

# MEMO

**To:** MMA Policy Council  
**From:** Janet Silversmith, Director of Health Policy  
**Re:** MinnesotaCare Buy-In/Public Option  
**Date:** October 24, 2017

## **Proposed Policy for Discussion**

In order to add stability and provide affordable options in the individual insurance market, the MMA will support inclusion of MinnesotaCare as a product offering if structured as follows: 1) available as an option to those without access to affordable coverage, defined as premiums greater than 9% of income; 2) available as an option in counties with one or fewer products; 3) minimum payment rates are set at no less than Medicare levels; and, 4) premiums cover the full cost of enrollment in the program.

## Background

Relative volatility and uncertainty in Minnesota's individual insurance market has increased in the past couple of years. Insurers have left the market (PreferredOne for 2015 product year and BCBS for 2017 product year), premium increases have been significant (59% average increase in 2017 over 2016 rates), the scope of provider networks narrowed, and insurers have limited their geographic offerings. Nationally, uncertainty about Congressional and/or administrative actions with respect to the Affordable Care Act has further challenged the individual market.

In 2017, the Minnesota Legislature enacted two separate proposals aimed at shoring up the individual market. The first action provided for short-term (i.e., calendar year 2017) premium relief. Individuals who did not receive federal tax credits were eligible for a 25% premium rebate, which was financed through a \$312 million General Fund appropriation.

The second action was the creation of the Minnesota Premium Security Plan, a reinsurance program that recently received federal approval. Under the program, the state (with some federal funds) will "reinsure" a portion of claim costs between \$50,000 and \$250,000. In 2018, the state portion will be 80% and in future years it could vary between 50%-80%. The Legislature authorized \$542 million for the program for 2018-2019, with 74 percent (\$400 million) of the funding coming from the Health Care Access Fund. It is estimated that this program reduced 2018 premium rates by an average of approximately 20% compared to what they would otherwise have been. The 2018 premium increases ranged from -13% to +3%.

The recently-approved federal waiver for the reinsurance program allows Minnesota to receive \$139 million in “pass-through” funds in 2018, and a total of \$1 billion over the five years, 2018-2022 (the waiver was approved for 5 years, although Minnesota only appropriated state funds for the waiver program for two years). The pass-through funding is the amount of money that the federal government would otherwise have saved in the form of reduced premium tax credits and cost-sharing reduction payments as a result of the lower premiums that the reinsurance program produces. Minnesota requested, but did not receive, federal approval for pass-through funding associated with the state’s Basic Health Program (MinnesotaCare). Under the ACA, a Basic Health Program is financed by 95% of the value of premium tax credits and cost-sharing reductions that individuals would have received if they purchased coverage through the exchange. The Dayton administration is continuing to negotiate with CMS on this funding, which amounts to a reduction of \$742 million over four years.

Although the reinsurance plan was adopted in 2017, an alternative proposal supported by Gov. Dayton would have allowed MinnesotaCare to be offered as a public option on MNsure (individuals would have been eligible to purchase or “buy-in” to the program). The MMA opposed the proposal in 2017 citing concerns about low payment rates (i.e., comparable to Medicaid payment rates) and potential erosion of the small group market (i.e., may encourage employers to drop coverage and thereby increase the number of individuals buying a public option).

#### Health Care Reform Forum

At the 2017 MMA Annual Conference, the health care reform policy forum was devoted to the future of MinnesotaCare. After reviewing background information (see attached slides), attendees worked in small groups to consider the following:

- Develop a table recommendation on a future option for MinnesotaCare
  1. Maintain the current program
  2. Repeal the program and shift enrollees to individual market (MNsure)
  3. Permit individuals to buy into program (public option)
  4. Other?

Six groups deliberated on this question. Three of the groups supported option three, and another group “leaned toward” option three; all four of these groups expressed some concern about the low payment rates. One of the four groups noted concerns about the lack of transparency in the rates paid by the state to the health plans, and another group suggested the inclusion of a work requirement. One of the two other groups supported option two; the final group did not choose a specific option, but supported the goal of universal coverage and a gradual transition to a Minnesota single-payer model (no details).

Attendees at the forum were also polled individually on the question and the results are noted below (N-58):

<b>What is your personal opinion regarding the future of MinnesotaCare?</b>		
1	Maintain current program	13.8%
2	Repeal it, shift enrollees to MNsure	8.6%
3	Convert it to public option, allow buy-in	58.6%
4	Other	19.0%

### Conclusion

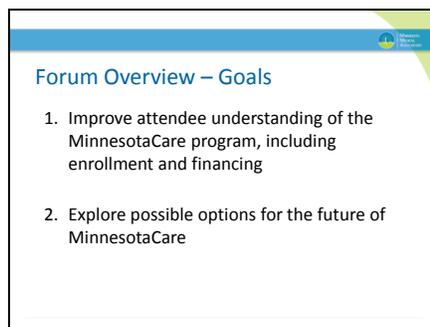
Based on the forum discussion and polling results, the draft policy statement proposed (above) is offered for Policy Council consideration. The proposal includes specific conditions for MMA support that are designed to protect individual market private plans and to limit small group market erosion (conditions #1 and #2); protect physicians and other providers from inadequate Medicaid payment levels (#3); and, limit public subsidy/financing of the MinnesotaCare program to those currently eligible (those between 138-200% of poverty).



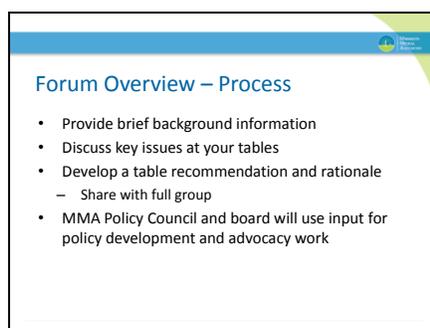
Slide 1



Slide 2

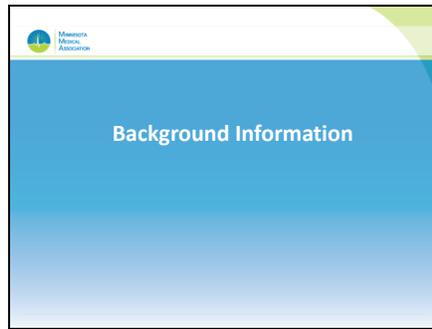


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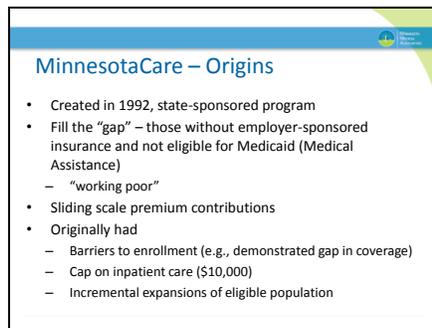




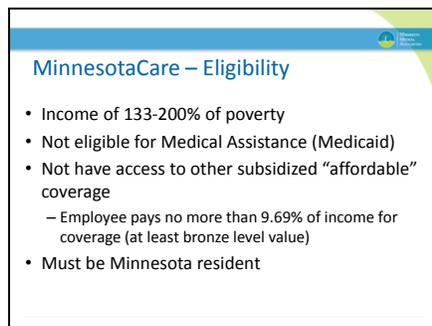
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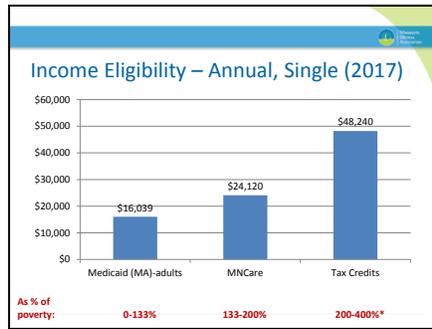


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Slide 7

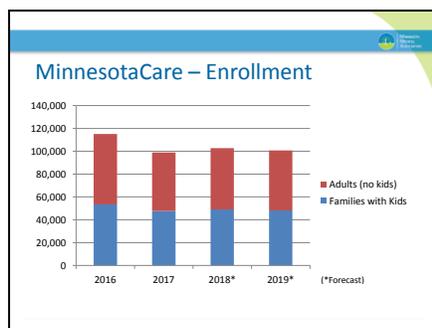


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### MinnesotaCare – Benefits & Delivery

- Benefits are similar to MA (except PCA, nursing home, and special transportation services)
- Administered by managed care plans
  - Payment by contract with physicians and other providers
  - Payment is generally the same as MA
  - Approximately 56% of commercial payment (est.)

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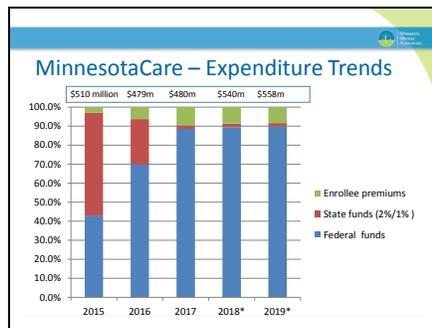


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### MinnesotaCare – Financing (HCAF)

1. Federal funds
2. 2% provider tax
  - Generates ~\$631 million (FY 2017)
3. 1% gross premium tax (non-profit health plans)
  - ~\$88 million (FY 2017)
4. Enrollee premiums

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### MinnesotaCare & The ACA

- Through 2014, some regular federal matching funds (50/50)
- Basic Health Program (BHP)
  - Option for states
    - MN and NY
- Receive 95% of value of tax credits & cost sharing subsidies on MNsure.
  - Varies with premium rates



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**Why Are Changes on the Table?**

- **Individual market uncertainty** (~5% of market)
  - Sharp premium increases
    - 59% average increase in 2017
  - Insurer pullouts
    - PreferredOne and BCBS
  - Limited choice or “bare” counties
- **2017 Legislature**
  - 25% premium reduction in 2017 (\$312 million)
  - \$540 million “reinsurance” plan – federal response
- **Philosophical concerns**

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**Option: Repeal and Shift Enrollees to MNSure**

<u>Pros</u>	<u>Cons</u>
<ul style="list-style-type: none"><li>• Increase size of individual market pool</li><li>• Higher payment rates for physicians/other providers</li><li>• Reduce pressure on state budget/provider tax<ul style="list-style-type: none"><li>– Medical Assistance impact</li></ul></li></ul>	<ul style="list-style-type: none"><li>• May not improve risk profile of pool</li><li>• Coverage may not be affordable<ul style="list-style-type: none"><li>– Increase uninsured rate?</li></ul></li><li>• Cost sharing subsidies may not be continued<ul style="list-style-type: none"><li>– Silver plans only; bad debt?</li></ul></li></ul>

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**Option: Let those in individual market buy into the program (public option)**

<u>Pros</u>	<u>Cons</u>
<ul style="list-style-type: none"><li>• Less expensive option</li><li>• Would ensure availability of plan choice statewide</li><li>• Build on existing (fairly broad) provider networks</li></ul>	<ul style="list-style-type: none"><li>• Medicaid payment rates<ul style="list-style-type: none"><li>– For more patients</li></ul></li><li>• Maintains pressure on provider tax/state funding</li><li>• “Unfair” competition with private products</li></ul>