks. The federal deficit impact resulting from lower Minnesota premiums for 2018 would be minimal because the design of this tax for the federal government perspective is fixed so as to receive a set amount nationally, as illustrated in Table E-9.

Table E-9

Federal health insurance providers' fee receipt, per IRS.gov

Fee Year	Applicable Amount
2014	$8,000,000,000
2015	$11,300,000,000
2016	$11,300,000,000
2017	$13,900,000,000
2018	$14,300,000,000

In 2019 and thereafter, the applicable amount is calculated as the amount of the preceding year's fee increased by the rate of national premium growth. The national premium growth will be immaterially influenced by Minnesota's MPSP, likely less than a 0.1 percent effect of the final national inflation value each year.

For more background on this tax, the percentage of net premiums written taken into account for each taxed entity per calendar year is shown in Table E-10.

Table E-10

Percentage of net premiums written taken into account, per IRS.gov

Covered entity's net premiums written during the data year that are:	Percentage of net premiums that are taken into account
Not more than $25,000,000	0
More than $25,000,000 but not more than $50,000,000	50
More than $50,000,000	100

Issuers that are not-for-profit receive a lower tax rate than those that are for profit, and certain issuers that are mainly in the Medicare and Medicaid markets have a full exemption from the tax.

Based on a conservative average health insurance provider fee estimate of 1.8 percent, and taking into account that approximately 20 percent of affected enrollees are with completely exempt entities in the individual market and the BHP, the following federal budget loss of revenues from Minnesota issuers is estimated (see Table E-11). Note that these losses may be partially recouped based on the national nature of this tax's design and benchmark, and Commerce actuaries have assumed that the tax would not be applied to the MPSP program proceeds. Thus, this is a conservative estimate.

Table E-11

Yearly Reduction in Health Insurer Providers' Fee

Year	Reduction in Health Insurer Providers' Fee
2018	$6,100,000
2019	$6,600,000
2020	$7,300,000
2021	$8,000,000
2022	$8,800,000
2023	$9,700,000
2024	$10,700,000
2025	$11,800,000
2026	$13,000,000
2027	$14,300,000

No Impact in Minnesota Related to Federal Exchange User Fees

Minnesota's proposed waiver will not influence federal revenue through exchange user fees, which are charged to insurers for using the Federally Facilitated Marketplace (FFM) and based on a percentage of the total premiums written through the federal exchange. Exchange user fees are collected on plans purchased through the FFM. Fee rates were 3.5 percent of premiums in 2015 and 2016.[13] The U.S. Department of Health and Human Services uses these fees to support the ongoing operations of the FFM by developing and implementing a system to calculate and collect user fees from participating issuers.[14]

Minnesota's health insurance marketplace, MNsure, is a State-Based Marketplace (SBM) and does not use the federal platform or partner with the federal government on Marketplace functions. Because of this status, exchange user fees collected by the FFM will not be affected by the waiver (see Table E-12).

[13] Federal Register / Vol. 80, No. 39 / Friday, February 27, 2015 / Rules and Regulations

[14] *General Guidance on Federally Facilitated Exchanges,* May 16, 2012. https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/ffe-guidance-05-16-2012.pdf. Pg. 11.

Table E-12

Yearly Reduction in Federal Exchange User Fees

Year	Reduction in Federal Exchange User Fees
2018	$0
2019	$0
2020	$0
2021	$0
2022	$0
2023	$0
2024	$0
2025	$0
2026	$0
2027	$0

Cost Sharing Reduction (CSR) Payments

All federal cost sharing reduction payments are unaffected by the MPSP, because the metal level designs (the actuarial value requirements) are not affected by the MPSP. No waiver is requested related to CSRs or benefit design.

In Minnesota, most CSR payments are provided to MinnesotaCare through the BHP funding formula, as provided under 42 C.F.R. Part 600, Subpart G. Very few of Minnesota's individual market participants enroll in plans eligible for CSR support, and those who are enrolled qualify for the 73 percent CSR variant, since the BHP covers all with 200 percent FPL or below and thus all who would have been eligible for the 87 and 94 percent CSR variants. For example, as of April 2016, Minnesota had 7,681 CSR enrollees, all enrolled in a 73 percent CSR variant (this is about 3.3% of the individual market enrollment).

The 20,000 people who are assumed to be in the market because of the MPSP are assumed to be ineligible for federal premium tax credits and cost sharing reduction (CSR) subsidies because premium escalations that caused the disenrollment from the individual market (from its high point of more than 300,000 participants in April 2015) did not financially affect those with premium tax credits (nor the very small subset of this population who are eligible for CSR subsidies), whether they are enrolled in the individual market or the state's basic health plan.

Risk Adjustment Payments

MPSP will not affect risk adjustment calculations, and thus not affect risk adjustment transfers between issuers. Since the risk adjustment program always produces $0 financial effect to the federal government for each

state's individual marketplace, there will be no financial effect to the federal government resulting from the MPSP. [15]

Employer Shared Responsibility Payment

MPSP support is not offered to employers and thus Commerce actuaries do not expect any measurable effect on the employer shared responsibility payment. Further, negative federal deficit impact due to employer shared responsibility payments is not expected because employers are generally prohibited[16] from making use of the individual market in a tax-effective manner, outside of the new QSEHRA ability granted under the CURES Act. Commerce actuaries monitor this issue, as does the IRS. The individual market's rates, even with the MPSP in place, will still be significantly higher than small and large group rates. Thus, there will be little interest by the group market in the individual market. Those employers with low-income workers might seek the QSEHRA opportunity, but must do so in a nondiscriminatory fashion and thus this would be a rare action. Employees with lower incomes who are eligible for a federal premium tax credit may seek out the individual market on their own, but the degree to which this occurs should be unaffected by the MPSP, since the ultimate premium they pay is unaffected by the MPSP.

Employer "Cadillac Tax"

The proposed program will have no effect whatsoever on the excise tax on high-cost employer-sponsored plans, also known as the "Cadillac tax."

[15] There is an important interplay between risk adjustment and the MPSP that effects issuers' financial performance. The State of Minnesota released a feasibility study in October 2016 on whether Minnesota should operate its own risk adjustment program. This study incorporated an analysis of the interplay between a theoretical state reinsurance program and risk adjustment (see pages 45-48 and Appendices 4D-I: https://www.leg.state.mn.us/docs/2016/mandated/161217.pdf). Based on this study's results, the reinsurance and risk adjustment interplay is material enough to potentially harm financial fairness to certain issuers in favor of other issuers. The study did not reflect the final MPSP parameters, which exacerbates this interplay from that which the study suggests. However, the study also did not reflect mitigating factors, such as important changes to the federal risk adjustment program and significant enrollment shifts which have worked to more fairly spread the high-cost case burden among issuers and largely remove such bias. The study and concept may be revisited, though state-based risk adjustment is a major undertaking and thus could not be implemented until plan year 2020 at the earliest. It would only be implemented assuming that MPSP is legislated to continue in its current form. It would only be possible if state law allows for it, with appropriations. It would only be considered if the administrative burden and cost make sense in terms of the value it produces to Minnesota residents. Much like the federal government's decision when faced with the same exact circumstances, Minnesota will not address refinements to risk adjustment or reinsurance in the near term, given the short-term nature of the situation. Because Minnesota has already studied this topic at length, Minnesota is in a unique position to be able to readily refine condition-specific factors if the federal risk adjustment administrative system allowed states to adopt their own custom risk scores.

[16] https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQs-Part-XXII-FINAL.pdf

Small Business Tax Credit

The proposed program will have no effect whatsoever on the tax credit available to certain small employers sold through the exchange.

Income Taxes

The proposed program will have no effect on income and payroll taxes. No employer tax exclusions or deductions are affected. Personal health care expense deductions are not affected, since this program relates to premiums (versus deductibles, coinsurance, co-pays).

Federal Administrative Costs

Commerce actuaries included an allotment for an allotment of existing staff time. See Table E-13.

Total Reduction in Federal Revenue

The major components of reduced federal revenue are shown in Table E-13.

Table E-13

Minnesota Modeled Impact of Reduction in Federal Revenue					
Year	**Reduction in Individual Shared Responsibility Payment Revenue (CBO + 20%)**	**Reduction in Health Insurance Providers' Fee Revenue**	**Reduction in Federal Exchange Use Fee Revenue**	**Federal Administration Expenses**	**Total Reduction in Federal Revenue**
2018	$2,800,000	$6,100,000	$0	$100,000	$9,000,000
2019	$2,700,000	$6,600,000	$0	$50,000	$9,350,000
2020	$2,700,000	$7,300,000	$0	$50,000	$10,050,000
2021	$3,600,000	$8,000,000	$0	$50,000	$11,650,000
2022	$3,600,000	$8,800,000	$0	$50,000	$12,450,000
2023	$3,600,000	$9,700,000	$0	$100,000	$13,400,000
2024	$3,400,000	$10,700,000	$0	$50,000	$14,150,000
2025	$3,400,000	$11,800,000	$0	$50,000	$15,250,000
2026	$4,300,000	$13,000,000	$0	$50,000	$17,350,000
2027*	$4,300,000	$14,300,000	$0	$50,000	$18,650,000
Totals	$34,400,000	$96,300,000	$0	$600,000	$131,300,000

**The CBO amount is only available through 2026. An estimate is applied for 2027.*

Combined Actuarial and Economic Analysis Results

The 10-year projection of the federal actuarial savings, federal economic losses, and basic health plan pass-through amounts are shown in Table E-14:

Table E-14

Year	Enrollment without Waiver	Enrollment with Waiver	Federal Premium Tax Credit Savings	Federal BHP Funds (pass through amount with waiver)	Federal Total Actuarial Savings & BHP pass-through amount	Federal Total Economic Loss	Federal Total Savings & BHP pass-through amount minus Economic Loss
2016	267,000	267,000					
2017	170,000	170,000					
2018	150,000	170,000	$ 138,309,239	$ 177,576,340	$ 315,885,579	$ 9,000,000	**$ 306,885,579**
2019	150,000	170,000	$ 150,926,611	$ 191,187,671	$ 342,114,282	$ 9,350,000	**$ 332,764,282**
2020	150,000	170,000	$ 164,726,839	$ 209,582,044	$ 374,308,883	$ 10,050,000	**$ 364,258,883**
2021	150,000	170,000	$ 179,823,082	$ 230,634,813	$ 410,457,895	$ 11,650,000	**$ 398,807,895**
2022	150,000	170,000	$ 196,339,480	$ 254,336,352	$ 450,675,832	$ 12,450,000	**$ 438,225,832**
2023	150,000	170,000	$ 214,412,234	$ 280,525,107	$ 494,937,341	$ 13,400,000	**$ 481,537,341**
2024	150,000	170,000	$ 234,190,786	$ 309,466,293	$ 543,657,079	$ 14,150,000	**$ 529,507,079**
2025	150,000	170,000	$ 255,839,120	$ 341,453,740	$ 597,292,860	$ 15,250,000	**$ 582,042,860**
2026	150,000	170,000	$ 279,537,188	$ 376,813,009	$ 656,350,197	$ 17,350,000	**$ 639,000,197**
2027	150,000	170,000	$ 305,482,484	$ 415,904,848	$ 721,387,332	$ 18,650,000	**$ 702,737,332**
						Total:	**$ 4,775,767,281**

Actuarial Certifications

Commerce actuarial staff certify that this waiver request meets the following federal requirements of the Affordable Care Act:

- The scope of coverage comparability requirements of Section 1332 (b)(1)(A)
- The affordability requirements of Section 1332 (b)(1)(B)
- The affected number of individuals requirements of Section 1332 (b)(1)(C)
- The deficit neutrality requirement of Section 1332 (b)(1)(D)
- The pass-through funding requirements of Section 1332(a)(3).

This waiver requires federal premium tax credit savings that would have otherwise been spent without the waiver (and its related legislation) be instead passed through to the MPSP. There is a financially immaterial effect on federal operations in terms of having existing IRS, HHS, CMS, and Office of the Actuary (OACT) staff review and approve this waiver request.

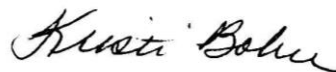
In performing the certification, we relied upon analysis for BHP projections prepared by Shawn Welch, Director, Reports and Forecasts Division, Minnesota Department of Human Services. We evaluated the analysis and results for reasonableness and consistency. A reliance statement has been provided related to this analysis.

Commerce actuarial staff are members of the American Academy of Actuaries in good standing. Commerce actuarial staff were requested to analyze this waiver request and document the results of our analysis in this report by our employer, the State of Minnesota. The use of this report is for federal regulators to review analysis in order to determine whether or not to support the requested waiver to which the report relates. The actuarial study should not be read without a full review of the waiver application.

Commerce actuarial staff have no conflict of interests in relation to the outcome of this waiver or the individual market affordability and sustainability to which this report and its related request.

Commerce actuarial staff have both met the education and experience necessary to perform this work. We have developed the assumptions, methods and findings in accordance with Actuarial Standards of Practice and the actuarial profession's Code of Professional Conduct.

Fred Andersen, FSA, MAAA
Acting Deputy Commissioner and Chief Life Actuary
Minnesota Department of Commerce
State of Minnesota



Kristi M. Bohn, FSA, EA, MAAA
Chief Health Actuary
Minnesota Department of Commerce
State of Minnesota

Appendices

Appendix 1 - More Data On Reinsurance Program Distributions

Because the 2018 attachment point and reinsurance cap are close to those used in the federal reinsurance program in 2014 and 2015, the relative coinsurance rate differences can be interpolated to infer the leveraged trend that various model results predict. An 8.75 percent reduction was made to take into account the attachment point difference of $50,000 instead of $45,000.

Another way to verify the level of appropriation to the MPSP is to review the core claims data most recently available from plan year 2015 to ensure that the appropriations are close in value to the distributions in the scenarios modeled. Table App-1 shows the development of expected reinsurance payments (matching state appropriations) under conservative assumptions that use actual 2015 high-cost case claims experience (when the market hit its highest enrollment levels to date). A claims trend of six percent at annual claim amounts in the $50,000 range to 10.5 percent at higher annual claim amounts is assumed. Also assumed is that high-cost people will have only left the market at about an eight percent rate, as compared to a significantly higher reduction in the entire enrolled population.

Table App-1

Range of Incurred Claims Trended to 2018		**Average Claims Within Range**	**Number of Enrollees with Annual Claims within Range (2015)**	**Average Cost of Claims by Number of Enrollees with Annual Claims Within Range**	**Aggregate Costs for Number of Enrollees**
Bottom of Range	**Top of Range**				
$39,571	$45,812	42,792	1,321	minimal amount	*$ 10,000*
$45,812	$52,508	49,512	1,058	$ (391)	*$ (413,456)*
$52,508	$58,498	55,409	804	$ 4,327	*$ 3,479,199*
$58,498	$119,795	82,403	3,222	$ 25,922	*$ 83,522,254*
$119,795	$245,222	165,776	1,212	$ 92,621	*$ 112,256,137*
$245,222	$327,784	288,395	237	$ 160,000	*$ 37,939,200*
$327,784	$374,643	342,234	67	$ 160,000	*$ 10,700,800*
$374,643	$512,029	435,969	132	$ 160,000	*$ 21,120,000*
$512,029	$647,250	582,393	85	$ 160,000	*$ 13,600,000*
$647,250	$1,281,255	841,248	60	$ 160,000	*$ 9,600,000*
$1,281,255	$2,364,516	1,552,559	10	$ 160,000	*$ 1,600,000*
Adjustment for Percentage of sick assumed				Aggregate	$ 293,414,135
still enrolled (compared to 2015):			**92.50%**	**Adjusted Aggregate**	**$271,000,000**

These evaluations indicate that plan year 2018 parameters have been reasonably, albeit conservatively, set to ensure that the MPSP will have sufficient funds in time to meet its obligations, an important consideration given the contingent nature of the waiver and the unknown cash flow timing of initial federal waiver support. For

later plan years, the scenario model assumes various reasonable ranges for leveraged trend for the cost of the MPSP (8.5 percent, 10 percent, and 13.5 percent). More background on the data used in this analysis is found in the Morbidity subsection of the Data Sources section of this report.

Appendix 2 - More Data Sources on Claims and Morbidty

Actuarial Value Calculator Continuance Tables

HHS provided issuers and the public with an actuarial value calculator in order to standardize plan design parameters to appropriate metal levels. Backing each metal level is a claims continuance table that outlines how claims distribution is assumed to develop. The actuarial value calculator tool is based on large group and self-insured employer data. This data indicates that Minnesota's 2015 individual market claims curve experience was very similar to group experience. However, given the enrollment changes underway for plan year 2017, Commerce actuaries do not expect that comparison of morbidity levels to hold for 2017 and beyond. This data source helped support the reasonable range of modeled premium scenarios under different morbidity/enrollment combinations.

The assumption underlying the actuarial value calculator tool has been that health care inflation (cost, utilization, and case mix trends) would trend at 6.5 percent. Commerce adopted 6.5 percent as the mid estimate assumption for claim and premium trend subsequent to 2018.

2016 Milliman Benchmarks

Commerce used the Milliman benchmarks, as this resource is a highly-cited basis for actuarial health insurance claims expectations. Using these benchmarks, and through comparing the continuance tables to the data Commerce has collected from issuers for 2015, Commerce found that 2015 individual market claims experience is not unlike the large group health insurance market. However, given the enrollment changes underway for plan year 2017, Commerce does not expect that comparison of morbidity levels to hold for 2017 and beyond. This data source helped support the reasonable range of modeled premium scenarios under different morbidity/enrollment combinations, and is very current.

2014 and 2015 Aggregate Individual Market Claims Experience

The 2017 Unified Rate Review Template (URRT) for each health insurer participating in the 2017 individual market in Minnesota was considered in developing a reasonable range of premium scenarios. Worksheet 1 of the URRT provides 2015 allowed and incurred claims and enrollment, along with morbidity and administrative cost projections. Commerce used health insurers' submitted URRT information to understand the claims, premiums, and member months from 2015. Commerce estimates that the aggregate Minnesota individual market simplified loss ratio (without adjustments such as quality assurance) would have been 138 percent for plan year 2015 if it were not for the now-expired federal reinsurance program. The filing public access link[17] can be used to find any issuer's actuarial memorandum, rate tables, and URRTs. This data was considered in the development of reasonable premium scenarios.

[17] https://filingaccess.serff.com/sfa/home/MN

The following data (Table App-2) was collected from nearly all issuers[18] and shows how allowed and incurred claims developed in 2015 in the individual market. This data helped us understand the underlying issues of rising premiums in the individual market, which has been driven by high-cost cases. This data is also key in understanding and calibrating parameters of the MPSP.

Table App-2

	2015 Aggregate Allowed Claims	2015 Aggregate Incurred Claims	Number of Members	Average Allowed Claim Size per Member
$0	(65,861)	(29,326)	27,118	(2)
$1 - $250	5,620,500	2,599,110	48,242	117
$251 - $500	12,924,186	6,738,790	34,461	375
$501 - $750	16,721,679	9,001,052	27,092	617
$751 - $1,000	17,677,591	9,205,224	19,896	888
$1,001 - $1,500	34,286,624	16,935,118	27,705	1,238
$1,501 - $2,000	30,417,248	14,347,661	17,198	1,769
$2,001 - $2,500	27,363,166	13,154,477	12,237	2,236
$2,501 - $3,000	25,351,047	12,656,877	9,257	2,739
$3,001 - $3,500	23,471,523	12,056,042	7,237	3,243
$3,501 - $4,000	22,526,847	12,000,058	6,022	3,741
$4,001 - $4,500	20,925,267	11,662,857	4,933	4,242
$4,501 - $5,000	19,476,186	11,013,874	4,107	4,742
$5,001 - $10,000	152,609,224	98,368,603	21,271	7,175
$10,001 - $15,000	119,089,116	88,389,114	9,692	12,287
$15,001 - $20,000	100,773,003	81,575,484	5,837	17,265
$20,001 - $25,000	77,109,597	64,514,650	3,458	22,299
$25,001 - $30,000	66,036,805	56,718,686	2,414	27,356
$30,001 - $35,000	57,020,025	50,323,019	1,758	32,435
$35,001 - $40,000	51,950,919	46,297,270	1,390	37,375
$40,001 - $45,000	47,957,590	43,356,080	1,130	42,440
$45,001 - $50,000	40,787,196	36,880,226	861	47,372
$50,001 - $100,000	234,156,257	215,824,720	3,403	68,809
$100,001 - $200,000	176,200,021	165,818,932	1,299	135,643
$200,001 - $300,000	79,537,756	75,461,108	330	241,024
$300,001 - $400,000	47,341,781	45,807,364	139	340,588
$400,001 - $500,000	39,562,553	38,594,584	88	449,574
$500,001 - $1,000,000	41,940,420	40,404,839	65	645,237
$1,000,000 - $2,000,000	13,503,392	11,972,495	10	1,350,339
> $2,000,000	4,312,977	4,229,635	2	2,156,489
Total	1,606,584,633	1,295,878,622	298,652	5,379

[18] Excludes Time and John Alden, which left the health insurance markets nationwide starting in 2016.

Past Federal Reinsurance Outcomes

Federal reinsurance is very similar to the MPSP. This temporary program was put into place in order to reduce individual market premiums during the first three years of the ACA from 2014 through 2016. The federal reinsurance program was funded through an assessment paid by health insurance companies and self-insured employer plans at a per person per year rate of $63 in 2014 and $44 in 2015. The initial funding projections for the program were based on collecting an estimated $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016 nationwide. Actual collections were then distributed to retrospectively reimburse individual market insurance companies for actual high-cost case claims. Issuers used the anticipated reinsurance reimbursements when they calculated their rates in 2014, 2015, and 2016.

In 2014 and 2015, actual reinsurance revenues exceeded expected payments, resulting in carriers receiving significantly higher assistance then they had initially anticipated and the federal regulators had originally designed. The following tables provide an overview of how the final parameters of the 2014 and 2015 federal reinsurance program design provided actual financial support for Minnesota's individual health insurance market. For both years, the attachment point was $45,000 and the reinsurance cap was $250,000. For 2014, the coinsurance rate was 100 percent, and for 2015 the coinsurance rate was 55.1 percent.

Table App-3

Carrier	Assistance from federal reinsurance, PMPM	Average Count	Total Paid, 2014
Blue Cross	$ 87.12	112,183	$ 117,276,164
Group Health	49.24	4,562	2,695,283
HealthPartners Ins Co	55.66	15,381	10,273,154
HealthPartners Inc.*	379.99	Incl above	1,402,533
Medica of WI	81.66	2,725	2,670,519
Medica Ins Co	30.58	22,606	8,295,441
PreferredOne	58.48	73,156	51,337,472
UCare	52.62	494	311,887
All Minnesota	$ 68.50	236,334	$ 194,262,452

**This issuer held a small closed block of conversion members who tended to be very unhealthy and have been merged.*

Table App-4

Carrier	Assistance from federal reinsurance, PMPM	Average Count	Total Paid, 2015
Blue Cross	$ 58.38	179,410	$ 125,694,015
Group Health	33.11	11,756	4,670,696
HealthPartnersIns Co	20.52	37,706	9,283,260
Medica of WI	78.60	6,414	6,049,812
Medica Ins Co	33.11	11,527	4,412,954
PreferredOne	53.97	6,517	4,220,736
UCare	16.92	9,647	1,958,644
All Minnesota	$ 49.17	270,444	$ 159,561,268

** *Both* tables exclude Time and John Alden, who left all health insurance markets in 2016 and beyond.

Appendix 3 - The Role of Enrollees' Income in the Model

Eligibility for public programs, MinnesotaCare (the basic health plan), and individual market subsidies is driven by income in comparison to the Federal Poverty Level (FPL). The table below shows the current FPL, as issued by the United States Department of Health and Human Services.

Table App-5

Number of Persons in Household	Assumed FPL
1	$ 12,060
2	$ 16,240
3	$ 20,420
4	$ 24,600
each 1 more	add $4,180

Minnesota is unique in that a high percentage of the people who qualify for federal subsidies enroll in MinnesotaCare. These are people with incomes at or below 200 percent of FPL. MinnesotaCare enrollment has been stable in comparison to enrollment in plans for people in other income bands, mainly due to longstanding county and community outreach and because Minnesotans are very aware of the program's value since the program has existed for twenty years, well before its conversion to a basic health plan. The federal portion of funding for MinnesotaCare is determined by the Office of the Actuary. Those who would normally be eligible for 87 and 94 percent Cost Sharing Reduction (CSR) plan variants[19] participate in MinnesotaCare instead of the individual market risk pool.

Data from individual market issuers over the last four plan years is used to understand the count for those enrolled in the 73 percent CSR plan variant. This data provides a very good proxy of those with incomes between 200 and 250 percent FPL and who collect CSR subsidies. That plan variant's enrollment is low[20] compared to the income class itself participating in the individual market because the 73 percent CSR plan variant does not provide much cost sharing subsidy support; the actuarial value is only 1 to 5 percent better than typical silver plans, making bronze plans attractive to many enrollees in terms of overall value.

The following table presents the income bands that reasonably represent the combined MinnesotaCare and individual market enrollment for plan year 2018, both with and without a reinsurance program/waiver in place, broken down by Premium Tax Credit (PTC) eligibility. The table demonstrates that there are individuals with incomes in low enough ranges to normally qualify for Medicaid, MinnesotaCare, or PTC, though fail to meet certain U.S. citizenship and immigration status requirements who instead use the individual market, although in low amounts due to the affordability issues affecting this income bracket. The table shows that that the additional enrollees in the individual market may likely come from those over 400 percent FPL. The individual

[19] Cost sharing reductions are not affected by this waiver request.

[20] 7,681 as of April 2016.

market hit an enrollment high point of 300,000 in 2015, and it is assumed that those who will return, or for the first time join, the individual market due to the reinsurance program's existence will be those who do not qualify for PTC. This is assumed because those with PTC were not materially affected by the rate increases that drove the enrollment declines. This assumption is supported by the fact that while there has been overall steep enrollment declines since 2015, the number of people who receive PTC has increased over the same time period.

Table App-6

Expected Enrollment Distribution - Non-group Enrollees					
Plan Year 2018	**Assuming Reinsurance/Waiver**		**Assuming No Reinsurance/Waiver**		
Income Band	**PTC-eligible**	**PTC-ineligible**	**PTC-eligible**	**PTC-ineligible**	**Default Program**
<100 FPL	0	27	0	27	Medicaid if eligible
100 FPL <= 138 FPL	0	12	0	12	Medicaid if eligible
138 FPL to 150 FPL	23,100	8	23,100	8	MinnesotaCare if eligible
150 FPL to 200 FPL	60,079	18	60,079	18	MinnesotaCare if eligible
200 FPL to 250 FPL	28,300	18	23,000	18	Individual Market
250 FPL to 300 FPL	20,900	18	25,000	18	Individual Market
300 FPL to 400 FPL	27,800	29	29,000	29	Individual Market
Over 400 FPL	0	92,870	0	72,870	Individual Market
SubTotal	160,179	93,000	160,179	73,000	
Total		253,179		233,179	MinnesotaCare + Individual Market

The table below shows our estimated expected contribution percentages impacting plan year 2018 subsidy levels.

Table App-7

Income Band	Estimated 2018 Federal Maximum (% of Annual Gross Income)
200 to 250 FPL	6.45 - 8.24 %
250 to 300 FPL	8.24 - 9.74 %
300 to 400 FPL	9.74%

One issue brought up during the public commentary period was whether or not Minnesota's top-down modeling approach missed that the reinsurance program financial effect always provides a full federal PTC savings in all circumstances, particularly for young single persons in lower cost rating areas. The following two charts help illustrate and answer the question posed. Table App-8 shows how premium as a percent of income for the least expensive adult age group (21-24) and in the least expensive rating area (rating area 8, the Twin Cities metro area) varies by income level both before and after the reinsurance program is reflected. For those that receive PTC with incomes between 200 and approximately 285 percent FPL, the full premium difference provides full savings to the federal budget because the federal support provides dollar-for-dollar assistance. However, for those between approximately 285 and 365 percent FPL, federal savings is not fully achieved: only about half of the difference should be applied overall for that income/age band. Between 365 percent FPL and 400 percent FPL, while the persons age 21-24 benefit from the reinsurance program, there is no federal PTC savings. This analysis can be compared to Table App-9, which shows that by age 45, full federal PTC savings can be credited throughout all of the PTC- eligible income band levels.

Table App-8

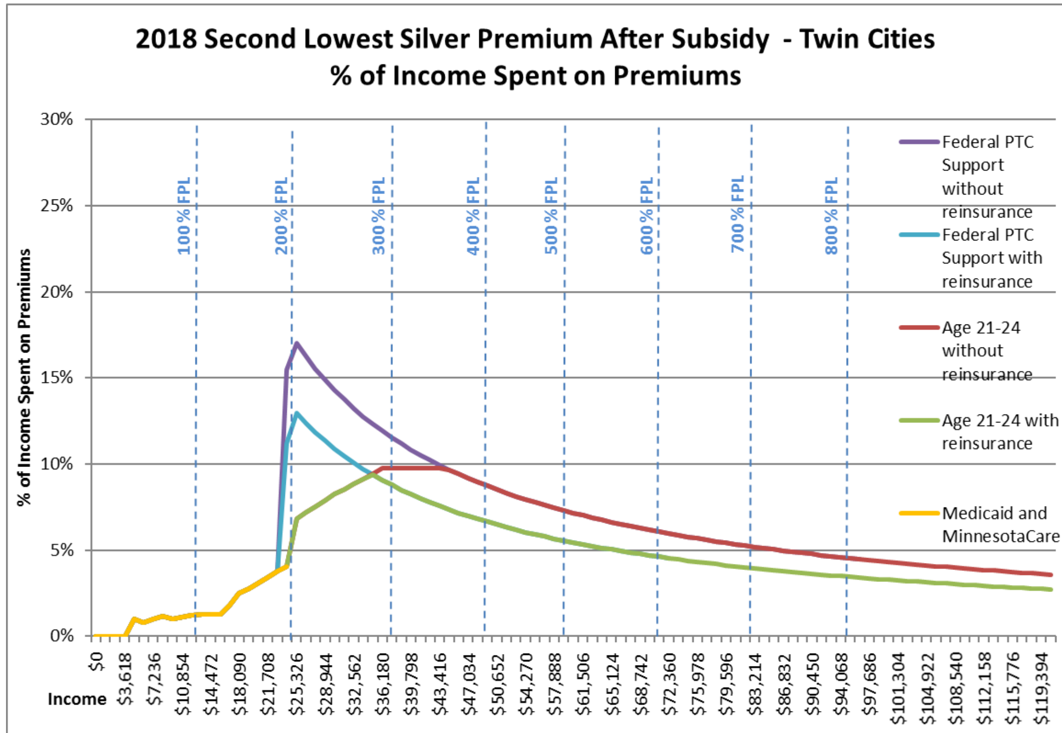
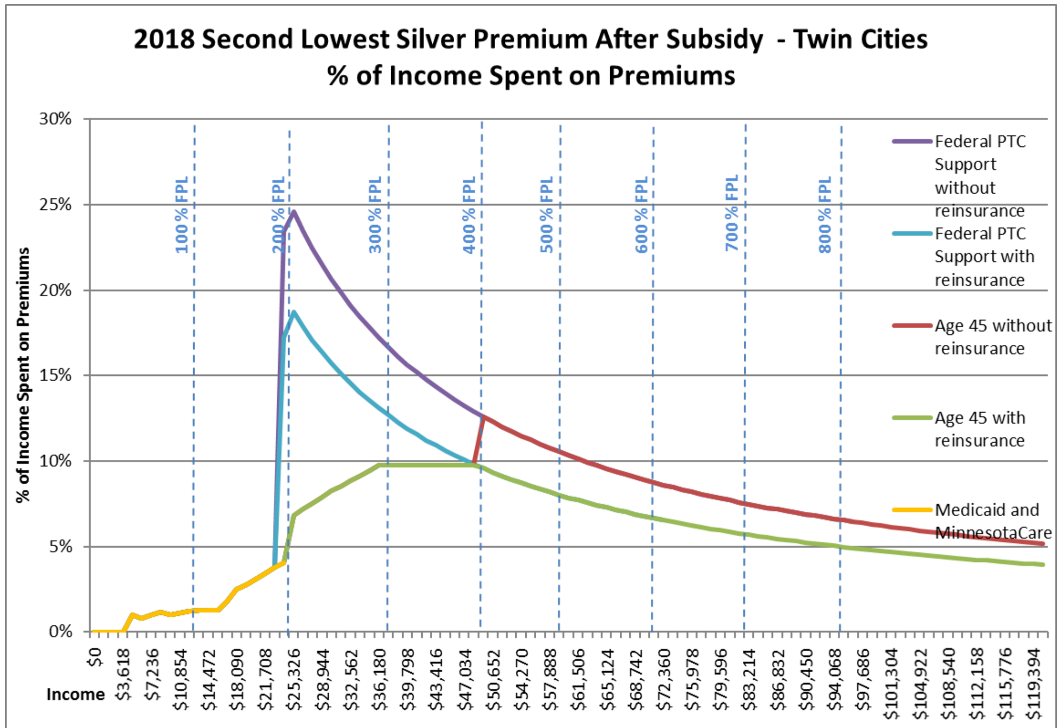


Table App-9



In order to determine the aggregate effect of this issue for all ages, rating areas, and income levels in the model, the table below helped demonstrate that this issue impacts the premium tax credits by only 0.2 percent in aggregate because there are very few young, single persons who are expected to receive PTC. Other assumptions play a major modeling role, such as the overall and specific issuer rate increases, the second lowest silver rate, and the proportion of PTC-eligible enrollees versus overall enrollees in the individual market.

Table App-10

PTC-eligible Estimated Income Factor												
	Rating Area	All		1	2	3	4	5	6	7	8	9
Geographic Cost Factor		1.000		1.300	1.071	1.172	1.242	1.153	1.054	0.989	0.937	1.071
Geo Rating Area Enrollment Proportion (x)		100.00%		7.76%	6.45%	4.86%	2.95%	4.35%	4.55%	9.05%	58.69%	1.34%
PTC-eligible Income Band (% FPL)		200-300%		300-400% Income Band--->								
Income Band Enrollment Proportion of PTC		63.9%		36.1%								
Average age-weighted income factor per area weighted by (z) (y) and (w)		99.99%		99.99%	99.72%	99.93%	99.98%	99.91%	99.63%	99.14%	98.37%	99.72%
Average income factor - weight by area (x)		99.6%		Weighted average Income Factor for single contracts								
Age Band	Proportion of Age PTC-eligible (z)	Single contract Proportion (y)	Age Curve (w)	Income Factors--->								
0-20	12.7%	0.002	0.890	0.848	0.310	0.584	0.746	0.527	0.262	0.139	0.062	0.310
21	1.0%	0.020	1.000	0.989	0.665	0.869	0.952	0.837	0.609	0.422	0.276	0.665
22	1.0%	0.020	1.000	0.989	0.665	0.869	0.952	0.837	0.609	0.422	0.276	0.665
23	1.0%	0.040	1.000	0.989	0.665	0.869	0.952	0.837	0.609	0.422	0.276	0.665
24	1.0%	0.040	1.000	0.989	0.665	0.869	0.952	0.837	0.609	0.422	0.276	0.665
25	1.1%	0.080	1.004	0.991	0.676	0.877	0.956	0.844	0.621	0.434	0.286	0.676
26	1.4%	0.080	1.024	0.998	0.728	0.907	0.974	0.880	0.679	0.497	0.339	0.728
27	1.4%	0.100	1.048	1.000	0.783	0.938	0.989	0.916	0.739	0.572	0.407	0.783
28	1.5%	0.100	1.087	1.000	0.858	0.975	1.000	0.959	0.822	0.681	0.521	0.858
29	1.5%	0.120	1.119	1.000	0.906	0.993	1.000	0.983	0.877	0.756	0.614	0.906
30	1.5%	0.120	1.135	1.000	0.926	0.997	1.000	0.991	0.899	0.788	0.656	0.926
31	1.5%	0.150	1.159	1.000	0.952	1.000	1.000	0.998	0.929	0.832	0.713	0.952
32	1.5%	0.150	1.183	1.000	0.971	1.000	1.000	1.000	0.954	0.871	0.764	0.971
33	1.5%	0.150	1.198	1.000	0.980	1.000	1.000	1.000	0.965	0.892	0.793	0.980
34	1.5%	0.200	1.214	1.000	0.988	1.000	1.000	1.000	0.977	0.912	0.822	0.988
35	1.5%	0.200	1.222	1.000	0.992	1.000	1.000	1.000	0.981	0.922	0.835	0.992
36	1.5%	0.250	1.230	1.000	0.994	1.000	1.000	1.000	0.985	0.930	0.847	0.994
37	1.5%	0.300	1.238	1.000	0.996	1.000	1.000	1.000	0.989	0.938	0.859	0.996
38	1.5%	0.350	1.246	1.000	0.998	1.000	1.000	1.000	0.992	0.945	0.871	0.998
39	1.5%	0.400	1.262	1.000	1.000	1.000	1.000	1.000	0.996	0.959	0.892	1.000
40	1.5%	0.450	1.278	1.000	1.000	1.000	1.000	1.000	1.000	0.970	0.911	1.000
41	1.5%	0.500	1.302	1.000	1.000	1.000	1.000	1.000	1.000	0.984	0.936	1.000
42	1.5%	0.550	1.325	1.000	1.000	1.000	1.000	1.000	1.000	0.993	0.956	1.000
43	1.5%	0.600	1.357	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.977	1.000
44	1.5%	0.650	1.444	1.000	1.000	1.000	1.000	1.000	1.000	1.000	0.993	1.000
45 and above	53.9%	0.681	2.091	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000	1.000
		45.1%	Single Contract Proportion						Income Factor (Single):	99.6%		
		54.9%	Family Contract Proportion						Income Factor (Family):	99.9%		
		100.0%	ALL PTC-eligible Contracts						Income Factor (All):	99.8%		

Note that for evaluating this issue, the Geographic Cost Factors (GCFs) are based on the plan year 2016 interim risk adjustment report issues by CMS on April 11, 2017; these factors represent an accurate estimate of the average rating area factors. Age and rating area proportional data are based on MNsure (Minnesota's exchange) enrollment from April 2016, as provided by an annual survey of issuers. Family versus single contract share and PTC-income band estimates between 200-400 percent FPL are based on information provided by MNsure staff in May of 2017.

Appendix 4 - Reliance Statement

As previously stated, Shawn Welch, Reports and Forecasts Director for the Minnesota Department of Human Services (DHS), provided the necessary analysis and information for the “Basic Health Plan Impact” section. This analysis is based on the formula that the state currently applies when determining the federal funding amounts available for the basic health plan under 42 C.F.R. Part 600, Subpart G and in consultation with the CMS’ Office of the Actuary. DHS’ certifies that this analysis is based on the most accurate, reasonable and complete data available to the state in determining the impact to the basic health plan with and without this waiver. DHS relied on current assumptions made in its state’s budget forecast along with the Department of Commerce’s premium data for the second lowest silver plan. Nothing in this analysis changed the federal funding formula for the basic health plan.

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Appendix 5 - Additional Modeling Results and Information on Targets

The impact of the waiver on the second-lowest silver rate for a representative consumer is used to validate the reasonableness of the statewide scenario results stated in the analysis. A combination of 2016-2017 data and 2018 assumptions are applied to place the anticipated 77,000 premium tax credit recipients into 3,570 groupings based on their county of residence, single/family status, income level, and age group. With the additional level of robustness, however, a shift from reliance on data to reliance on assumptions is necessary due to a number of data factors being available on a statewide basis rather than a rating area- or county-by-county basis, including single/family status, income levels, and age groups. A data-driven statewide analysis with validation from an assumption-based county-by-county analysis provides additional comfort that the results are reasonable if results consistent with the scenario results occur. The top-down approach (statewide analysis) and bottom-up approach (county-by-county analysis) produced similar results. Due to a degree of uncertainty in the county-by-county assumptions on age groupings, family status, and income levels, the county-by-county results were calibrated to the statewide midpoint results. The county-level results for mid-level scenario federal savings both with and without the waiver are displayed.

Table App-11

APTC with and without waiver, by county		
County	**2018 APTC With Waiver**	**2018 APTC Without Waiver**
Aitkin	$ 1,100,000	$ 1,600,000
Anoka	13,400,000	20,400,000
Becker	2,900,000	4,300,000
Beltrami	2,100,000	3,100,000
Benton	1,900,000	2,900,000
Big Stone	1,100,000	1,600,000
Blue Earth	4,600,000	6,800,000
Brown	3,500,000	5,000,000
Carlton	1,500,000	2,200,000
Carver	6,200,000	9,500,000
Cass	2,400,000	3,500,000
Chippewa	1,300,000	1,900,000
Chisago	3,200,000	4,700,000
Clay	3,200,000	4,700,000
Clearwater	600,000	900,000
Cook	600,000	900,000

Table App-11, continued

County	2018 APTC With Waiver	2018 APTC Without Waiver
Cottonwood	1,600,000	2,300,000
Crow Wing	4,500,000	6,700,000
Dakota	18,600,000	28,200,000
Dodge	1,400,000	2,000,000
Douglas	4,200,000	6,100,000
Faribault	1,800,000	2,700,000
Fillmore	2,200,000	3,200,000
Freeborn	2,900,000	4,200,000
Goodhue	4,000,000	5,700,000
Grant	900,000	1,400,000
Hennepin	63,400,000	96,300,000
Houston	1,800,000	2,600,000
Hubbard	1,500,000	2,200,000
Isanti	2,000,000	2,900,000
Itasca	2,300,000	3,300,000
Jackson	1,500,000	2,100,000
Kanabec	800,000	1,100,000
Kandiyohi	3,900,000	5,700,000
Kittson	600,000	900,000
Koochiching	700,000	1,100,000
Lac qui Parle	1,300,000	1,900,000
Lake	600,000	900,000
Lake of the Woods	600,000	900,000
Le Sueur	1,800,000	2,600,000
Lincoln	1,000,000	1,400,000
Lyon	2,500,000	3,600,000
Mahnomen	300,000	500,000
Marshall	1,500,000	2,300,000
Martin	2,200,000	3,200,000
McLeod	3,000,000	4,400,000
Meeker	2,300,000	3,400,000
Mille Lacs	1,600,000	2,400,000
Morrison	3,000,000	4,500,000
Mower	1,800,000	2,500,000
Murray	1,900,000	2,700,000
Nicollet	2,000,000	2,900,000
Nobles	2,500,000	3,600,000
Norman	2,500,000	3,600,000
Olmsted	5,900,000	8,400,000
Otter Tail	5,100,000	7,400,000

Table App-11, continued

County	2018 APTC With Waiver	2018 APTC Without Waiver
Pennington	800,000	1,000,000
Pine	1,300,000	1,700,000
Pipestone	1,700,000	2,200,000
Polk	2,500,000	3,200,000
Pope	2,200,000	2,900,000
Ramsey	18,400,000	24,600,000
Red Lake	400,000	500,000
Redwood	2,800,000	3,500,000
Renville	2,600,000	3,400,000
Rice	3,600,000	4,600,000
Rock	1,800,000	2,200,000
Roseau	1,000,000	1,300,000
Scott	7,800,000	10,500,000
Sherburne	4,600,000	6,200,000
Sibley	1,600,000	2,100,000
St. Louis	8,400,000	10,900,000
Stearns	8,300,000	11,100,000
Steele	2,000,000	2,500,000
Stevens	1,500,000	2,000,000
Swift	1,300,000	1,600,000
Todd	1,900,000	2,500,000
Traverse	700,000	900,000
Wabasha	1,900,000	2,500,000
Wadena	1,500,000	1,900,000
Waseca	1,600,000	2,100,000
Washington	13,000,000	17,500,000
Watonwan	1,700,000	2,100,000
Wilkin	1,100,000	1,500,000
Winona	2,500,000	3,200,000
Wright	7,300,000	9,700,000
Yellow Medicine	1,300,000	1,700,000
Total	$ 322,600,000	$ 460,900,000

Table App-12

APTC with and without waiver, single/family		
	2018 APTC With Waiver	2018 APTC Without Waiver
Single	$ 145,100,000	$ 213,200,000
Family	177,500,000	247,700,000
Total	$ 322,600,000	$ 460,900,000
		138,300,000

Table App-13

APTC with and without waiver, by income		
% Federal Poverty Level Income	2018 APTC With Waiver	2018 APTC Without Waiver
200-250%	$ 143,200,000	$ 192,800,000
250-300%	86,300,000	125,800,000
300-400%	93,100,000	142,300,000
Total	$ 322,600,000	$ 460,900,000

Table App-14

APTC with and without waiver, by age grouping		
Age	2018 APTC With Waiver	2018 APTC Without Waiver
0-21	$ 3,700,000	$ 6,300,000
22-29	15,500,000	24,700,000
30-39	27,700,000	43,200,000
40-49	38,400,000	57,700,000
50-59	115,800,000	162,500,000
60-64	119,300,000	163,500,000
65+	2,200,000	3,000,000
Total	$ 322,600,000	$ 460,900,000

Table App-15

APTC with and without waiver, by year			
Statewide	2018 APTC With Waiver	2018 APTC Without Waiver	Difference
2018	$ 322,632,514	$ 460,941,752	$ 138,309,239
2019	352,064,925	502,991,535	150,926,611
2020	384,256,573	548,983,411	164,726,839
2021	419,471,421	599,294,501	179,823,082
2022	457,999,051	654,338,529	196,339,480
2023	500,157,176	714,569,407	214,412,234
2024	546,294,397	780,485,180	234,190,786
2025	596,793,238	852,632,354	255,839,120
2026	652,073,474	931,610,658	279,537,188
2027	712,595,793	1,018,078,272	305,482,484

Table App-16

Affordability - Average Individual Market Premium Contribution Per Member, with waiver						
	Year	Q1	Q2	Q3	Q4	Annual
Projected	2018	$ 1,111	$ 1,111	$ 1,111	$ 1,111	$ 4,443
Projected	2019	1,171	1,171	1,171	1,171	4,682
Projected	2020	1,233	1,233	1,233	1,233	4,932
Projected	2021	1,298	1,298	1,298	1,298	5,192
Projected	2022	1,366	1,366	1,366	1,366	5,464

Table App-17

Affordability - Average Individual Market Premium Contribution Per Member, without waiver						
	Year	Q1	Q2	Q3	Q4	Annual
Projected	2018	$ 1,386	$ 1,386	$ 1,386	$ 1,386	$ 5,545
Projected	2019	1,458	1,458	1,458	1,458	5,834
Projected	2020	1,534	1,534	1,534	1,534	6,135
Projected	2021	1,612	1,612	1,612	1,612	6,448
Projected	2022	1,693	1,693	1,693	1,693	6,772

Table App-18

Year	Total Individual Market Premiums, with waiver
2018	$ 1,078,020,000
2019	1,139,554,800
2020	1,204,235,712
2021	1,272,181,868
2022	1,343,511,608
2023	1,418,341,573
2024	1,496,785,657
2025	1,578,953,794
2026	1,664,950,567
2027	1,754,873,608

Table App-19

Year	Total Individual Market Premiums, without waiver
2018	$ 1,238,400,000
2019	$ 1,318,896,000
2020	$ 1,404,624,240
2021	$ 1,495,924,816
2022	$ 1,593,159,929
2023	$ 1,696,715,324
2024	$ 1,807,001,820
2025	$ 1,924,456,938
2026	$ 2,049,546,639
2027	$ 2,182,767,171

Table App-20

Assumed 2018 2nd Lowest Silver Premiums*, With Waiver, by Age							
County	**20**	**26**	**35**	**45**	**55**	**62**	**65**
Aitkin	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Anoka	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Becker	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Beltrami	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Benton	$ 239	$ 275	$ 328	$ 388	$ 599	$ 772	$ 806
Big Stone	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Blue Earth	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
Brown	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Carlton	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
Carver	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Cass	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Chippewa	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Chisago	$ 269	$ 310	$ 370	$ 437	$ 674	$ 869	$ 907
Clay	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Clearwater	$ 302	$ 348	$ 415	$ 491	$ 758	$ 976	$ 1,019
Cook	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
Cottonwood	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Crow Wing	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Dakota	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Dodge	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Douglas	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Faribault	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
Fillmore	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Freeborn	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Goodhue	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Grant	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Hennepin	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Houston	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Hubbard	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Isanti	$ 269	$ 310	$ 370	$ 437	$ 674	$ 869	$ 907
Itasca	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
Jackson	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Kanabec	$ 271	$ 312	$ 373	$ 440	$ 680	$ 876	$ 915
Kandiyohi	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Kittson	$ 272	$ 313	$ 374	$ 441	$ 682	$ 878	$ 917
Koochiching	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
Lac qui Parle	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058

Table App-20, continued

2018 2nd Lowest Silver Premiums*, With Waiver, by Age							
County	20	26	35	45	55	62	65
Lake	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
Lake of the Woods	$ 296	$ 341	$ 406	$ 480	$ 742	$ 955	$ 998
Le Sueur	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
Lincoln	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Lyon	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Mahnomen	$ 302	$ 348	$ 415	$ 491	$ 758	$ 976	$ 1,019
Marshall	$ 272	$ 313	$ 374	$ 441	$ 682	$ 878	$ 917
Martin	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
McLeod	$ 313	$ 360	$ 430	$ 508	$ 784	$ 1,011	$ 1,055
Meeker	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Mille Lacs	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Morrison	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Mower	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Murray	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Nicollet	$ 306	$ 352	$ 420	$ 497	$ 767	$ 988	$ 1,032
Nobles	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Norman	$ 302	$ 348	$ 415	$ 491	$ 758	$ 976	$ 1,019
Olmsted	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Otter Tail	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Pennington	$ 272	$ 313	$ 374	$ 441	$ 682	$ 878	$ 917
Pine	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Pipestone	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Polk	$ 272	$ 313	$ 374	$ 441	$ 682	$ 878	$ 917
Pope	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Ramsey	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Red Lake	$ 272	$ 313	$ 374	$ 441	$ 682	$ 878	$ 917
Redwood	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Renville	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Rice	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
Rock	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Roseau	$ 253	$ 291	$ 347	$ 410	$ 633	$ 816	$ 852
Scott	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Sherburne	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Sibley	$ 313	$ 360	$ 430	$ 508	$ 784	$ 1,011	$ 1,055
St. Louis	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
Stearns	$ 239	$ 275	$ 328	$ 388	$ 599	$ 772	$ 806
Steele	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Stevens	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Swift	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
Todd	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920

Table App-20, continued

2018 2nd Lowest Silver Premiums*, With Waiver, by Age							
County	20	26	35	45	55	62	65
Traverse	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Wabasha	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Wadena	$ 273	$ 314	$ 375	$ 443	$ 684	$ 881	$ 920
Waseca	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
Washington	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
Watonwan	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
Wilkin	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
Winona	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
Wright	$ 239	$ 275	$ 328	$ 388	$ 599	$ 772	$ 806
Yellow Medicine	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
*Actual 2018 2nd Lowest Silver Premiums will be proposed by issuers and be subject to the rate review process							

Table App-21

Assumed 2018 2nd Lowest Silver Premiums*, With Waiver, by Rating Area and Age							
Rating Area	20	26	35	45	55	62	65
1	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
2	$ 285	$ 327	$ 391	$ 462	$ 713	$ 919	$ 959
3	$ 315	$ 362	$ 432	$ 511	$ 789	$ 1,016	$ 1,061
4	$ 356	$ 409	$ 488	$ 577	$ 891	$ 1,148	$ 1,199
5	$ 314	$ 361	$ 431	$ 509	$ 786	$ 1,013	$ 1,058
6	$ 298	$ 343	$ 409	$ 484	$ 747	$ 963	$ 1,005
7	$ 269	$ 310	$ 370	$ 437	$ 674	$ 869	$ 907
8	$ 234	$ 270	$ 322	$ 380	$ 587	$ 757	$ 790
9	$ 272	$ 313	$ 374	$ 441	$ 682	$ 878	$ 917
*Actual 2018 2nd Lowest Silver Premiums will be proposed by issuers and be subject to the rate review process							

Table App-22

Assumed 2018 2nd Lowest Silver Premiums*, Without Waiver, by Age							
County	**20**	**26**	**35**	**45**	**55**	**62**	**65**
Aitkin	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Anoka	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Becker	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Beltrami	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Benton	$ 311	$ 358	$ 427	$ 505	$ 780	$ 1,005	$ 1,049
Big Stone	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Blue Earth	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
Brown	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Carlton	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
Carver	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Cass	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Chippewa	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Chisago	$ 350	$ 403	$ 481	$ 568	$ 878	$ 1,131	$ 1,181
Clay	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Clearwater	$ 394	$ 453	$ 540	$ 639	$ 986	$ 1,271	$ 1,327
Cook	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
Cottonwood	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Crow Wing	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Dakota	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Dodge	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Douglas	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Faribault	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
Fillmore	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Freeborn	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Goodhue	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Grant	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Hennepin	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Houston	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Hubbard	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Isanti	$ 350	$ 403	$ 481	$ 568	$ 878	$ 1,131	$ 1,181
Itasca	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
Jackson	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Kanabec	$ 353	$ 407	$ 485	$ 573	$ 885	$ 1,141	$ 1,191
Kandiyohi	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Kittson	$ 354	$ 408	$ 486	$ 575	$ 888	$ 1,143	$ 1,194
Koochiching	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
Lac qui Parle	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377

Table App-22, continued

2018 2nd Lowest Silver Premiums*, Without Waiver, by Age							
County	20	26	35	45	55	62	65
Lake	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
Lake of the Woods	$ 385	$ 443	$ 529	$ 625	$ 965	$ 1,244	$ 1,299
Le Sueur	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
Lincoln	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Lyon	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Mahnomen	$ 394	$ 453	$ 540	$ 639	$ 986	$ 1,271	$ 1,327
Marshall	$ 354	$ 408	$ 486	$ 575	$ 888	$ 1,143	$ 1,194
Martin	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
McLeod	$ 408	$ 469	$ 560	$ 661	$ 1,021	$ 1,316	$ 1,374
Meeker	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Mille Lacs	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Morrison	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Mower	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Murray	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Nicollet	$ 398	$ 458	$ 547	$ 646	$ 998	$ 1,286	$ 1,343
Nobles	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Norman	$ 394	$ 453	$ 540	$ 639	$ 986	$ 1,271	$ 1,327
Olmsted	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Otter Tail	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Pennington	$ 354	$ 408	$ 486	$ 575	$ 888	$ 1,143	$ 1,194
Pine	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Pipestone	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Polk	$ 354	$ 408	$ 486	$ 575	$ 888	$ 1,143	$ 1,194
Pope	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Ramsey	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Red Lake	$ 354	$ 408	$ 486	$ 575	$ 888	$ 1,143	$ 1,194
Redwood	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Renville	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Rice	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
Rock	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Roseau	$ 329	$ 378	$ 452	$ 534	$ 824	$ 1,062	$ 1,109
Scott	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Sherburne	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Sibley	$ 408	$ 469	$ 560	$ 661	$ 1,021	$ 1,316	$ 1,374
St. Louis	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
Stearns	$ 311	$ 358	$ 427	$ 505	$ 780	$ 1,005	$ 1,049
Steele	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Stevens	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Swift	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
Todd	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198

Table App-22, continued

2018 2nd Lowest Silver Premiums*, Without Waiver, by Age							
County	20	26	35	45	55	62	65
Traverse	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Wabasha	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Wadena	$ 355	$ 409	$ 488	$ 577	$ 890	$ 1,147	$ 1,198
Waseca	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
Washington	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
Watonwan	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
Wilkin	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
Winona	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
Wright	$ 311	$ 358	$ 427	$ 505	$ 780	$ 1,005	$ 1,049
Yellow Medicine	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
*Actual 2018 2nd Lowest Silver Premiums without waiver will be submitted by issuers, per MN Statutes section 62E.22							

Note that actual second lowest silver plan premiums under the waiver will be reported on an annual basis in addition to estimates of the premiums assuming no waiver.

The table below provides information on 2016 Advanced Premium Tax Credits (APTC) as reported by MNsure.

Table App-23

Assumed 2018 2nd Lowest Silver Premiums*, Without Waiver, by Rating Area and Age							
Rating Area	20	26	35	45	55	62	65
1	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
2	$ 370	$ 426	$ 509	$ 601	$ 928	$ 1,196	$ 1,249
3	$ 410	$ 471	$ 563	$ 665	$ 1,027	$ 1,323	$ 1,381
4	$ 463	$ 533	$ 636	$ 751	$ 1,160	$ 1,495	$ 1,561
5	$ 409	$ 470	$ 561	$ 663	$ 1,024	$ 1,319	$ 1,377
6	$ 388	$ 447	$ 533	$ 630	$ 973	$ 1,253	$ 1,309
7	$ 350	$ 403	$ 481	$ 568	$ 878	$ 1,131	$ 1,181
8	$ 305	$ 351	$ 419	$ 495	$ 765	$ 985	$ 1,029
9	$ 354	$ 408	$ 486	$ 575	$ 888	$ 1,143	$ 1,194
*Actual 2018 2nd Lowest Silver Premiums without waiver will be submitted by issuers, per MN Statutes section 62E.22							

Table App-24

Enrollment by Rating Area	
Rating Area	**% of state individual market enrollment, 2016**
1	5.26%
2	4.04%
3	4.59%
4	3.63%
5	5.31%
6	5.63%
7	8.22%
8	60.73%
9	2.58%

Table App-25

Rating Area	2016 APTC
Area 1	$15,679,019
Area 2	$10,221,167
Area 3	$7,768,654
Area 4	$5,502,593
Area 5	$6,822,918
Area 6	$6,569,712
Area 7	$11,471,453
Area 8	$40,934,506
Area 9	$1,857,239
Total	$106,827,261

Note that 2017 rate increases ranged from an average of 50 percent to 66.8 percent. This increase is the primary reason why projected premium tax credits are substantially higher than 2016 premium tax credits.