



**The Woodrow Wilson School**  
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# 2017 and Beyond: Using the ACA Innovation Waiver to Reach Minnesota's Triple Aim

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## List of Acronyms

<b>ACA</b>	Patient Protection & Affordable Care Act	<b>MMB</b>	Minnesota Management and Budget
<b>ACO</b>	Accountable Care Organization	<b>QHP</b>	Qualified Health Plan
<b>APTC</b>	Advance Premium Tax Credit	<b>SEGIP</b>	State Employee Group Insurance Plan
<b>BHP</b>	Basic Health Plan	<b>SHADAC</b>	State Health Access Data Assistance Center
<b>CCIIO</b>	Center for Consumer Information and Insurance Oversight	<b>SIM</b>	State Innovation Model
<b>CHIP</b>	Children’s Health Insurance Program		
<b>CMS</b>	Centers for Medicare and Medicaid Services		
<b>DHS</b>	Minnesota Department of Human Services		
<b>DOC</b>	Minnesota Department of Commerce		
<b>EPSDT</b>	Early and Periodic Screening, Diagnostic, and Treatment		
<b>ESI</b>	Employer Sponsored Insurance		
<b>FPG</b>	Federal Poverty Guidelines		
<b>GMC</b>	Vermont’s Green Mountain Care		
<b>HHS</b>	U.S. Department of Health and Human Services		
<b>IRS</b>	Internal Revenue Service		
<b>IT</b>	Information Technology		
<b>MA</b>	Minnesota’s Medicaid Program: Medical Assistance		
<b>MAGI</b>	Modified Adjusted Gross Income		
<b>MC</b>	MinnesotaCare		
<b>MCO</b>	Managed Care Organization		

## Executive Summary

Section 1332 of the Affordable Care Act gives states the opportunity to waive certain requirements of the law and build programs that provide affordable, comprehensive health care in innovative ways. Minnesota's Department of Human Services and its health insurance Marketplace, MNsure, have expressed interest in using the 1332 waivers to advance health reform in their state. This report, drafted by graduate students at the Woodrow Wilson School of Public and International Affairs at Princeton University and based upon extensive interviews with health system stakeholders in Minnesota as well as independent research, provides a set of recommendations for the direction health care reform could take under a 1332 waiver program.

While Minnesota is a national leader on several health care indicators, there are a number of areas where it could use a waiver to improve the provision of care. The insurance market for individuals between 0% and 400% of the federal poverty guidelines (FPG) is a patchwork of programs, and changes in life situation can lead an individual to "churn" between programs with different eligibility criteria, costs, provider networks, and administrative procedures. The state has made progress on driving delivery system and payment reform, but has yet to scale up its promising pilot programs. While Minnesota's uninsured rate is quite low, hundreds of thousands of people are still without coverage. In evaluating options for reform, we ask six questions: Does the option smooth the coverage continuum for individuals? Make care more affordable? Help the state offer comprehensive, universal coverage? Is it financially feasible? Administratively feasible? Does it allow the state to drive delivery system reform?

The state can begin by making a number of incremental changes that are not specific to any particular global vision of reform. It can enhance current programs by making further investments in service delivery alternatives, web-based user experience, and navigator programs. Program alignment can be improved through standardized definitions of income and household and consistent enrollment procedures and income verification systems. The state can fix the family glitch and can expand coverage among immigrant communities. Finally, Minnesota can shape choice architecture on MNsure to nudge individuals into higher-quality coverage.

The 1332 waiver can also be used more ambitiously. We outline three potential paths that the state could go down in pursuing its goals. All options aim to smooth the cost continuum for individuals, mitigate churn, and spur delivery system reform, but they take very different approaches. "Option A" relies on public programs, and would restore MinnesotaCare to 275% FPG, with delivery system reform largely driven by state procurement. "Option B" takes a more MNsure-centric approach, and would replace the current Basic Health Program for the 138%-200% FPG population with subsidies for qualified health plans. Additional subsidies would be provided for people up to 275% FPG, and delivery system reform and cost control would be driven by active purchasing. Finally, "Option C" would maintain the current program boundaries at 138% FPG and 200% FPG, but would implement various carrier regulations to ease transitions between programs.

We conclude that either Option A or Option B would best help Minnesota achieve its health care goals, and that the decision to pursue a public path or a regulated market path should ultimately be a philosophical one. It is crucial to choose one path or the other. Option C, which would institutionalize the current coverage patchwork, does not maximize leverage for driving reform.

## Introduction

Health reform is tradition in Minnesota. The state has long been at the forefront of efforts to improve quality, lower costs, expand coverage, and coordinate care. It is home to the nation's first health maintenance organizations and was one of the first states to take advantage of federal demonstration waivers, creating a pioneering public insurance program for working families. In 2008 the legislature passed a set of initiatives that laid out a path to payment reform, invested in public health, and introduced new transparency measures.<sup>1</sup> The 2010 Affordable Care Act (ACA) takes these reforms nationwide and offers new tools for Minnesota to pursue its triple aim of improving patient experience and population health, while reducing per capita costs.

The year 2017 brings another opportunity. Section 1332 of the ACA makes available "innovation waivers" that will allow states to waive many of the law's requirements and develop their own delivery and insurance systems, all while receiving the same level of federal subsidies that would have gone to the state's residents. The Minnesota Department of Human Services (DHS) and MNsure have expressed an interest in using a "1332" or "2017" waiver to carve out a unique path for health reform in Minnesota. This report explores the possibilities that such a waiver could unlock.

In our research, we spoke to individuals representing fourteen Minnesota organizations, including government agencies, advocacy groups, and research institutions. While each offered a unique perspective on the current health system, certain common themes emerged. Minnesota's efforts to provide comprehensive and universal coverage have led to a very low uninsured rate, but also created a patchwork of programs with numerous churn points. Stakeholders across the state want a more coherent and seamless continuum of coverage.

In addition, we repeatedly heard that Minnesota is committed to reforming delivery and payment systems to improve the quality and lower the costs of care. The state has developed innovative models of care delivery, but there is still a long way to go before these new models are widespread. Many stakeholders expressed interest in using the next round of health reform to expand the delivery system reforms now underway in Medical Assistance (MA), MinnesotaCare, Medicare, and private insurance. At the same time, they reminded us that any changes must promote the affordability, comprehensiveness, and universality of health care in Minnesota.

This report reflects the goals and priorities of Minnesota's health reform experts as well as our own research on Minnesota and other states. It begins with background on the 1332 waivers and discusses other states' waiver plans. It then goes on to outline what we heard from stakeholders in Minnesota. We summarize the weaknesses of the current system, and we list six principles that we believe to be the priorities for Minnesota's health care system going forward. The six principles serve as decision criteria when we weigh options for reform against one another.

We then make our recommendations. First, we present a set of reforms that we believe Minnesota's leaders should make regardless of whether or how they use a 1332 waiver. These fixes range from



administrative reorganizations to adjustments of the subsidy schedule for low- to middle-income families. Many of these changes can be feasibly accomplished without a 1332 waiver.

The three options that follow are more ambitious. Each option involves significant changes (and, we believe, improvements) to the status quo, and each positions the state to continue to lead in health reform efforts in the decades to come. Finally, we use the decision criteria generated from our conversations with Minnesota stakeholders to evaluate each option and suggest a course of action.

This is an exciting time for health reform in Minnesota. Due to the state's pioneering and sustained investments over the preceding decades, its health system is among the best in the nation. In the next few years, Minnesota will have the opportunity to make further strides in quality, efficiency, and innovation. The path it chooses could determine the direction of American health care for years to come.

# Part I: The 1332 Waiver

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## The 1332 Waiver

### Background on 1332 Waivers

#### Understanding the 1332 Waiver

Section 1332 of the ACA allows states to waive core requirements of health reform legislation in order to experiment with alternative paths to achieving the ACA's goals. This section reviews the known opportunities and constraints afforded by the waiver, the application process, and possibilities under exploration by other states.

#### *Provisions that may be waived*

Under Section 1332, states can propose modifications to the following elements of the ACA:<sup>2</sup>

- **The qualified health plans.** States may change the requirements for qualified health plans (QHPs), including the definition of essential health benefits, limits on cost-sharing, rules for participating plans, and the metal levels.<sup>3</sup> For example, a state might expand access to lean insurance by introducing a “copper” plan at 50 percent actuarial value.<sup>4</sup> By contrast, a state could—without a waiver—choose to limit reliance on low-actuarial-value insurance by eliminating Bronze plans.<sup>5</sup>
- **The health insurance Marketplaces.** States have the option to modify or eliminate the Marketplace system. For example, states could waive specific requirements by extending access beyond citizens and lawful residents or by capping the small group market at 50 employees.<sup>6,7</sup> They could also make broader changes, such as replacing the Marketplace with a private exchange, allowing the purchase of subsidized coverage outside the Marketplace, or eliminating the private market outside the Marketplace.<sup>8</sup>
- **Tax credits and cost-sharing reductions.** States might modify the rules concerning the provision of cost-sharing and premium subsidies. For example, states could smooth cost-sharing “cliffs,” tie tax credits to quality metrics, eliminate the family glitch (see page 26), or change the income limits for subsidy eligibility. In conjunction with an 1115 Medicaid waiver, states could alter the premium and cost-sharing schedule to smooth differences between public coverage and the Marketplace.<sup>9</sup>
- **The employer mandate.** States may adjust or eliminate penalties for large employers who do not offer coverage to their full-time employees. For instance, a state might introduce exemptions for mid-sized employers, change the definition of covered employees, adjust the level of qualifying coverage, or potentially eliminate the mandate altogether.
- **The individual mandate.** States may adjust or eliminate the tax penalty for individuals who go without health coverage. For example, a state might expand or narrow mandate exemptions or implement late enrollment penalties.<sup>10</sup>

#### *Waiver Constraints*

Generally, waiver proposals need to provide similar coverage outcomes in terms of both quality and quantity at equal or lesser cost. Specifically, proposals under Section 1332 are constrained by the following criteria:

- **Affordability:** Proposals must provide coverage that is at least as affordable as it would be under the original provisions, including protections against excessive out-of-pocket spending. The precise measures of affordability (e.g. premiums, cost-sharing, total expected cost) have not been specified.
- **Comprehensiveness:** Proposals must provide coverage that is, at a minimum, as comprehensive as Marketplace coverage. The chief actuary at the Centers for Medicare & Medicaid Services (CMS) must certify estimates of comprehensiveness. Whether this calculation will be based on benefit category or actuarial equivalence is still unclear.
- **Scope of coverage:** Proposals must provide coverage to at least as many people as the ACA would have in the absence of a waiver. The method by which this will be calculated has not been specified.
- **Federal deficit:** Proposals cannot increase the federal deficit.<sup>11</sup>

The following provisions of the ACA cannot be waived: guaranteed issue, community rating, and non-discrimination regulations.<sup>12</sup>

### *Application Process*

Prior to submitting an application, states must demonstrate that they have the authority to enact a waiver and have solicited public input on the design of their waiver. States can either enact a new law that provides for the waiver or refer to authority under existing law in their proposal.<sup>13</sup> States must (1) hold a public hearing after drafting the waiver proposal; (2) collect and respond to comments after the application is submitted; and (3) hold annual public forums on the waiver following approval.<sup>14</sup>

The application itself must include actuarial and economic analyses, an implementation timeline, and a ten-year budget plan. Following submission of a complete application, the Departments of Health and Human Services (HHS) and the Treasury have 180 days to approve or reject that application.

Applications can be submitted at any time, though proposals cannot be implemented until January 1, 2017. If a waiver is approved, the state must submit quarterly and annual reports on the waiver program to HHS and the Treasury. Waivers are renewable, but their initial duration cannot exceed five years.

### *Funding*

Funds that would otherwise go towards subsidizing residents' purchase of insurance through premium tax credits and cost-sharing reductions on the Marketplace can be redirected to the waiver program.<sup>15</sup>

The process for calculating the amount of funding in the absence of the waived provisions is unclear, but will take into account the experience of other states.

### *Waiver Coordination*

The text of Section 1332 calls for the creation of a coordinated state waiver application process that would enable states to submit a single application for multiple waivers. In other words, a 1332 application could be combined with Section 1115 Medicaid waivers as well as Medicare waivers. Note that 1332 does not actually expand waiver authority over Medicaid or Medicare, and existing boundaries for waivers still apply.<sup>16</sup>

A potential benefit of a single application is that states may be able to estimate the combined financial impact of two waivers. HHS could then consider the waivers in tandem when determining whether the

Section 1115 waiver is budget neutral and whether the section 1332 waiver increases the federal deficit.<sup>17</sup>

### Unanswered Questions

Many questions remain unanswered by the original text of Section 1332. Some experts anticipate that further instructions for the application process will be released in the spring of 2015, but the federal government has yet to announce such plans.

## Other States and the 1332 Waiver

Hawaii and Vermont are both tentatively working towards a 1332 waiver application to achieve their respective health coverage goals. Several other states, including Arkansas and Oregon, are also well positioned to apply for waivers.

### Arkansas

Arkansas has also established itself as a leader in reform innovation and is well positioned to apply for a 1332 waiver. Arkansas's existing 1115 waiver enables it to fund a private option model for Medicaid users. A 1332 waiver could increase access to private health insurance and reduce the burden on public programs. Given the potential for combined budget neutrality, a 1332 waiver may offer a bipartisan approach to coverage expansion through a private-insurance based approach. Under the Arkansas Health Care Payment Improvement Initiative, the state has already made progress, moving towards the creation of patient-centered medical homes, health homes for individuals with complex needs, and an "episode-based" payment and delivery model.<sup>18</sup>

### Hawaii

Hawaii has expressed interest in pursuing a 1332 waiver, in part due to the desire to preserve its 1974 employer mandate, which is more expansive than the ACA provision and has helped bring uninsured rates below 10 percent in the state. In 2014, Hawaii passed legislation creating a State Innovation Waiver Task Force to explore options. In its October 2014 meeting, the Task Force agreed a potential waiver should pursue the goal of universal coverage and access and should preserve Hawaii's employer mandate. Waiver development subcommittees have been set up to explore options related to premium rating, state agency information technology (IT) collaboration, resource allocation for reform, and metrics.<sup>19</sup>

### Oregon

Oregon is also well situated to pursue a 1332 waiver through its creation of Medicaid coordinated care organizations, with incentives to support population health outcomes.<sup>20</sup> In 2009 the legislature created the Oregon Health Policy Board and the Oregon Health Authority, which have the ability to coordinate public purchasing of insurance for public employees. The state is seeking to develop common contracting standards to improve quality, performance, and cost-effectiveness. Ultimately, Oregon intends to create uniformity in benefit designs and develop a plan for value-based purchasing.<sup>21</sup>

## Vermont

Vermont was considering using the waiver to achieve its goal of a universal and unified single-payer healthcare system under Green Mountain Care (GMC). As was envisioned, GMC would redirect ACA subsidies to offer gold-level benefit plans, covering approximately 90 percent of state residents. GMC sought to lower costs through reduced fraud and abuse, administrative simplification, and delivery system reform, with savings supporting universal coverage. Medicare, Medicaid, and CHIP were to be folded into a single administrative system while maintaining current benefits.<sup>22</sup> Legislation in 2012 called for the creation of a single-payer plan and pursuit of a 1332 waiver, and Vermont has been in meetings with CMS since early 2013. Until December 2014, Vermont was working on a model to define federal funding and required state financing, with the goal of submitting a final proposal by early 2015 and beginning consultations with the public.<sup>23</sup> Unfortunately, the model recently showed that the proposed plan would require an additional \$2.5 billion in revenue within the first year alone, necessitating an increase in payroll taxes of 11.5 percent and income tax of 9 percent. With these numbers in mind, on December 17, 2014, Governor Peter Shumlin announced he would delay single-payer health care system.<sup>24</sup>

## Part II: Minnesota's Remaining Challenges

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## Minnesota's Remaining Challenges

### The Coverage Landscape

Minnesota's longstanding commitment to the health of its residents has led to one of the highest rates of insurance coverage in the nation.<sup>25</sup> In 2014, 95 percent of all Minnesotans, including 93 percent of adults, had health insurance.<sup>26</sup> Of the total population, 56 percent were insured through their employer, 16 percent had Medicare, 15 percent had MA, and one percent had MinnesotaCare. Six percent of the population purchased private, individual insurance, including less than one percent via MNSure.<sup>27</sup> Estimates of the early impact of the Affordable Care Act found that Minnesota's uninsured rate fell by 41 percent between September 2013 and May 2014, reaching an all-time low. This decline was largely driven by enrollment in MA, which in 2014 extended coverage to adults without dependent children and allowed eligibility determination via a shared IT system.<sup>28</sup>

### Opportunities for Improvement

Despite progress in expanding access to insurance, experts we spoke with in Minnesota saw a number of opportunities to improve continuity and affordability of coverage and care.

#### Eligibility Changes

Minnesotans face disruptions in coverage and care when their income and eligibility change. A patchwork of free or subsidized health insurance programs is available to Minnesotans between 0% and 400% FPG. Changes in income, age, or pregnancy status can cause enrollees to shift between MA, MinnesotaCare, and the Marketplace. As a result, enrollees may face steep premium hikes, find that their preferred doctors are not part of their new networks, or fail to reapply for insurance and lose coverage altogether.

In addition to the potential for one person to change eligibility over time, parents and children are often covered under different programs. In families earning between 133% and 275% FPG, children are eligible for MA, while parents must purchase MinnesotaCare or a private MNSure plan.<sup>29-30</sup>

A national study of people earning between 100% and 200% FPG found that 38 percent of those initially below the 138% FPG Medicaid cutoff had incomes above the cutoff one year later. Similarly, 24 percent of those initially above the cutoff dropped below it after one year.<sup>31</sup> Although the study looks only at the 100%–200% FPG range and Minnesota-specific data is not available, it seems likely that a large number of Minnesotans change program eligibility from year to year. These Minnesotans will be affected by differences in premium costs and provider networks between programs.

#### Affordability Cliffs

Minnesotans also face sharp changes in affordability as they shift from one program to another. Before 2014, MinnesotaCare covered adults up to 250% FPG and parents up to 275% FPG. In order to access significant funding under the ACA, the state modified MinnesotaCare to conform to federal standards for a Basic Health Program (BHP), including capping eligibility at 200% FPG. Minnesotans between 200% and 275% FPG may now shop for QHPs on MNSure; some will qualify for tax credits and cost-sharing



reductions to help pay for coverage. Even with federal help, however, those transitioning from MinnesotaCare to the Marketplace can expect higher premiums and less generous cost coverage.

MinnesotaCare enrollees at 200% FPG pay a \$50 monthly premium, with nominal copays and monthly deductibles.<sup>32,33</sup> In contrast, Minnesotans at 201% of FPG are eligible for plans on MNsure that have higher premiums and cost-sharing. A 40-year-old non-smoker at this income level living in the Twin Cities could purchase a silver plan for \$125 or a bronze plan for \$82 per month after the federal subsidy.<sup>34</sup> MinnesotaCare's actuarial value—the portion of medical costs the program will pay for on average—is estimated at over 96 percent.<sup>35</sup> A silver QHP has 70 percent actuarial value (73 percent with cost-sharing reductions) a bronze plan 60 percent.

Higher cost-sharing in the QHPs is a real concern. Research indicates that even when people have health insurance coverage, they may find the cost of care unaffordable. In a recent survey, 27 percent of Minnesotans between ages 18 and 64 said they had foregone needed health care due to cost.<sup>36</sup> While the ACA's tax credits help low-income consumers afford monthly premiums, cost-sharing assistance is only available to those who purchase silver-level plans.

### **Provider Networks**

Minnesotans may face disruptions in access to preferred providers as they shift between programs. Unfortunately, statistics on the extent of these disruptions are, to our knowledge, unavailable. To our knowledge, there are no statistics on the number of Minnesotans who lose access to their preferred providers when their program eligibility changes. Minnesota has few narrow networks compared to other states, although some exist.<sup>37,38</sup> At least two carriers, UCare and Medica, created MNsure plans to mirror their MinnesotaCare products, but many consumers leaving MinnesotaCare in 2014 chose other, lower-cost plans instead.<sup>39</sup> In rural areas with few providers, all health plans may need to contract with all providers to meet network adequacy requirements, and networks may overlap almost completely.<sup>40</sup> In provider-dense areas, however, consumers may have to research networks or choose a higher-cost plan to keep their providers.

### **The Remaining Uninsured**

Although Minnesota's uninsured rate is almost 50 percent lower than the national average, stakeholders remain committed to expanding coverage.<sup>41,42</sup> In 2014, 6.7 percent of adults aged 18 to 64 and 4.9 percent of all Minnesotans, or approximately 264,000 people, lacked health insurance.<sup>43,44</sup> Although detailed demographic information about the uninsured is not available for 2014, past surveys show that uninsured Minnesotans are more likely to be low-income, non-white, non-US-born, unmarried, and in poorer health compared to the population as a whole.<sup>45</sup> In 2013, the uninsured were 60.9 percent white, 20.2 percent Hispanic, 11.1 percent black, 7.6 percent Asian, and 3.6 percent American Indian.<sup>46</sup> After ACA implementation, up to 12 percent of the remaining uninsured may be undocumented immigrants without access to public insurance programs or MNsure coverage.<sup>47</sup>

### **MNsure and BHP Funding**

MNsure and MinnesotaCare will both see major shifts and some uncertainty in their revenue sources over the next three years. The federal CCIIO grant that provides over 60 percent of MNsure's 2015

revenue will expire in 2016. Somewhat offsetting that loss, MNSure's revenue from premium assessments will triple by 2017 due to an increase in the percent withheld. To accommodate its lower budget, MNSure plans to reduce expenditures across the board, most significantly on the IT system.<sup>48</sup>

MinnesotaCare, meanwhile, begins receiving federal BHP funding in 2015 as its Medicaid waiver funding ends. Expenditures not covered by BHP funding will need to come from enrollee premiums and the state's Health Care Access Fund, which is funded largely by the 2 percent provider tax. State expenditures on MinnesotaCare are projected to more than double by 2017 due to rising enrollment and managed care rates; as a result, the Health Care Access Fund will be \$62 million in deficit in 2017.<sup>49</sup> Federal BHP funding hinges on the second lowest cost silver plan on MNSure; low premiums on MNSure mean less federal funding and higher state outlays. Projections for 2015 BHP funding were revised upward when premiums increased 10 percent over 2014 levels, but gains were offset by the large numbers of new enrollees in the metro region, where rates are lowest.<sup>50</sup>

### Delivery System Reform

Minnesota is a national leader and early adopter of many delivery system reform initiatives.

- Public and private payers and provider networks are experimenting with shared savings contracts such as Accountable Care Organizations (ACOs), including three Medicare ACOs and nine Medicaid ACOs. Such contracts now apply to about one-sixth of MA enrollees and between one-third and two-thirds of commercial plan enrollees.<sup>51,52,53</sup>
- State law requires all payers to make coordination-of-care payments to primary care clinics certified as "health care homes," encouraging clinic staff to take responsibility for the well-being of their patients between visits, including coordinating mental health and social services.<sup>54</sup>
- All clinics and hospitals participate in the Statewide Quality Reporting Monitoring System, making clinic-by-clinic comparison possible for certain process and outcome measures, such as optimal diabetes care.<sup>55</sup>
- Hennepin Health, a Medicaid HMO, is demonstrating how investments in housing, social services, and preventive mental health and medical care can improve patients' health and save the state money on care for high-risk patients.
- Minnesota has one of the highest rates of electronic health record adoption nationally, thanks to a legislative mandate.<sup>56</sup>

Still, many of these initiatives are in their infancy. Although shared savings contracts are in place for a significant number of patients, only two to seven percent of participating health systems' revenues are affected. Different payers also measure and reward different health outcomes, creating confusing signals for providers.<sup>57,58</sup> Indeed, for most medical conditions and procedures, quality measures do not yet exist.<sup>59</sup> While Hennepin Health has been successful at integrating medical care, behavioral health, and social services, other health systems are at the very beginning of the learning curve.<sup>60</sup> One hundred ninety primary care clinics have been certified as health care homes, but the first study of their impact has yet to be released.<sup>61</sup> A 2008 initiative to report quality and cost measures for individual doctors (in addition to clinics) was suspended due to provider concerns that ratings based on de-identified patient records could not be verified.<sup>62</sup> Finally, MNSure has the statutory authority to select plans based on

criteria such as quality and value, but has yet to take this step.<sup>63</sup>

### **Decision Criteria**

Later in this report, we rate each waiver option according to the following six criteria based on the priorities we heard from DHS, MNsure, and other stakeholders during interviews.

#### ***1. A smooth continuum of coverage from 0% to 400% FPG***

Does the option (a) eliminate premium cliffs, (b) reduce the number of transition points at which people may lose coverage, (c) allow patients to keep provider networks when their income changes, and (d) keep family members on the same insurance plan?

#### ***2. Affordability***

Under each waiver option, is the cost of insurance coverage affordable for consumers? Will insured consumers be able to afford the out-of-pocket costs of care under their plans?

#### ***3. Universality and comprehensiveness of coverage***

Can the option improve insurance access for the remaining five percent of Minnesotans who are uninsured? Can it improve the comprehensiveness of the benefits offered?

#### ***4. Financial feasibility***

Is the option (a) cost-neutral to the federal government, and (b) affordable for the State of Minnesota?

#### ***5. Administrative feasibility***

Does the option require a difficult administrative transition, and once established, will it be difficult to sustain?

#### ***6. Leveraging delivery system reform***

How will the option affect state efforts to control health care costs, improve quality, and pursue current reform initiatives, including accountable care organizations, Health Care Homes, and efforts to integrate social services and mental health care into the medical system?

## Part III: Using the 1332 Waiver to Achieve Minnesota's Goals

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## Using the 1332 Waiver to Achieve Minnesota's Goals

### Opportunities for Incremental Change

This section describes three areas where Minnesota can invest in short-run changes: (1) enhancements to Minnesota's current policies and programs; (2) technical changes to better align programs; and (3) affordability improvements for certain populations.

All of these incremental changes can be implemented alongside any of the three global reform options presented in the following three sections (p. 28-41). We recommend making these adjustments regardless of which, if any, of three reform options Minnesota chooses to pursue. Some of these changes, particularly in the second two categories, will require a 1332, 1115, or joint waiver. They are thus best considered in the context of a more ambitious global waiver application.

#### Category 1: Enhancements to Minnesota's Current Policies and Programs

##### *Build on Successes of the Minnesota Accountable Health Model*

Minnesota is a leader in service delivery reform and is receiving funding from the State Innovation Model Grant through October 2016 to test its growing accountable health model.<sup>64</sup> The state should continue prioritizing the testing and expansion of service delivery alternatives. Since it is uncertain whether CMS will provide a third round of funding, Minnesota should consider integrating its service delivery reform needs into a future federal waiver application.<sup>65</sup>

##### *Improve the DHS and MNsure Web-Based Consumer Experiences*

The MNsure website experienced a bumpy start during the 2013 launch of the Marketplace.<sup>66</sup> In 2014, the website was markedly improved, though some glitches remained.<sup>67,68</sup> Regardless of other measures taken to improve the health insurance system, MNsure should continue to ensure adequate IT funding, allowing for website enhancements that promote ease of use. Examples for additional improvements include creating automatic information transfer of MNsure enrollees to their insurers, simplifying the reenrollment process for beneficiaries whose income or circumstances change, and conducting customer satisfaction surveys that elicit additional feedback.<sup>69</sup>

##### *Use Navigators for Reenrollment Processes and Health Insurance Literacy*

The Assister Network is already an important resource in Minnesota. However, federal establishment funds and navigator-specific grants that finance this program are temporary, and it will be up to the states to continue funding the program. Navigators were used in the initial launch of the ACA to assist individuals in the transition to the new system. However, they remain important given that: (1) Changes brought by the 2017 waiver may require navigator assistance; (2) New consumers unfamiliar with MNsure may enter into the market (e.g. by graduating from their parents' insurance at age 26); (3) Consumers are still adjusting to the new system and may need assistance in understanding reenrollment procedures through the near-term; and (4) MNsure can use navigators to encourage consumers to "shop" during reenrollment.

To gauge the success of the navigator program, MNsure should consider conducting a survey similar to the Health Insurance Literacy Survey by the American Institute for Research.<sup>70</sup> National surveys already indicate that many consumers are not informed about the various forms of financial assistance for health insurance.<sup>71</sup> The study could identify areas where consumer understanding is still lacking and inform navigator training. For instance, a multi-tiered training would generate navigators at different levels: new assisters, advanced navigators who have deeper expertise in eligibility issues, and expert in-house navigators who provide support to assisters working directly with families.<sup>72</sup>

As individuals become familiar with reenrollment procedures, navigators can also expand their services and provide continuing education around the use of health insurance, including how to interpret a health plan's benefits and how to select a provider. Continuing the Assister Network program and expanding the role of navigators will require additional funding in the coming years, and, given the unpredictability of federal financing, it may be necessary to seek state and private resources.

### **Active Purchasing Authority and Choice Architecture**

MNsure can use active purchaser authority and choice architecture to help low-income consumers look beyond sticker-price premiums and pick the plan that is best for them.

There is evidence that consumers tend to overweight premiums and underweight out-of-pocket costs when considering the cost of insurance.<sup>73</sup> There are two behavioral explanations for this. First, while premiums are relatively simple to understand, deductibles, copays, and coinsurance can be opaque to consumers.<sup>74</sup> Second, lower-premium plans allow consumers to defer high payments until later, which is attractive given the human tendency to discount future losses.<sup>75</sup>

While the preference of many consumers for lower levels of coverage is understandable, it is frequently suboptimal for them. More comprehensive coverage allows consumers to smooth the cost of healthcare over the course of a year and avoid financial shocks—particularly important for families without significant savings.

### **Premiums and Metal Level Choice**

Minnesota's Marketplace offered the lowest premiums in the country in 2014. Despite significant rate increases in 2015, premiums for benchmark silver and bronze plans in the Twin Cities remain among the lowest for all major metropolitan areas.<sup>76</sup>

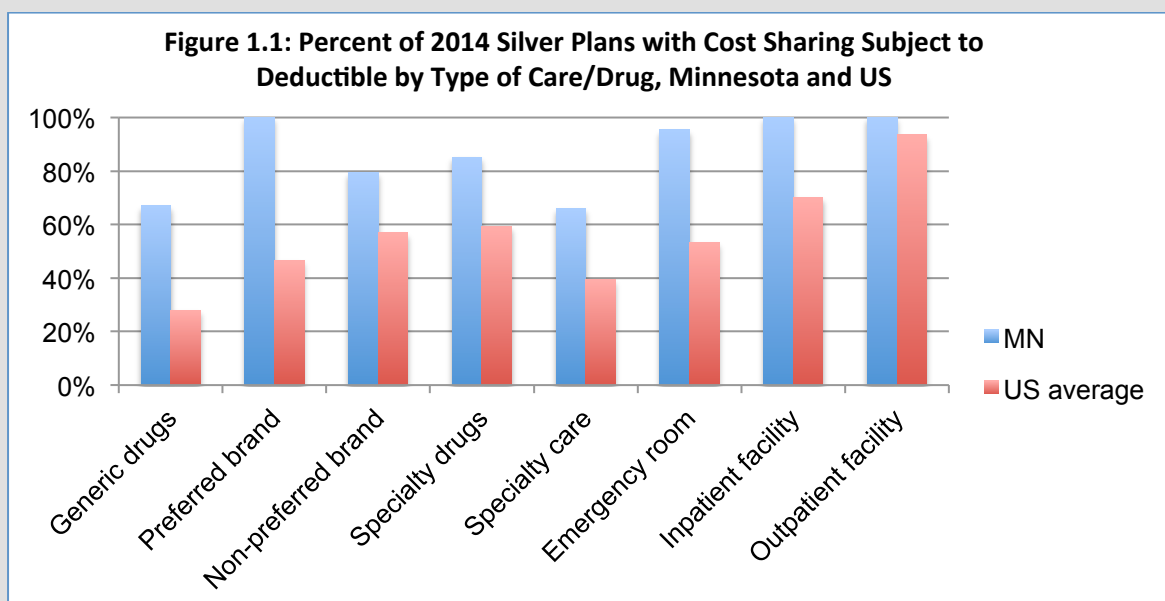
In the first month of MNsure's open enrollment for 2015, 34 percent of QHP enrollees opted for bronze plans, which carry the highest out-of-pocket costs at an actuarial value of 60 percent. In 2014, 25 percent of Minnesotans enrolling in QHPs chose bronze plans, compared to 20 percent nationwide.<sup>77,78</sup> Consumers between 200% and 250% FPG are eligible for federal cost-sharing reductions only if they enroll in silver plans, but not if they enroll in plans in other metal tiers.

Affordable premiums are attractive to consumers, but premiums are only one piece of the true cost of coverage. Out-of-pocket costs, which are higher in lower metal tiers, offset the benefits of low premiums.

### **Cost-Sharing Subject to a Deductible**

In a study of 15 states, Minnesota's Marketplace plans for 2014 were found to have the highest deductibles, at \$4,061 on average.<sup>79</sup> Furthermore, the plans on Minnesota's Marketplace tended to subject a wider variety of services and drugs to the deductible than the national average. In 95 percent of plans on MNsure, for example,

consumers would have to pay the entire cost of all emergency department visits until they met their deductible, compared to 53 percent of plans nationwide. High-deductible plans are not inherently bad, but consumers need to understand and plan for the potential costs in order to avoid financial hardship.



Source: "Geographical Patterns in Cost Sharing in Silver Plans."  
Robert Wood Johnson Foundation. November 2014. Web.

#### **Implications for Low-Income Minnesotans**

A Minnesotan transitioning from MinnesotaCare to the QHPs might look for the plan on MNsure with the lowest premium. A Twin Cities resident at 201% FPG could purchase the Fairview UCare Choices Bronze plan for \$82 per month after a premium subsidy of \$58 and no cost-sharing assistance. If this consumer ends up with an unexpected hospital stay, she could end up paying the full in-network deductible of \$5,000. The most she might have to pay out of pocket over the course of the year is the federal limit of \$6,600, or 28 percent of her income.<sup>80</sup> High-deductible plans rely on consumers having a financial cushion, which may not be manageable for low-income Minnesotans.

#### **Implications for MNsure and DHS funding**

The ACA's financing mechanisms make it advantageous for states to nudge enrollees toward adequate coverage. In a market where consumers shop and plans compete based on premium alone, Minnesota misses out on a number of benefits of the ACA. For example, when low-income consumers choose bronze plans, they forfeit the federal cost-sharing reductions available for silver plans.

Lower-than-expected premium and cost-sharing assistance are particularly problematic given Minnesota's pursuit of alternative coverage programs under the ACA. MinnesotaCare's federal funding is based on the premium assistance the eligible population would have received if they had enrolled in the Marketplace. A 1332 waiver would be financed similarly.

#### **Strategies for MNsure: Active Purchaser and Choice Architecture**

MNsure could employ two strategies to help consumers choose realistically affordable plans in 2016 open enrollment. Active purchaser and improved choice architecture are already on the board's agenda for the coming year, and we recommend moving forward with both.

- A. First, MNSure could exercise **active purchaser** authority to standardize cost-sharing structures within metal levels and to exclude plans that are judged unaffordable or misleading to consumers. For example, the Massachusetts Health Connector requires standardized cost-sharing structures for over 80 percent of its plans. Annual deductibles, out-of-pocket maximums, and copays are constant across plans in each of seven metal categories (Platinum A/B, Gold A/B/C, Silver, and Bronze).<sup>81</sup> This standardization allows consumers to compare “apples to apples” and use premiums as a reliable indicator of affordability.<sup>82</sup> MNSure could take a similar approach to standardization, excluding cost-sharing structures that have high hidden costs and pose financial risks for low-income consumers.
- B. Second, MNSure could structure its **choice architecture** to help consumers understand the true cost of care, encourage them to look beyond premiums, and guide them toward silver plans if they would benefit from federal cost-sharing reductions. Rather than standardizing cost-sharing, MNSure would employ web-based decision tools to guide consumers toward affordable plans and discourage shopping on premiums alone.<sup>83</sup>

MNSure’s current design does highlight the importance of cost-sharing by asking consumers to indicate the maximum annual deductible they would be comfortable with and providing a link for more information. At the same time, a message on the MNSure website’s “Find a plan” page states, “If you are looking for a lower deductible the plan will cost more.”<sup>84</sup> This language may imply to consumers that total cost is determined by premiums rather than by the combined premium and cost-sharing structure, and may nudge them toward lower-premium plans. The website could instead emphasize that the premium is only one aspect of total costs, flag the risk of unexpected spending on high-deductible plans, and make premiums less prominent in the initial plan presentation.

For consumers between 201% and 250% FPG who are considering bronze plans, MNSure could take extra care to highlight any out-of-pocket costs subject to the deductible and indicate that cost-sharing reductions are only available for silver plans.

## Category 2: Technical Changes to Better Align Programs

Although DHS and MNSure coordinate well, there are differences between the public and Marketplace insurance systems that cause confusion for consumers. The technical changes proposed here would create a smoother consumer experience at churn points. Some may require a 1332, 1115, or coordinated waiver to be implemented.

### *Implement Annual Projected Income Across All Programs for Continuing Eligibility Determination*

MA currently asks consumers to determine point-in-time income, while MinnesotaCare and the Marketplace use annual projected income.<sup>85,86</sup> Using one standard across programs will promote continuity of coverage and predictability of health care costs for families. Between the two options, annual projected income may provide a more accurate picture of a family’s financial status, especially for those whose earnings are seasonal.<sup>87</sup>

As a first step, Minnesota should consider using projected annual income to assess continuing eligibility for MA, an option provided to states under the ACA.<sup>88,89</sup> Once this is implemented, DHS will be better positioned to judge whether projected annual income should be used to assess eligibility for all MA enrollees, a change that might require a waiver. Questions to consider when expanding projected



annual income include: (1) What is the potential for miscalculations or fraud when using projected income? (2) What will be the financial recourse for individuals who under-calculate their incomes and are eligible for MA? (3) Are families with ongoing MA eligibility, and thus potentially new applicants, able to accurately estimate their projected income?

### ***Create Consistent Enrollment Procedures Across Public Programs***

The lag time between application and enrollment date differ between programs, causing consumer confusion and gaps in coverage at the churn points. Medical Assistance provides coverage retroactively to the first day of the month and is available up to three months before the month of the application, while MinnesotaCare begins the month following receipt of the premium.<sup>90,91</sup> Medical Assistance's retroactive approach and lack of delay regarding premium payment provides continuous coverage for longer. Thus, we suggest that MinnesotaCare consider adopting this procedure. It should be noted that shifting MinnesotaCare's procedures towards the generous retroactive enrollment of MA will likely increase costs. Furthermore, neither program is aligned with the Marketplace, where coverage begins on the first of the month after enrollment during an open or special enrollment period.

### ***Implement Uniform Post-Eligibility Verification of Income Across Programs***

Medical Assistance requires that consumers submit all documentation, including income, citizenship, and immigration statuses, before determination of eligibility can be made.<sup>92</sup> MinnesotaCare and the Marketplace allow for post-eligibility verification and provide for a grace period of 95 days for receipt of documentation.<sup>93</sup> Aligning these verification procedures across programs would promote administrative ease and decrease consumer confusion at churn points. We recommend an allowance for post-eligibility verification in MA so that consumers can receive coverage quickly and experience smooth transitions at churn points. In order to control losses due to fraud and error, the Marketplace allowance period may be shorter than MinnesotaCare's: for instance, 60 days instead of 95 days.

### ***Utilize Uniform Household Definition Across Programs***

The Marketplace, MA, and MinnesotaCare all use different household definitions. In general, the Marketplace defines a household based on tax filing status in determining Advance Premium Tax Credit (APTC) eligibility, while the public programs also consider living arrangements and the relationships of members within a household.<sup>94</sup> Depending on the definition used, family members may have different FPG calculations, making them eligible for different programs depending on the definition.<sup>95</sup> This leads to confusion for families and an additional administrative burden in attempting to manage three definitions.<sup>a</sup> Given the problems with differing eligibility and the additional administrative work this

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<sup>a</sup> The following are three examples in which definitions are not aligned: MA accounts for the income of both unmarried parents in eligibility determination, while the Marketplace only includes the income of the parent that claims the child as a dependent; MinnesotaCare considers the relationship of a step-parent to a step-child that of a parental relationship, while MA only does so under specific circumstances; and MinnesotaCare is the only state health program that considers guardianship in determining household size. [Source: *Minnesota Health Care Programs Manual*. Minnesota Department of Human Services. December 2014. Web. 26 December 2014.]

creates, we recommend using a coordinated waiver to standardize household definition across MA, MinnesotaCare, and the Marketplace.

### Category 3: Affordability Improvements

#### *Use a Waiver to Resolve the “Family Glitch”*

Under the ACA, if an individual receives an offer of employer-sponsored insurance (ESI), only the cost of individual coverage is considered in the IRS’s definition of “affordable.” Those with an “affordable” ESI offer are not eligible for APTCs on the Marketplace. For some, the cost of individual ESI coverage may be affordable but the cost of family coverage is not. These families are then unable to purchase affordable Marketplace coverage. This problem is referred to as the “family glitch.”<sup>96</sup> Minnesota’s 1332 waiver application could include a “family waiver,” similar to Senator Al Franken’s proposed Family Coverage Act of June 2014.<sup>97</sup> This would allow family members in this situation to receive APTCs for which they were previously ineligible, ensuring that children and spouses who do not have access to affordable ESI through a family member can access affordable insurance through MNsure. Such an amendment to current regulations would require a federal waiver and additional funds for the subsidies.

#### *Expand Affordable Coverage for Currently Ineligible Immigrants*

In order to expand coverage to the last five percent, Minnesota may need to support those ineligible for public insurance, including undocumented immigrants.

Most non-citizens are in the income ranges required to qualify for MA or APTCs.<sup>98</sup> However, even lawfully present immigrants are subject to restrictions, including a five-year waiting period for MA. States have the option to waive this provision for children and pregnant women, but not for other adults.<sup>99</sup> In Minnesota, lawfully present noncitizens up to 200% FPG are eligible for MinnesotaCare, lawfully-present pregnant women and children regardless of date of entry into the United States are eligible for MA, and undocumented pregnant women are eligible for certain MA services.<sup>100,101</sup> Lawfully present immigrants are eligible to purchase QHPs and receive APTCs without a waiting period.

Undocumented immigrants are excluded from both the Medicaid expansion and Marketplace coverage at a national level. Some states, however, use their own funds to provide expanded coverage for noncitizens. For example, Illinois, New York, and Washington all use state funds to provide forms of medical assistance for children regardless of immigration status.<sup>102</sup>

By 2016, 210,000 individuals in Minnesota are expected to remain uninsured, with 12 percent being undocumented immigrants.<sup>103</sup> The state may want to consider providing affordable coverage to noncitizens by: (1) expanding MA eligibility to all documented immigrants regardless of entry date; (2) expanding financial support through MA, MinnesotaCare, or MNsure APTCs to children who are undocumented; and/or (3) expanding financial support through MA, MinnesotaCare, or MNsure APTCs to all undocumented immigrants.

Minnesota may need to request a 1332 and/or 1115 waiver to bypass the federal restrictions on undocumented immigrant participation in MA, the BHP, and the Marketplace. Funding to subsidize coverage for this population would need to come from the state.

### Smooth the Premium and Cost-Sharing Schedule to Minimize Cliffs

For any of the three options that follow, we recommend that Minnesota include in its waiver application a proposal to smooth premium and cost-sharing cliffs along the 0%–275% FPG spectrum. The eligibility thresholds and vehicles for subsidized insurance will differ across the options, but the commitment to providing an affordable, smooth continuum of coverage is constant.

Table 2.1 shows the changes in premium and actuarial value across the 138% and 200% churn points for 2015. The most significant cliff for both premiums and cost-sharing is at 200% FPG, between the current MinnesotaCare and QHP guidelines. This section presents a few alternatives to this disjointed system. These simply serve to illustrate a few directions the state could pursue if it would like to create a smoother continuum of premiums and cost-sharing for low-income residents.

**Table 2.1. 2015 Premiums and actuarial value for MA, MinnesotaCare, and QHPs for a 25-year-old non-smoker in the Twin Cities**

2015	Silver QHP		Bronze QHP		Federal Requirements	
%FPG	Premium (\$) <sup>104,105</sup>	AV (%) <sup>106</sup>	Premium (\$)	AV (%)	Premium as percent of income (%) <sup>107</sup>	AV (%) <sup>108</sup>
0	0	96+	0	96+	–	94
138	0	96+	0	96+	2.01	94
139	21	96+	21	96+	3.02	94
200	50	96+	50	96+	6.34	87
201	125	73	82	60	6.34	73
250	183	73	140	60	8.1	73
275	183	70	140	60	9.56	70

The shape of a revised premium and cost-sharing schedule will hinge on the availability of state and federal funding. Minnesota could seek, for example, to maintain current premiums and cost-sharing for those under 200% FPG, providing assistance to those above the cliff to help ease the transition. MinnesotaCare premiums were reduced effective January 2014 in order to comply with anticipated BHP requirements and improve affordability.<sup>109</sup> In order to preserve this level of affordability in the public plans while also providing assistance to those under 275% FPG currently shopping on the Marketplace, Minnesota would need to secure significant additional funding for premium assistance beyond what a 1332 waiver can provide. One way Minnesota could partially offset the decrease in premiums is to slightly increase cost-sharing for portions of the population currently on public plans with over 96 percent actuarial value.

### Premium Smoothing

We recommend that Minnesota create a more linear sliding scale of premiums across the 0%–275% FPG spectrum. In particular, we propose having premiums increase more gradually between MA and MinnesotaCare and between MinnesotaCare and the QHPs. Figure 2.1 maps the current premium schedule for a 25-, 40-, and 60-year-old non-smoker living in the Twin Cities, according to their income level and eligibility for MA, MinnesotaCare, or a silver QHP.

Figure 2.1. Effective 2015 premiums for a 25-, 40-, and 60-year-old purchasing a silver plan on MNsure

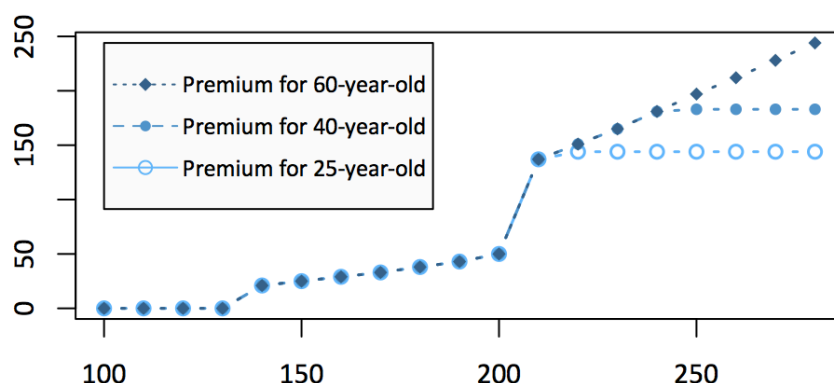


Figure 2.2. Proposed premium schedule relative to 2015 effective premiums for a 25-year-old choosing a silver QHP

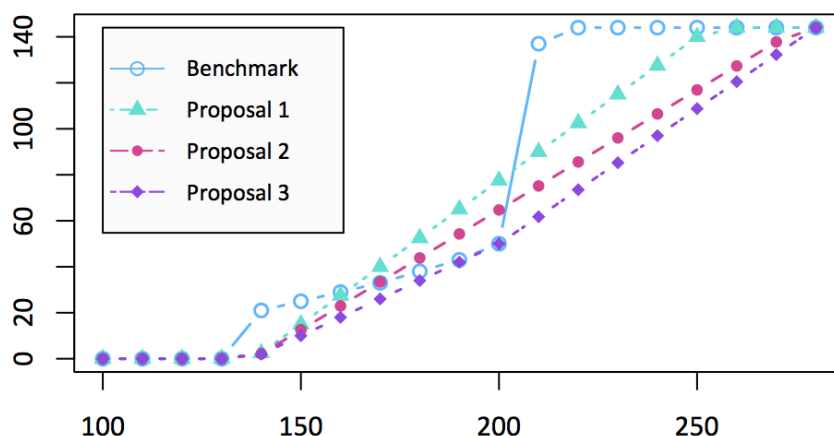


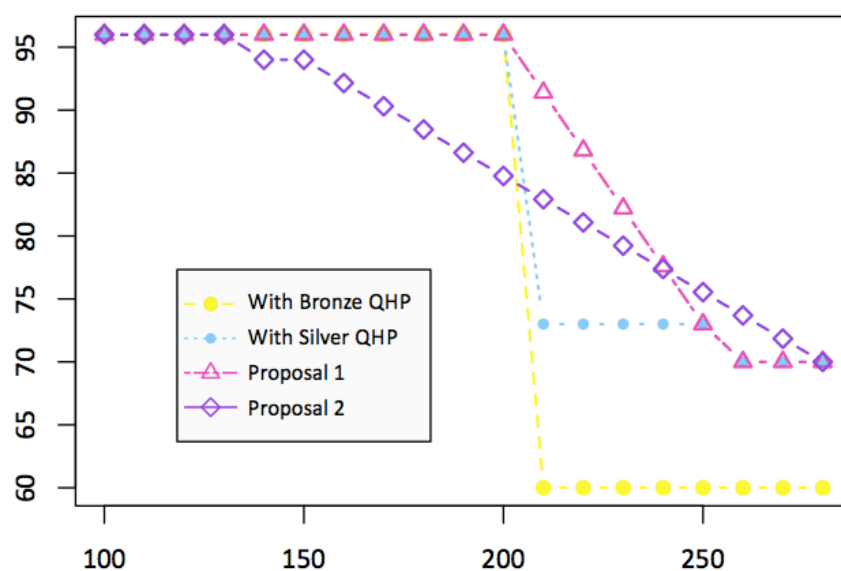
Figure 2.2 uses the 2015 effective premiums for the 25 year-old choosing a silver plan as the benchmark and offers three alternatives: Proposal 1 includes premiums of roughly \$2 at 139% FPG, \$77 at 200% FPG, and \$144 at 275% FPG. It requires increasing premiums for some current MinnesotaCare enrollees in order to slightly offset premium reductions for those at both lower and higher income levels. Proposal 2 includes premiums of roughly \$2 at 139% FPG, \$65 at 200% FPG, and \$144 at 275% FPG. It also requires increasing premiums for some current MinnesotaCare enrollees, but less steeply than in Proposal 1. Proposal 3 includes premiums of roughly \$2 at 139% FPG, \$50 at 200% FPG, and \$144 at 275% FPG. It maintains the \$50 maximum premium in MinnesotaCare and reduces premiums for all others between 138% and 275% FPG.

Ultimately the adjusted premium schedule will need to take into account the variation in Marketplace premiums by age and geographic location, and seek to harmonize this with the age- and location-invariant premiums for MinnesotaCare.

### Cost-sharing Adjustments

We also recommend providing greater cost-sharing assistance to those currently without access to public programs, who are most vulnerable to financial shocks due to high out-of-pocket spending. This is a particular concern for those in the 200%–275% FPG range who purchase bronze plans, making them ineligible for federal cost-sharing reductions. Figure 2.3 shows current and proposed actuarial value, with the ACA’s requirements as a benchmark. Proposal 1 requires additional cost-sharing assistance for the 200%–250% FPG population to smooth cliffs in out-of-pocket spending. Depending on the global reform option pursued, this assistance would be provided either through a public plan with low cost-sharing requirements or through subsidies on MNsure. In order to offset the cost of additional subsidies for this population, Minnesota could consider gradually increasing cost-sharing for part of the 150%–200% population to provide gradually decreasing actuarial value (Proposal 2). However, this may require a federal waiver if actuarial value drops below federal requirements. A sliding scale of deductibles and/or copays could also be difficult to administer if this population remains on a public program.

Figure 2.3. Actuarial Value for MA, MinnesotaCare, and Bronze and Silver QHPs

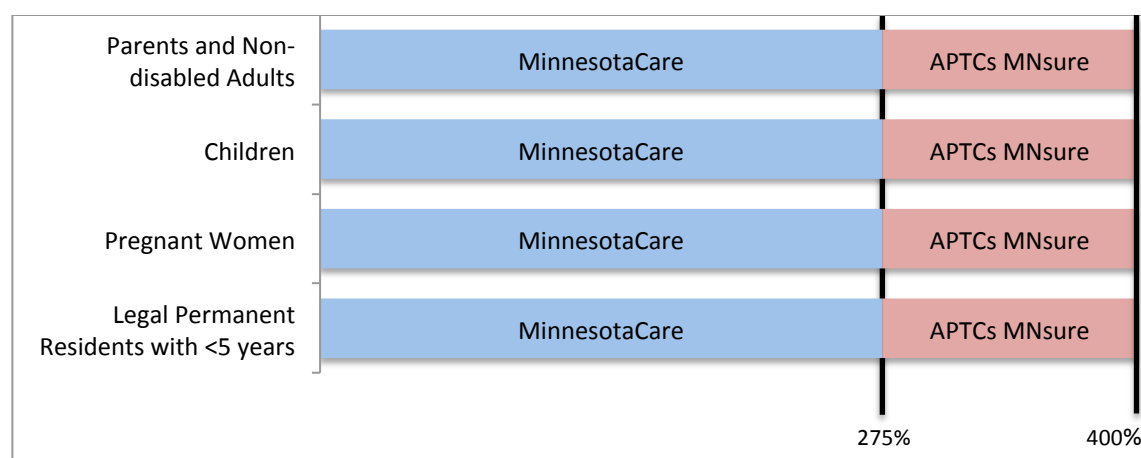


## Option A: DHS-Driven Consolidation of Public Programs

### Vision

This option expands Minnesota’s existing high-quality public programs. A single, consolidated public plan will serve most families and individuals with incomes between 0% and 275% FPG, eliminating the 138% FPG churn point and raising the threshold between the public programs and private Marketplace to a higher income level. The state will be able to leverage its greater market share to drive delivery system reform through the procurement process, rather than by relying on indirect and uncertain market mechanisms. Since the number of customers shopping for subsidized private insurance will decline, MNsure will play a smaller role in Minnesota’s health reform program.

Figure 1: Coverage Under Option A



### Description

Option A will enroll all non-“high-need” children and adults living in households between 0% and 275% FPG in a single program called MinnesotaCare. High-need populations, such as long-term care and disabled patients, will remain in the traditional MA program, following the example of Arkansas’s Medicaid expansion.<sup>110</sup> For the sake of alignment, the eligibility ceiling for pregnant women for the public program will be decreased to 275% FPG from its current position of 280% FPG.<sup>b</sup> Instituting a 275% FPG ceiling for all individuals restores MinnesotaCare to its former eligibility cutoff, as recommended by the legislature.<sup>111</sup> By establishing the same ceiling for children and pregnant women, these changes will allow families to receive care on the same plan.

The consolidation of programs could take a variety of forms. At a minimum, DHS could rebrand non-high-need MA as MinnesotaCare, taking advantage of the existing unified application process while maintaining separate back-end administration of the programs. A more ambitious option would be to fully consolidate the programs, creating a single system for program administration, provider payment,

<sup>b</sup> One consideration in shifting pregnant women from MA to MinnesotaCare is that the former offers transportation services that the latter does not. DHS should consider carrying over those services for pregnant women during the integration of the programs.

managed care contracting, and beneficiary contributions. In any scenario, the state should attempt to harmonize the benefits packages of the two programs, so that all of the covered services available under one program are available in the other, albeit with greater cost-sharing among higher income groups.

Medical Assistance and MinnesotaCare currently operate with an unwieldy mixture of integration and separation. They run on separate funding streams, with the former relying on Medicaid and CHIP waivers and the latter relying on the BHP funding mechanism established in the ACA. Furthermore, MA is overseen at the state level by DHS and implemented by the counties, while MinnesotaCare is administered by the DHS MinnesotaCare office.<sup>112</sup> Yet for several important functions, DHS is required by state law to coordinate between the programs, as in application procedures, provider payment, managed care, and service delivery.<sup>113,114,115,116</sup>

The upcoming 2016 statewide managed care procurement is an opportunity to further integrate the two programs.<sup>117</sup> Carriers providing plans in MinnesotaCare are required to provide plans in MA as well, but not in every county. MinnesotaCare enrollees in some counties are therefore vulnerable to disruptions in care if they become eligible for MA.<sup>118</sup> DHS could set a new requirement that plans wishing to participate in public programs accept enrollees from MA in every county. A coordinated 1332 and 1115 waiver application for 2017 could further rationalize this administrative tangle, merging program requirements and consolidating administration.

### Looking Ahead

The implementation of Option A in 2017 could set the stage for several different expansion paths after the first 1332 waiver period ended in 2022. We highlight two paths, each of which would further institutionalize health care expansion and would represent strong progressive achievements.

One vision would extend MinnesotaCare up to 400% FPG. This option would eliminate all churn points except the one at 400% FPG and would boost DHS's influence over delivery system reform. However, it would also eliminate much of MNSure's customer base. MNSure would still play an important role as a small business Marketplace, an individual Marketplace for those above 400% FPG, and a portal to public programs, but it would not sell subsidized private insurance to individuals. This would perhaps undermine the investments Minnesota has made in establishing a state-based Marketplace. Even more problematic is that this plan would weaken Minnesota's individual private insurance market and may make it more difficult for individuals and families above 400% FPG to obtain coverage.

An alternative expansion vision would create an optional MinnesotaCare buy-in program for Minnesotans between 275% and 400% FPG, or for anyone above 275% FPG. This program would virtually eliminate churn among enrollees; as household incomes shift, premiums and cost-sharing would adjust, but providers and coverage would stay constant. The Congressional Budget Office analyzed the budgetary effects of a national coverage buy-in program and estimated that the program would have premiums seven to eight percent cheaper than private plans offered on the exchange from 2016-2023 and would reduce overall government outlays. Nevertheless, there are potential downsides to such a path. The buy-in program might crowd out private carriers or attract a disproportionate share

of high-cost individuals. Furthermore, there are political and policy risks in imposing the lower provider reimbursement rates of public plans on a larger segment of the market.<sup>119</sup>

## Evaluation

### *Smoothing the Coverage Continuum*

By integrating MA into MinnesotaCare, this plan eliminates the 138% FPG churn point and helps smooth the continuum of coverage compared to the status quo. Furthermore, implementing the cost-sharing recommendations discussed in the “Opportunities for Incremental Change” section (p. 19) will significantly smooth the payment continuum.

Another crucial aspect of coverage continuity is the possible change in provider networks between MinnesotaCare and the QHP market. In rural areas with few providers, consumers may be more likely to keep the same provider network, as all health plans may have to contract with nearly all providers to meet network adequacy requirements. In urban areas with more care options, health plans can selectively contract. In these areas, when a consumer transitions between MinnesotaCare and a QHP, it is generally possible to choose a new plan with a similar network. However, people with low health insurance literacy may inadvertently lose access to their current providers if they do not fully understand the plans they are choosing. Furthermore, the lowest-price QHPs may have achieved these low costs by creating more narrow networks than MinnesotaCare.

### *Affordability*

Option A could offer increased affordability to consumers up to 275% FPG depending on the formula adopted to determine premiums (and possibly deductibles) paid. See “Smooth the Premium and Cost-Sharing Schedule to Minimize Cliffs” (page 25).

In the long term, if Minnesota continues to expand public coverage to individuals above 275% FPG, a higher percentage of the state’s population will be enrolled in state-run programs. In theory, greater consolidation in public procurement could enable the state to negotiate lower rates and reduce overall administrative costs.

### *Universality and Comprehensiveness of Coverage*

Reducing churn alone could marginally increase the percentage of the population with health insurance. With fewer coverage gaps due to churn, more people will be covered at any given time. However, since undocumented immigrants remain ineligible for MinnesotaCare, this expansion alone does little to cover the remaining uninsured population in Minnesota. Nevertheless, benefits will be more comprehensive for the 200%–275% FPG population if the state maintains the current service package offered by MinnesotaCare: several benefits currently offered by MinnesotaCare are not offered by QHPs, such as interpreters and mental health case management.<sup>120</sup>

### *Financial Feasibility*

See “Financial Feasibility: A Comparative Analysis” (page 42).



### *Administrative Feasibility*

This option relies heavily on DHS, which will be responsible for providing coverage to the 0%–275% FPG population. DHS already participates in procurement for MA and MinnesotaCare, so this should not require an entire reworking of the agency’s operations. However, if the intended back-end integration of MA and MinnesotaCare is significant as opposed to a mere rebranding, implementation will require greater attention and resources within DHS.

### *Leveraging Delivery System Reform*

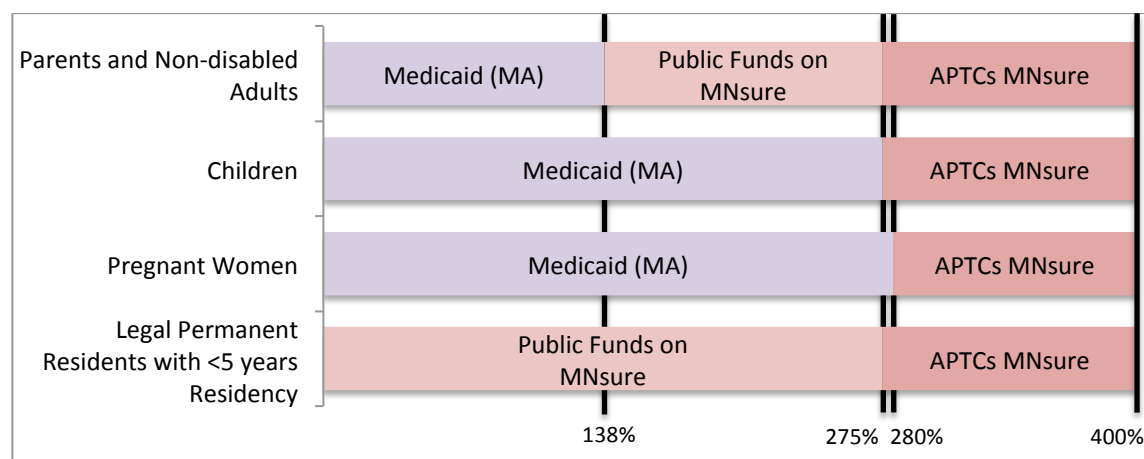
Option A maintains DHS’s prominent position as the purchaser of health care for over one-sixth of the state’s population.<sup>121</sup> The additional MinnesotaCare enrollees would marginally increase DHS’s purchasing power. DHS has initiated several reforms in recent years, including the introduction of competitive bidding for Medicaid Managed Care plans, and ACO contracts with nine provider groups covering 145,000 patients, demonstrating its willingness to use the procurement process for delivery and payment reform.<sup>122,123</sup> In the future, DHS could push for the inclusion of Managed Care Organization (MCO) and ACO contract provisions that improve the delivery system beyond payment reform: for example, future contracts could promote coordination of providers and reduce the occurrence of patients switching doctors, expanding DHS’s Integrated Health Partnerships (Medicaid ACOs), or incentivizing integration in funding for social services, behavioral health, and medical care.

## Option B: Coverage Expansion through the Marketplace

### Vision

This option uses the QHP Marketplace (MNSure) as the primary tool to expand coverage and leverage buying power for delivery system reform. Rather than relying on the state to administer the Basic Health Program (MinnesotaCare), it provides premium support for eligible individuals to purchase equivalent QHPs on MNSure, shifting the state's role from service delivery to subsidization of private insurance. This approach empowers MNSure to use its regulatory power to demand lower rates and more effective service delivery from private insurers. It provides greater consumer choice and relies on marketplace competition to drive down rates. Practically, this option allows individuals above the Medicaid eligibility line to stay on the exact same plan at any income level, reducing churn across the income spectrum.

Figure 2: Coverage Under Option B



### Description

Like Option A, this option would begin by restoring eligibility for MinnesotaCare to 275% FPG. However, instead of enrolling these individuals in a public plan, Minnesota would use public funds to subsidize the purchase of a private plan on the MNSure Marketplace. The 200%–275% FPG population would stay in the Marketplace but benefit from additional cost-sharing and services, while the 138%–200% FPG group would be moved *into* this reformed Marketplace.

Consumers in the 138%–275% FPG income range face large jumps in premium and out-of-pocket costs when they move onto the private market (see “Opportunities for Incremental Change,” page 19). Under Option B, Minnesota would wrap QHP plans purchased on MNSure with additional premium subsidies and lower cost-sharing requirements to make them financially similar to MinnesotaCare. Medically frail and disabled individuals would continue to be served by a DHS-administered public plan, such as MA, to protect them from potentially high out-of-pocket costs.

For the non-medically-frail population, the requirements for QHPs that can be sold on the Marketplace would become identical to the requirements for MinnesotaCare plans. As a result, any silver plan offered on MNSure would be eligible for purchase by a MinnesotaCare enrollee, using federal and state subsidies. Currently, MinnesotaCare offers several services not included in QHPs, such as dental and

vision services for adults, mental health case management, and interpreters.<sup>124,125</sup> These can be provided by the state on a fee-for-service basis as “add-ons” to a Marketplace plan. While MinnesotaCare enrollees would have the opportunity to shop on MNsure and choose their own plans, there would also be a procedure for placing them into a “default” plan if they did not make a choice.

One model for this option comes from Arkansas’s approach to Medicaid expansion, although in the case of Minnesota it would apply to the MinnesotaCare population rather than the MA program. Arkansas is using premium assistance to purchase QHPs for its Medicaid enrollees, with the exception of individuals who are considered “medically frail,” disabled, or in need of long-term services and supports. Because Medicaid offers benefits that are typically not covered by private plans, such as non-emergency transportation and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefits for 19- and 20-year olds, Arkansas continues to offer these “wraparound” services through traditional fee-for-service Medicaid. In addition, cost-sharing is capped at Medicaid state plan amounts for enrollees between 100% and 138% of FPG and eliminated entirely for enrollees below the federal poverty line.<sup>126</sup>

Iowa has taken a similar approach to Medicaid expansion. In its model, newly eligible Medicaid beneficiaries between 100% and 138% of FPG will receive premium assistance to help them purchase QHPs in the Marketplace, while newly eligible adults below 100% FPG will be enrolled in Medicaid managed care. As in Arkansas, services that Medicaid covers and QHPs do not, such as EPSDT and transportation, will be provided by traditional Medicaid on a fee-for-service basis. In addition, Iowa beneficiaries earning more than 50% of FPG will owe small (\$5 or \$10) monthly premiums, which can be waived if they complete certain “healthy behavior activities.” However, their coverage cannot be terminated for failing to pay premiums if their income is below 100% FPG.<sup>127</sup> Other states have considered similar options for Medicaid expansion; however, to our knowledge, no other state has considered using the vehicle of a BHP to provide similar subsidies and wraparound services to people above 138% FPG.

### *Leveraging Delivery System Reform*

Under Option B, Minnesota would build on Arkansas and Iowa’s examples to not only expand access to insurance, but also to drive delivery system reform. MNsure’s authorizing legislation gives it the power to be selective about the plans offered under its auspices, considering factors such as affordability, quality, value, and advancement of payment and delivery reform.<sup>c</sup> MNsure has several tools with which to accomplish this:<sup>128</sup>

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<sup>c</sup> “The board shall certify and select a health plan as a qualified health plan to be offered through the Minnesota Insurance Marketplace, if:...(2) the board determines that making the health plan available through the Minnesota Insurance Marketplace is in the interest of qualified individuals and qualified employers.” The board may consider the following: “(1) affordability; (2) quality and value of health plans; (3) promotion of prevention and wellness; (4) promotion of initiatives to reduce health disparities; (5) market stability and adverse selection; (6) meaningful choices and access; (7) alignment and coordination with state agency and private sector purchasing strategies and payment reform efforts; and (8) other criteria that the board determines appropriate.” The exceptions are that MNsure may not exclude a health plan from the exchange on the basis that it is fee-for-

- Setting additional certification criteria that reflect the state’s goals for such factors as population health, plan quality, access to providers, delivery system reform, and transparency
- Using a selective contracting process to negotiate better prices and higher-quality plans
- Managing product choices and setting parameters for cost-sharing
- Aligning with other large purchasers in the state, such as large employer coalitions or the state government employee benefits agency to send consistent purchasing signals to health insurance carriers and providers
- Providing information and web-based decision tools to encourage better consumer decision-making (see “Active Purchasing Authority and Choice Architecture,” page 20).

While MNsure has the authority to do all this now, it currently serves a relatively small number of Minnesotans, just over 100,000 people, and therefore may lack the leverage to drive major changes in insurer behavior.<sup>129,130</sup> (By comparison, MA currently serves over 800,000 Minnesotans.) Moving MinnesotaCare enrollees onto the Marketplace would increase the potential customer base that insurers can reach and therefore incent them to change their behavior in order to reach this desirable market.

California provides a model for leveraging insurers’ interest in access to Marketplace consumers to drive delivery system reform. Covered California, the state’s Marketplace, used a negotiation process to obtain lower costs and higher-quality networks from the dozens of health plans that expressed interest in offering plans. Working with providers, health plans, and regulators, they developed selection criteria, standardized benefit designs, solicitation procedures, and contract standards to create a competitive mix of 11 health insurance companies offering various types of coverage. During negotiations, some plans were rejected due to high costs or duplicative or inadequate offerings, while other plans lowered their prices or revised their proposals. The standardized benefit designs applied to plans offered outside of the Marketplace as well, reducing opportunities for risk selection and simplifying comparisons for consumers. The state also used a multiyear contracting policy to encourage insurers to enter the market during the first year of open enrollment and provide stability to its market. A Kaiser Family Foundation report found that Covered California’s work improved the competitiveness of its individual insurance market relative to the market that existed before the ACA, providing an example of the potential for state Marketplaces to encourage competition, higher quality, and lower costs.<sup>131</sup>

Massachusetts has also used proactive techniques to improve cost and quality in its Connector Marketplace. The part of the Connector that offers subsidized insurance has behaved as a large employer would, structuring the bidding and enrollment process to encourage lower costs and recruiting carriers with tighter provider networks and lower cost structures. The result was an annual increase in premiums of less than five percent, which was less than half the annual increase in the commercial insurance market. In addition, on the unsubsidized section of the market that serves small

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service, that it imposes premium price controls, or that it provides treatments necessary to prevent patients’ deaths that the Exchange determines inappropriate or too costly. Minnesota Statutes 2012, section 13.7191, subdivision 5.

businesses, the Connector required plans to meet a “Seal of Approval” before being offered in the marketplace, encouraging quality and efficiency even when they had less leverage over cost.<sup>132</sup>

In addition to the options outlined above, the process of assigning enrollees to default plans can be used to encourage certain types of competition or plan design. For example, Arkansas encouraged market entry and competition by assigning default enrollees through a method that guaranteed a certain market share for smaller insurers, encouraging them to enter new markets and compete with the larger and more established plans. MNSure can choose an approach to default enrollment that supports the market behaviors it desires in the Minnesota context.

### Looking Ahead

If this model is successful in lowering premium costs, spurring innovation in care delivery, and reducing churn for the population above the MA eligibility cutoff, it could be expanded. For instance, the population currently served by MA managed care programs (about 73 percent of all MA enrollees<sup>133</sup>) could be shifted onto the QHP market, again with subsidized out-of-pocket costs. This would allow an enrollee to remain on the exact same insurance plan regardless of their income, with varying subsidies from 0% to 400% FPG, uniting families on a single plan and virtually eliminating churn. Because the MA population is large relative to the current QHP market, this extension would dramatically increase MNSure’s leverage to encourage delivery system reform.

While this may seem like a radical change, it would be less disruptive from the consumer perspective than one might expect. Since the majority of MA enrollees are currently served by private managed care plans, a QHP with reduced cost-sharing would likely *feel* quite similar to the beneficiary. However, the administrative and philosophical shift would be substantial. This extension is therefore a long-term option, rather than one that should be attempted in the five-year timeframe of the 1332 waiver.

### Evaluation

#### *Smoothing the Coverage Continuum*

This option represents a major improvement over the status quo in smoothing the continuum of coverage. It eliminates the churn point at 200% of FPG, allowing anyone over 138% of FPG (the MA cutoff) to remain on the same plan, with varying degrees of subsidies and cost-sharing. In addition, added subsidies, reduced cost-sharing, and active regulation of MNSure plans can ensure that consumers have similar coverage and costs on both sides of the 138% FPG line, eliminating the cliffs that consumers currently face when their incomes change.

However, this option does not fully eliminate coverage transitions. There is still a danger of churn at the 138% FPG eligibility cutoff, which presents a particular concern because people living closer to the poverty line tend to have less stable incomes and less time and capacity to surmount the bureaucratic hurdles of re-enrollment. In addition, although anyone above this eligibility line can remain on the same plan, MinnesotaCare enrollees will lose add-on services and cost-sharing subsidies when they cross the 275% FPG line and become regular QHP customers, which could make a comprehensive plan suddenly cost-prohibitive. Finally, in the short term, this option does little to unify families under the same plan. Since children are generally eligible for MA up to 275% FPG, moving their parents from MinnesotaCare

onto the QHP market will not change the fact that parents and children often have different plans with different networks of providers.

### ***Affordability***

By definition, this plan will preserve the same levels of affordability for consumers between 138% and 200% of FPG. The subsidies and cost-sharing assistance provided to this group in the QHP market will be designed to hold their costs roughly constant with those they are currently paying as MinnesotaCare enrollees. At the same time, people between 200% and 275% of FPG, who are currently only eligible for federal subsidies, would become MinnesotaCare beneficiaries and thus eligible for additional subsidies and cost-sharing reductions. This will help to smooth affordability “cliffs” and assist low-income working adults with the costs of their coverage. As a result, this option represents a modest but clear improvement over the status quo.

### ***Universality and Comprehensiveness of Coverage***

Since this option is likely to reduce churn, it would also be likely to slightly increase the percentage of Minnesotans who are covered by health insurance at any given time. In addition, the provision of “add-on” services such as dental and vision benefits for QHP enrollees below 275% FPG will increase the comprehensiveness of their plans to some degree. However, this option does little to reach the small percentage of Minnesotans who are currently not covered by any health insurance. As noted above, many of these uninsured are believed to be immigrants; covering them will likely require a willingness to use state funds to make them eligible for subsidized insurance, whether public or private.

### ***Financial Feasibility***

See “Financial Feasibility: A Comparative Analysis” (page 42).

### ***Administrative Feasibility***

This option presents a significant administrative lift. It relies heavily on MNSure to negotiate with insurers, propose model contracts, and hold carriers and providers to quality standards. MNSure does not currently fulfill any of these functions, and as a young agency whose role is still in flux, it is unclear how quickly it could add this additional capacity. In addition, MNSure would have to work closely with the DOC on plan approval, while DHS would have to coordinate with insurers to administer cost-sharing subsidies and “add-on” services. Once this system is established, it has the potential to work effectively, but the challenge of setting up the necessary internal capacity to negotiate effectively with insurers and administer a public-private hybrid system is substantial and represents an important barrier to this option’s success.

### ***Leveraging Delivery System Reform***

This option’s potential to drive changes in health care delivery relies on MNSure’s ability and political will to effectively set a high bar for insurers. By providing the twin incentives of competition on cost and access to a large pool of customers if quality standards are met, MNSure can spur innovation in the private insurance market, building on Minnesota’s long history of private sector improvements in health care provision. However, this potential may not be realized if MNSure lacks the capacity to enforce tough cost and quality standards.

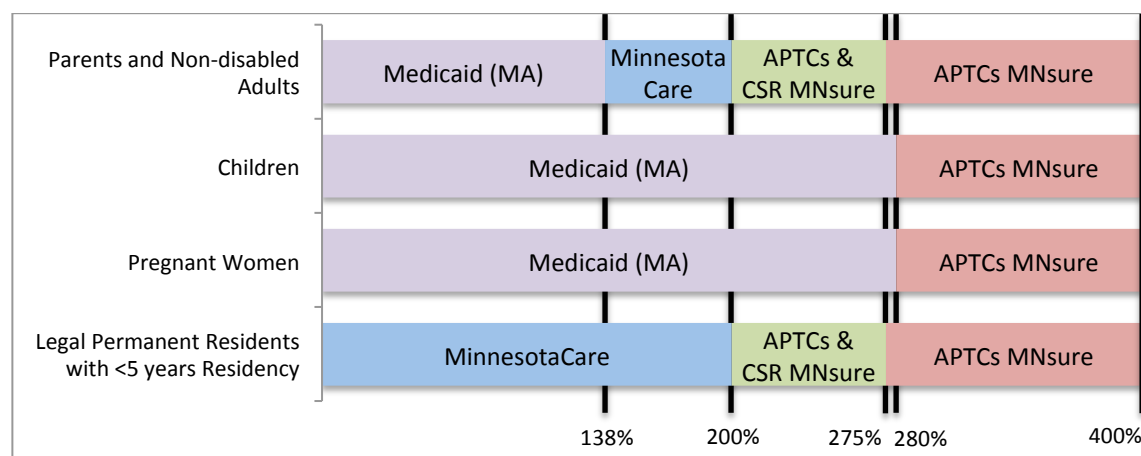
In addition, it is not clear that the pool of people served on the QHP market under this plan is sufficiently large to drive major changes in insurer and provider behavior: during last year's open enrollment, only about 91,000 people enrolled in either MinnesotaCare or a QHP through MNsure, compared to about 109,000 people who enrolled in MA during the same time period.<sup>134</sup> Even if this pool is not large enough to encourage major changes today, however, this proposal leaves open the option of creating an even more enticing pool of customers by bringing MA enrollees into the QHP market in the long term, which would more than double the size of the market if 2014 trends continue. In this long run scenario, the potential to encourage delivery system changes would be greatly enhanced.

## Option C: Coordinated Purchasing Path

### Vision

This option builds on the short-term policy options presented in the section “Opportunities for Incremental Change” (page 19). It attempts to bring consistency to the consumer experience and more effectively harness the state’s purchasing power to drive delivery system reform *without* radically altering the current system. Rather than moving eligibility boundaries, this option favors incremental improvements to the existing continuum of care, such as ensuring (through carrier mandates or consumer incentives) that similar plans are available regardless of eligibility for MA, MinnesotaCare, or Marketplace subsidies. Additionally, this approach calls on DHS and MNsure to work closely together to define and implement standards for plans available in all parts of the market. Such coordinated purchasing will help support the diffusion of delivery system reforms that will cut costs and increase quality of care throughout the system.

Figure 3: Coverage Under Option C



### Description

In contrast to Options A and B, this option maintains each of the state-supported health care programs—MA, MinnesotaCare, and the MNsure QHP market—as separate and distinct markets. The eligibility levels for MA and MinnesotaCare will remain unchanged (0%–138% FPG and 138%–200% FPG, respectively).

In addition to implementing more incremental premium and cost-sharing changes for those transitioning between programs, this option aims to further smooth the care continuum by requiring insurance carriers who cover consumers in the QHP market to also offer plans in the MinnesotaCare and MA markets. Currently, enrollees in both MinnesotaCare and MA primarily receive coverage through the same group of MCOs: Blue Plus, HealthPartners, Itasca Medical Care, Medica, Hennepin Health, PrimeWest Health, South County Health Alliance, and UCare. Fortunately, all of these plans except Hennepin cover both MA and MinnesotaCare enrollees, and for the most part they rely on the same network of providers for both programs.<sup>135</sup> However, these plans may, in some counties, choose to cover only MinnesotaCare enrollees.<sup>136</sup> For example, there are 10 counties in which UCare’s network



covers those eligible for MinnesotaCare, but *not* MA. Those enrolled in UCare's MinnesotaCare plan whose incomes fall below 138% of FPL would need to switch into a different MCO for MA coverage.

For those transitioning from MA to MinnesotaCare or from MinnesotaCare to the QHP market, consistency in coverage is possible, but not assured. To ensure continuity of care, the state could mandate that all carriers offering MA and MinnesotaCare plans also offer plans in the QHP market.

Alternately, if the state does not wish to mandate action by the carriers, it could incentivize consumers to purchase plans that are available in all three markets by offering additional subsidies to lower the premium costs of these plans.

Whether the state decides to impose a mandate or create an incentive, the goal is to ensure clients with ongoing treatments or chronic illnesses maintain access to the same system as their eligibility changes. Furthermore, family members who are eligible for different programs could all have the same plan, should it suit their needs. Regardless of the mechanism used to achieve these goals, changes to the market need not be drastic. Currently, every county still has at least one plan that serves both MinnesotaCare and MA enrollees.<sup>137</sup> As noted, four out of five of the carriers in the QHP market already offer MA and MinnesotaCare plans.<sup>d,138</sup>

In addition, the state should mandate that carriers also offer *similar* plans in each of the three markets/programs. The plans should provide similar levels of coverage and similar, if not the same, provider networks so that those transitioning from one market to another will be able to maintain continuity of care. As above, the same goal could be achieved by offering additional subsidies to customers who select a carrier with consistent network coverage.

Finally, to enhance delivery system reform efforts, MNSure must coordinate its product offerings with DHS's procurement standards for the MA and MinnesotaCare programs. MNSure can invoke active purchaser authority to be just as prescriptive with the carriers in the Marketplace as DHS is with its procurement standards. MNSure and DHS should work together to develop common standards for procurement by DHS and approval to sell plans on MNSure. These standards should be included in both DHS's request for proposals for managed care and MNSure's QHP guidelines, using common language. It may be advantageous to coordinate with Minnesota Management and Budget (MMB) as well to leverage the buying power associated with the State Employee Group Insurance Plan (SEGIP).

### Looking Ahead

The Coordinated Purchasing Path offers a streamlined consumer experience without drastic changes to the status quo. While it maintains much of the current system, which is working well for many Minnesotans, it offers incremental improvements to ensure greater continuity of care for those at the churn points between programs. It further capitalizes on the state's existing purchasing authorities to support promising delivery system reforms. Although other options may generate greater continuity of

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<sup>d</sup> The five carriers offering QHPs in the MNSure market in 2015 include: Blue Cross and Blue Shield, Blue Plus, HealthPartners, Medica, and UCare.

care or stronger delivery system reforms, this option has the advantage of not further disrupting the markets, as many substantial changes have been made to the Minnesota health system in recent years.

Should the state pursue this path and aim to deepen its commitment to coordinated purchasing down the road, it could partner with major employers to voluntarily embed the same purchasing standards used by DHS and MNsure in the employer-sponsored insurance (ESI) market. This would further drive delivery system reform given the reach and influence of ESI.

## **Evaluation**

### ***Smooth Continuum of Coverage***

This option improves upon the current system by promoting continuity of care when individuals move between programs. While all the churn points will remain, their impact will be less drastic for consumers. The mandates that carriers participate in all three markets and offer similar plans in each market will allow families to be on similar or the same plans, even when program eligibility varies among family members. However, consumers may still experience churn, as the eligibility thresholds remain the same across the continuum. Furthermore, the mandate that carriers offering MA and MinnesotaCare plans also offer QHPs would give DHS complete control over who can offer plans on MNsure, a feature that may not be desirable for the state.

### ***Affordability***

Beyond the cost-sharing and premium-smoothing suggested in “Smooth the Premium and Cost-Sharing Schedule to Minimize Cliffs” (page 25), this option is unlikely to substantially impact health care costs in Minnesota.

### ***Universality and Comprehensiveness of Coverage***

While this option does not address the goal of covering the final five percent of uninsured in the state, it will increase the comprehensiveness of coverage in the QHP market by aligning MNsure’s active purchasing efforts with the procurement standards of DHS.

### ***Financial Feasibility***

See “Financial Feasibility: A Comparative Analysis” (page 42).

### ***Administrative Feasibility***

By relying on the coordination of DHS’ procurement standards for MA, MinnesotaCare, and SEGIP with the active purchasing strategies of MNsure, this option requires extensive interdepartmental coordination in order to be successful. Even beyond DHS and MNsure, coordination would be required with other entities, such as MMB and the DOC, meaning that there are many points at which coordination could break down. The administrative burden to ensure effective coordination will be quite high. Additionally, it will be a challenge to institutionalize these practices as staff turnover may impact coordination efforts.

### *Leveraging Delivery System Reform*

By building off of the strengths of the current system, this option avoids interference with existing delivery system reform efforts but also does little to enhance them. Assuming DHS and MNsure are able to coordinate their purchasing standards effectively, this option will support the diffusion of promising delivery system reform efforts throughout the Minnesotan health system. However, because DHS and MNsure remain separate entities with distinct missions and authorities, coordination alone may be insufficient to harness the full potential of the state or the market to realize cost-saving and quality-enhancing reforms.

Further, strengthening current delivery system reform efforts relies on MNsure realizing its vision as an active purchaser for the QHP market. This goal may still be many years off as MNsure focuses on providing eligibility and enrollment services through a fully functioning web portal.

### Financial Feasibility: A Comparative Analysis

The financial impact of health reform options on state and federal budgets will be a crucial consideration for Minnesota. However, several obstacles prevent us from producing any but the most rudimentary projections. For one, the cost of programs depends on future premiums, which not even the carriers themselves may know more than one year in advance. For another, we lack the actuarial expertise that would be necessary to make rigorous predictions. Nevertheless, with a generous application of assumptions and simplifications, we can make some educated guesses about the impacts of our proposals on the size of various programs and discuss the financial implications thereof. We conclude that the options that do the most to broaden coverage and drive reform, Options A and B, are also more expensive in the short term.

### Enrollment

We first attempt to give projections of number of enrollees in each program in 2016 under our three options. For our MA enrollment figures, which remain constant between the three options, we rely upon DHS projections. For the 138%–400% FPG adult population, which is distributed differently between programs depending on the option, we draw from a variety of sources: DHS budget projections, economic and actuarial projections of the impact of the ACA in Minnesota, 2013 American Community Survey data, and Urban Institute/RWJF projections for enrollment in state-based Marketplaces.<sup>139,140</sup>

Under Option C, the eligibility cutoffs for the BHP will be unchanged, and we can rely upon DHS’s MinnesotaCare enrollment projections. Options A and B both feature a BHP expansion. We assume that 1) BHP enrollment will be roughly the same under both options, and 2) the proportion of the eligible expansion population that enrolls will approximately equal the proportion of the eligible 138%–200% FPG population projected to enroll in the BHP.<sup>141</sup>

Finally, we project the MNsure population. We use the Urban Institute/RWJF projections for enrollment in state-based Marketplaces to predict MNsure’s 2016 enrollment. Then, to calculate the MNsure enrollment for Options A and B, we assume that 70 percent of the projected MNsure enrollment will consist of individuals above 275% FPG—a rough estimate extrapolated from the proportion of MNsure enrollees who received cost-sharing subsidies.

**Table 3.1. 2016 Enrollment projections for MA, BHP, and MNsure under each option**

	Option A	Option B	Option C
<b>Medical Assistance</b> (administered as MinnesotaCare in Option A)	1,061,012	1,061,012	1,061,012
<b>BHP</b> (administered by DHS in Options A and C, or by MNsure in Option B)	297,795 (138-275% FPG)	297,795 (138-275% FPG)	147,799 (138-200% FPG)
<b>MNsure</b>	76,063	76,063	108,661

While Options A and B look identical in Table 3.1 above, they call for very different designs of the BHP program. Table 3.2 uses the same data as above, but breaks down enrollment in each of our scenarios by the concentration of market power within state agencies:

**Table 4.2 2016 Enrollment projections by controlling state agency under each option**

		<b>Option A</b>	<b>Option B</b>	<b>Option C</b>
<b>Enrollment in DHS-led programs</b>	Number	1,358,807	1,061,012	1,208,811
	Percentage of non-ESI market, 0%-400% FPG, age 0-64	95%	74%	92%
<b>Enrollment in MNsure-led programs</b>	Number	76,063	373,858	108,661
	Percentage of non-ESI market, 0%-400% FPG, age 0-64	5%	26%	8%

### **Financials**

Because the federal government has already signed off on the current structure of the proposed BHP expansion to 200% FPG, Option C leaves only a few lingering financial problems. Namely: how will the state plug the gap if federal BHP revenues, provided to the states under the 95% formula, do not meet the costs of running the BHP? And how will MNsure become financially self-sustaining after its Center for Consumer Information and Insurance Oversight (CCIO) grant expires in 2016 if enrollment does not grow significantly over the coming years?

These two problems apply to the other options as well. Yet, for Options A and B, the crucial financing questions relate to the BHP expansion. There will be a financial cost to the state to subsidizing the care of the 200%–275% FPG population, especially if the expanded BHP adheres to MinnesotaCare’s generous benefits package, low premiums, and high actuarial value. The financial burden will be especially great if federal subsidies remain low as a result of low Marketplace premiums. However, it bears mentioning that while a 1332 waiver proposal must not increase the federal deficit as a whole, there is no need for each component to be budget-neutral. Savings could be found elsewhere in the Minnesota health system to counterbalance the cost of the BHP. The current delivery system reform pilot programs are a potential source for such savings.

What’s more, while Options A and B cost more in the short run, they have a much greater potential for bending the long-term cost curve than Option C. As table 4.2 shows above, both options would shift enrollees toward one state agency whose purchasing power to pursue cost savings would be strengthened, either through procurement or active purchasing. But this plan relies upon the willingness and ability of the agencies to drive prices down, which is far from assured.

The bottom line is that Options A and B both enhance coverage for populations that are currently financing much of their own care. These plans will cost money, and the federal government may not be willing to pay for all of it. Under a holistic approach to the 2017 waiver process, the state may be able to come out even. But it is beyond the scope of this report to test that hypothesis. Based on what we know, Option C is the safest financial bet.

## Part IV: Comparative Analysis of the Options

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## Comparative Analysis of the Options

### Smoothing the Coverage Continuum

<b>Most Effective</b>	<b>Option A</b>
<b>Least Effective</b>	<b>Option C</b>

Smoothing the continuum of coverage has four components: (1) eliminating premium cliffs; (2) reducing the number of churn points at which people may lose coverage; (3) allowing patients to maintain provider networks when their incomes change; and (4) uniting families on the same insurance plan. Since premium cliffs can be eliminated under all options, this comparison will focus on the latter three criteria.

#### Churn Points

Options A and B most effectively reduce the number of churn points across the coverage continuum, while Option C maintains all existing churn points. Both Options A and B require just one transition from MA or MinnesotaCare to the QHP market. However, the transition occurs at a higher income level under Option A (275% FPG) than Option B (138% FPG). This gives the edge to Option A, as research shows that fluctuations in income are less likely to occur among those at higher income levels.<sup>142</sup>

#### Similar Provider Networks

Smoothing the coverage continuum requires maintaining similar provider networks across different types of coverage. Under Option A, individuals may change networks when their incomes surpass the 275% FPG threshold. Under Option B, this difference will occur at 138% FPG, though this option promises financial supports and active regulation of MNsure plans to provide beneficiaries similar coverage on both sides of the 138% FPG line. Nevertheless, under Option B, MinnesotaCare enrollees lose add-on services and cost-sharing subsidies when they cross the 275% FPG line. In the short term, Option C could have the most direct impact on increasing continuity of care if it mandates carriers to participate in all three markets (MA, MinnesotaCare, and MNsure), offering similar plans with similar networks in each. If this mandate is to occur, Option C may be successful in maintaining similar provider networks, but not diminishing churn. This mandate is compatible with Options A and B as well, though it would be administratively complex to implement and would require much cooperation from private insurers.

#### Uniting Families

Both Options A and C ensure families are on the same or similar plans. Under Option A, all non-elderly individuals up to 275% FPG will be enrolled in MinnesotaCare, regardless of age or pregnancy status, keeping families together. Option C also improves upon the status quo by requiring carriers to provide similar plans in all three markets. While families will not be on the same plan, they will have the opportunity to be on similar plans of the same carrier. In contrast, Option B does not allow families to be

on the same plan as it maintains current MA eligibility thresholds. To conclude, while both Options A and C make efforts to unify family insurance, only Option A fully succeeds.

## Affordability

<b>Most Effective</b>	<b>Options A and B</b>
<b>Least Effective</b>	<b>Option C</b>

### Short-Run Affordability

The three options, by design, offer comparable short-run affordability for consumers. Minnesotans between 0% and 133% of FPG will continue to receive comprehensive, low-cost coverage through a public program. If the recommended cost-smoothing measures are implemented, those between 133% and 275% of FPG will have affordable coverage roughly comparable to MinnesotaCare. Whether consumers access coverage through public programs (Option A), on the QHP marketplace (Option B), or in a mix (Option C), premiums and cost-sharing will gradually increase up the income spectrum. Premiums may vary by age and smoking status for those on the Marketplace; the actuarial value of plans will gradually decrease from 90 percent to 73 percent up the income spectrum. Finally, in all three options those above 275% of FPG will have access to the same levels of coverage they are currently eligible for on MNsure.

### Long-Run Affordability

The two options that consolidate purchasing power ultimately have greater potential to slow the growth in health care costs, leading to greater affordability for consumers in the long run. Option A, which increases the population in DHS-administered public programs, allows the state to continue to promote the delivery system innovations that currently show promise for cost containment. Option B, which brings more consumers into MNsure, allows MNsure to stimulate competition and drive down costs in the Marketplace and potentially in the broader private market. Option C may help promote delivery system reform if DHS and MNsure successfully coordinate purchasing strategies, but has less potential to improve long-run affordability than the other two options.

## Universality and Comprehensiveness of Coverage

<b>Most Effective</b>	<b>Options A and B</b>
<b>Least Effective</b>	<b>Option C</b>

### Universal Coverage

Universality of coverage refers to the goal of expanding access to health insurance to all Minnesotans. None of the three options actively pursues coverage for the remaining uninsured 5 percent.<sup>143</sup> Extending public program and QHP eligibility to undocumented immigrants, as recommended in “Opportunities for Incremental Change” (page 19), could cover up to 12 percent of the remaining uninsured population.



By restoring MinnesotaCare eligibility, both Options A and B would diminish the number of people who lose or change coverage at any given income level, slightly increasing the percentage of Minnesotans covered by health insurance at any given time. In contrast, Option C does not reduce churn enough to meaningfully impact the number of transitorily uninsured Minnesotans. Options A and B both do more than Option C to advance universal coverage, with A taking the lead due to the higher churn point at 275% rather than 138% FPG.

### Comprehensive Coverage

Each option increases the comprehensiveness of benefits offered to covered Minnesotans. By restoring MinnesotaCare to populations up to 275% FPG under Option A, individuals with incomes between 200% and 275% FPG will have more robust benefits than they would otherwise have in the QHP market. Similarly, Option B adds additional services, such as dental and vision benefits, to plans sold to enrollees under 275% FPG.

Option C could potentially increase the comprehensiveness of coverage by mandating that carriers offer similar plans with similar networks in all three markets. Therefore, Options A and B are superior to Option C in terms of increasing benefits available to enrollees up to 275% FPG.

### Financial Feasibility

<b>Most Effective</b>	<b>Option C</b>
<b>Least Effective</b>	<b>Options A and B</b>

See “Financial Feasibility: A Comparative Analysis” (page 42).

### Feasibility of Administrative Coordination

<b>Most Effective</b>	<b>Options A</b>
<b>Least Effective</b>	<b>Option C</b>

Administrative feasibility involves two separate questions: (1) which options will be easier to implement and (2) which options will be easier to sustain. Our analysis suggests that there are significant trade-offs between these two concerns. The option with the lowest implementation hurdles also offers the most challenging long-term prospects, whereas the state could reap significant long-term efficiency gains if it takes on some upfront costs.

Option C, the coordinated purchasing option, is unique in that it does not reallocate responsibilities between DHS and MNsure. It calls for streamlining and coordination within the current system and requires no bureaucratic alterations. However, it requires two agencies with different goals, functions, cultures, and funding streams to work permanently in tandem. While the cooperation between DHS and

MNsure has been laudable thus far, and any option will require significant coordination between the agencies for the foreseeable future, it may be unwise to institutionalize an arrangement where crucial policy, financing, and operation decisions must be reached as a consensus between equals.

On the other hand, Options A and B both promise difficult transitions. In each scenario, one agency will have to absorb functions traditionally performed by the other and implement a significant internal reorganization. However, both options would simplify administration in the long run. Each establishes a “leading partner” that would be responsible for a larger segment of the non-ESI 0%–400% FPG population. Health system integration will be simpler after agency integration.

However, Option A promises tighter integration than Option B. Even if Option B is implemented perfectly, there are still likely to be more people enrolled in MA than in the MNsure Marketplace, which means that coordination between the two agencies will need to be almost as tight as under Option C. Option A therefore has a significant advantage in this category, as it has the ability to concentrate much more of the administrative burden within a single agency. Of course, in any scenario, DHS and MNsure—as well as the DOC and Department of Health—must continue to play a role.

### Leveraging Delivery System Reform

<b>Most Effective</b>	<b>Options A, B, and C</b>
<b>Least Effective</b>	–

State agencies have three primary levers to influence the cost and quality of healthcare: (1) DHS and the Department of Employee Relations can negotiate new contracts with health insurers; (2) MNsure can become an active purchaser; and (3) the DOC can review proposed insurance plan rates and networks. Option A relies on the first lever and Option B on the second and third; Option C seeks to pull them all at the same time. Regardless of the option chosen, insurers can continue to drive reforms in the private individual and group markets, which cover 61 percent of Minnesotans, and the legislature can initiate multi-payer initiatives, as it did with Health Care Homes.<sup>144</sup>

Option A relies on DHS procurement to drive delivery system reform. Under this option, DHS will continue to purchase health care for its existing market of close to one million people, or 17 percent of the state's population.<sup>e,145,146</sup> DHS can continue leading cost-containment efforts, including competitive MCO bidding and Medicaid ACOs. The estimated addition of nearly 150,000 MinnesotaCare enrollees between 200% and 275% FPG represents a 10-15 percent increase for DHS's insured population, but a much larger loss to MNsure's population.<sup>147</sup>

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<sup>e</sup> As of October 2014, combined average monthly enrollment in Minnesota Care and Medical Assistance was projected to reach 939,000 in 2014 and 1,160,000 in 2015.

Option B relies on active purchasing, DOC rate review, and private sector innovation to a greater degree than other options. Under Option B, all individuals between 138% and 275% of FPG would shop on MNsure, a loss to DHS of 10-15 percent of its population, but could increase MNsure’s enrollment by three times what it would have been under the status quo (see “Financial Feasibility: A Comparative Analysis,” page 42).<sup>148</sup> This additional population would make delivery system reform through active purchasing more feasible. Since insurers participating in MNsure are required to offer the same plans outside the Marketplace, a portion of the 300,000 people who purchase individual insurance without subsidies would also benefit from reforms initiated on MNsure.<sup>149</sup> The additional MNsure plans would also fall under DOC rate review.

Under Option C, DHS and MNsure would each maintain responsibility for the same number of people they currently cover. The coordination of purchasing strategies between DHS and MNsure, if successful, could also pave the way for further reforms.

The choice between options is in part a choice between preferred levers for reform; namely, DHS procurement or MNsure active purchasing. DHS has thus far led the way due to its longer history, larger population, and ability to negotiate specific provisions of insurance contracts. However, the choice of option is also a choice over who should hold the levers in the long term: DHS or MNsure, the DOC, and private insurers, an issue on which this report remains agnostic.

In summary, all options are compatible with payment and delivery reform. Options A and C benefit from the relative strength of direct procurement compared to active purchasing. Ultimately, the choice of options depends on preference for public or private leadership.

#### Overall Efficacy of Options as they Relate to Decision Criteria

	Smoothing the Coverage Continuum	Affordability	Universality and Comprehensiveness of Coverage	Financial Feasibility	Feasibility of Administrative Coordination	Leveraging Delivery System Reform
Most Effective Option(s)	Option A	Option A Option B	Option A Option B	Option C	Option A	Option A Option B Option C
Least Effective Option(s)	Option C	Option C	Option C	Option A Option B	Option C	–

## Additional Concerns

### Reimbursement Rates

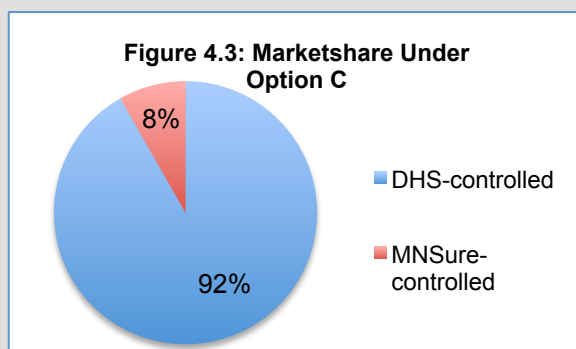
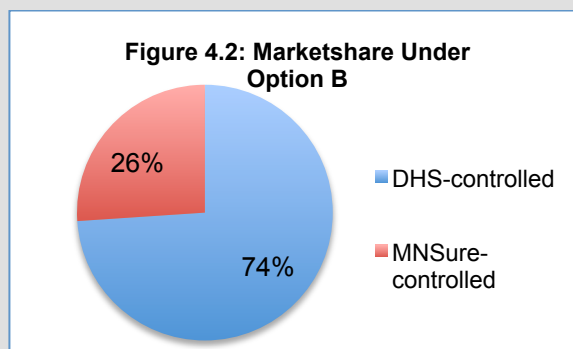
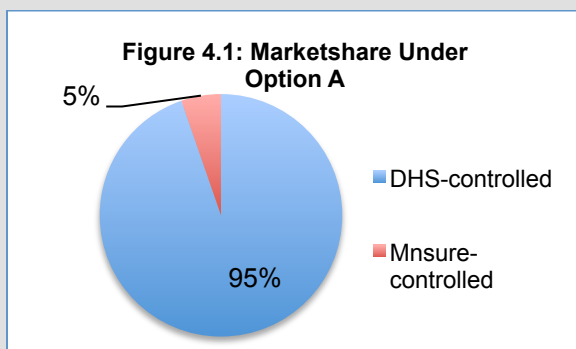
Under the 2014 MinnesotaCare statute, reimbursement rates under MA and MinnesotaCare are essentially the same, with only a few exceptions.<sup>150,151,152</sup> Historically, however, QHPs have had higher reimbursement rates for the same services. Any major change to Minnesota's insurance landscape will raise the question of how providers will be reimbursed.

Under Option A, providers may strongly resist an expansion of public insurance unless DHS negotiates higher rates for at least part of the covered population or compensates providers who see a significant portion their patients from public programs. However, assuming that Option B leaves the status quo of higher QHP rates unchanged, it will result in higher costs to the taxpayer, at least in the short term, as public subsidies cover the higher QHP reimbursements. Option C leaves the basic structure unchanged, but does nothing to alleviate the cost-shifting that currently happens when public insurance rates are too low to cover costs, leading providers to shift costs onto patients with private insurance.

Regardless of which option Minnesota chooses to pursue, the issue of reimbursement rates will need to be thoughtfully negotiated between providers, insurers, DHS, and the state legislature.

### Market Dynamics

Each of the proposed options affects the structure of the insurance market in different ways. Moving more people into a certain segment of the insurance market necessarily affects the market dynamics in the other segments.



For example, under Option A, more of the population would be covered by MinnesotaCare, leaving only people earning above 275% FPG in the QHP market on MNSure. This smaller market could result in reduced competition and higher prices as fewer insurers choose to offer plans to this population.

Option B, by contrast, would move the working adults who currently qualify for MinnesotaCare into the QHP market, changing the risk pool for both the QHP market and DHS programs. In addition, the subsidies used to purchase this insurance could alter incentives, changing the pricing and structure of the plans offered, as well as the frequency with which people use services.

By lowering the cost of individual insurance, either of these options could also lead to “crowd-out,” in which consumers who would have otherwise been privately covered (e.g. through employer-sponsored insurance) would instead enroll in the expanded MinnesotaCare program. Empirical estimates of crowd-out vary tremendously, and much of the prior research demonstrating its existence was done on insurance markets without an individual mandate, but it nonetheless a factor to consider carefully.<sup>153</sup>

### *Active Purchasing*

We heard from various stakeholders in Minnesota that they had serious concerns about MNSure’s potential use of active purchasing. To generalize, insurance carriers and providers are skeptical of the ability of government agencies to accurately measure quality and value, and they worry that attempts to do so could create perverse incentives and stifle innovation in new ways of delivering care. While Minnesota has made impressive progress toward consensus measures of quality of care, such as the Minnesota Community Measurement standards developed by the Minnesota Medical Association and the Minnesota Council of Health Plans, there are still serious limits on the state’s ability to distinguish between high- and low-quality care. As a result, attempts to selectively contract with insurers and providers based on quality and value will be likely to face political opposition from those affected.

This barrier is a serious concern for Option B, which relies heavily on MNSure’s active purchasing ability to push delivery system reforms forward. Without effective active purchasing, Option B loses its main tool to improve health care costs and quality. However, the same concerns are likely to apply to DHS’s procurement processes if they are used to limit insurers’ access to a large segment of the population on the basis of quality and value measures. Like MNSure, DHS has the statutory authority to consider cost and quality measures in its contracting decisions, but may be hampered in exercising those powers by imperfect measures of these goals and by political opposition from key stakeholders.

### *Stigma*

Any expansion of public insurance programs or subsidies has to consider the impact of stigma associated with low-income programs on the potential beneficiaries. This is a particular concern for Option A, which folds MinnesotaCare and Medical Assistance into a single program. Middle-income individuals who are newly eligible for this program may be deterred from enrolling due to the stigma of participating in a means-tested government program.

However, evidence of stigma is mixed: some studies suggest that the greatest deterrent to enrolling in Medicaid programs is poor administration, not the means-tested nature of the program.<sup>154,155,156</sup> Furthermore, since the vast majority of public insurance beneficiaries in Minnesota are enrolled in managed care, from the perspective of the consumer, there may be little perceptual difference: for the enrollee, a Blue Cross MinnesotaCare managed care plan and a Blue Cross QHP sold on the exchange and bought with public subsidies look very much the same.

### *Technological capacity*

All of the options we outline rely on DHS and MNSure developing the technological capacity to implement them smoothly. As it currently stands, the IT system created to facilitate MA, MinnesotaCare, and MNSure enrollment is not capable of crucial tasks needed to smooth transitions between types of coverage, such as re-assessing and re-enrolling consumers whose income or circumstances have changed.

This is a particular barrier for Option C, which relies on smooth coordination, not only between the leadership of the two agencies, but also between their day-to-day operations. Smoothly moving a person from MinnesotaCare into the private market, for instance, should include a simple eligibility determination process and a default option to direct them to an insurance plan with a similar network of providers; these goals rely on a smart IT system that can accurately process the back end of complex rules and make the change seem simple to the consumer. However, Options A and B also rely on DHS and MNsure's IT system to process applications quickly and accurately, direct enrollees to the best plan for them, and create a true "one stop shop" for consumers. Whichever option Minnesota chooses to pursue, continuing to improve its technological capacity will be a crucial ingredient.

## Recommendations

After research, discussion, and debate, we have arrived at the following recommendations. They represent our best evaluation of the situation in Minnesota based on the six principles outlined above.

### *1. Do Not Let Reform Efforts Stagnate*

It may sound obvious to recommend that Minnesota continue its long tradition of health reform, but we want to emphasize that this history is not complete. By many measures, Minnesota has one of the best health care systems in the country, and after several rounds of major reforms over the last few years, it would be easy for the state to breathe a sigh of relief and rest on its laurels. However, while Minnesota has a strong foundation compared to many other states, its health care system has yet to realize its full potential. The status quo is still quite fragmented, which is confusing to families, burdensome to administrators, and less effective than it could be at reforming care delivery and payment systems.

Meaningfully reducing fragmentation will require administrative reorganization, since in the long term, a single agency will be better positioned to negotiate for lower prices and greater quality than multiple agencies trying to coordinate their different missions and goals. For this reason, we believe that Option C, which preserves the current administrative structure and makes only incremental changes to the status quo, would not represent a meaningful improvement in the long term.

### *2. Combine Incremental Changes with the Option Selected*

As described above, there are various incremental changes that can be made to Minnesota's current programs and policies. These changes can be pursued on their own or combined with the other options we have outlined. They include continued technological improvement, expanded community assistance, technical fixes to eligibility rules, family affordability waivers, and a modified cost-sharing structure. While these adjustments are less ambitious in scope than the more sweeping changes proposed by Options A and B, they could have an even greater impact on the consumer experience and administrative burden for program administrators in the short term.

In some cases, a 1332 waiver would ease the way: for example, under a waiver, federal funding could be redirected to continue the navigator and assistor programs, provide subsidies for families currently excluded by the "family glitch," or modify the premium subsidies for families under 275% FPG. However, state funds could also be used to accomplish these goals, and many important changes, including the cost-sharing adjustments, could be also accomplished by layering state funds over federal subsidies. Whichever option Minnesota chooses to pursue, and regardless of the specific funding source, we recommend that any reform proposal include these changes.

### *3. Make a Philosophical Choice Between Options A and B*

As noted above, we believe that Option C lacks the potential to drive meaningful change. Despite their differing approaches, however, Options A and B both represent high-potential steps forward. Option A does this by simplifying and expanding public programs, relying on DHS's procurement processes to push for lower costs and higher quality, while Option B shifts MinnesotaCare enrollees onto the private market, offering additional supports for their transition and relying on MNsure's active purchasing

standards and private competition to incentivize better care at a lower cost. Both approaches reduce churn by simplifying the constellation of programs for low- and middle-income Minnesotans. Both options also concentrate more of the market under a single agency's umbrella and therefore strengthen that agency's hand in negotiations with insurers and providers. As a result, both provide significant opportunities to streamline the continuum of coverage and drive delivery system reform.

The choice between Options A and B therefore depends less on their relative potential to create long-term change than on Minnesota's preferred approach. Whether a public program or a private marketplace is better positioned to create long-term change is ultimately a question of belief and experience, as well as a state's unique history, political circumstances, and administrative capacity.

Minnesota's leaders are best positioned to judge these factors. The long-term direction of the state's health care system is a decision that merits in-depth discussion and debate among Minnesota's voters and those they choose to represent them. Regardless of which option is more appropriate for Minnesota, however, we believe that either Option A or B has the potential to drive meaningful delivery system reform and greatly improve the consumer experience, representing a significant improvement to the status quo in both the short and long term.



## Conclusion

Minnesota's health care system is at a crossroads. Both its public programs and its private plans are experimenting with payment for quality and other measures to contain cost growth, while simultaneously extending more affordable and comprehensive coverage to consumers than ever before. We commend the extensive progress Minnesota has made up to this point in insuring more than 90 percent of its population and providing increasingly high quality care.

In every conversation we had with stakeholders in Minnesota, we heard a deep commitment to excellence and continuous improvement. As a result, we are confident that the state's reform efforts will not stagnate, despite its remarkable progress. We have prepared this report in the hopes that it will assist Minnesota in these continued efforts. We believe that our two recommended options represent various roads toward the ultimate "triple aim" of improved patient experience and population health, alongside lower per capita costs. While the roads may have different bumps and detours, we believe that they both lead to the same destination: a health care system that works better for all Minnesotans.

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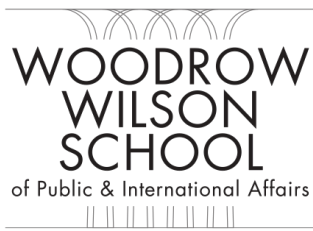
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