



STATE OF MINNESOTA

Office of Governor Mark Dayton

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

May 5, 2017

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

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

Dear Secretary Mnuchin and Secretary Price:

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

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

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


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

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

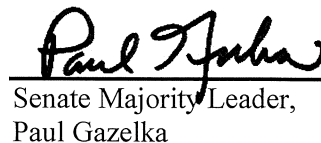
Sincerely,

May 5, 2017

Page 2


Governor Mark Dayton


House Speaker Kurt Daudt

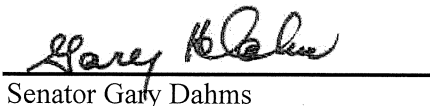

Senate Majority Leader,
Paul Gazelka

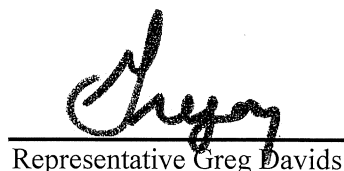

House Minority Leader,
Melissa Hortman

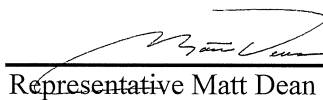

Senate Minority Leader,
Tom Bakk

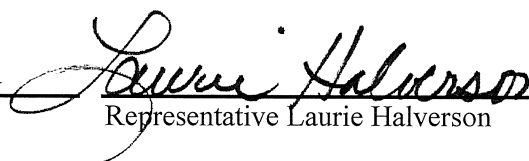

Senator Jim Abeler


Senator Michelle Benson


Senator Gary Dahms


Representative Greg Davids

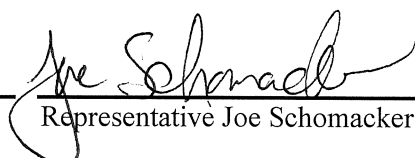

Representative Matt Dean


Representative Laurie Halverson


Representative Joe Hoppe


Senator Mary Kiffmeyer


Senator Tony Lourey


Representative Joe Schomacker

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

Congress of the United States
Washington, DC 20515

May 16, 2017

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

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

Dear Secretary Mnuchin and Secretary Price:

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

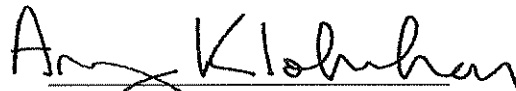
This year, the Minnesota Legislature voted to establish MPSP with bipartisan support from the Governor and Democratic and Republican Leadership to address premium increases in the individual market. This is particularly important to our rural and underserved areas, where it is critical that we reduce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

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

Sincerely,



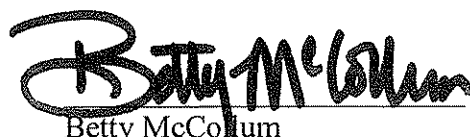
Collin C. Peterson
Member of Congress



Amy Klobuchar
U.S. Senator



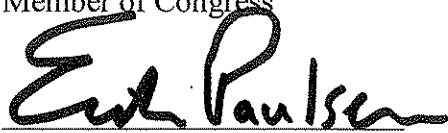
Al Franken
U.S. Senator



Betty McCollum
Member of Congress



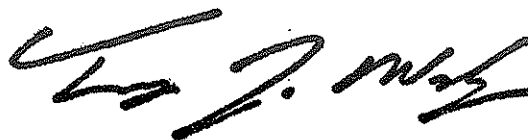
Keith Ellison
Member of Congress



Erik Paulsen
Member of Congress



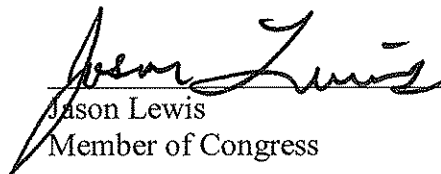
Tom Emmer
Member of Congress



Tim Walz
Member of Congress



Richard M. Nolan
Member of Congress



Jason Lewis
Member of Congress

Minnesota 1332 Waiver Application

Minnesota Department of Commerce

May 30, 2017

Table of Contents

| | |
|---|----|
| Minnesota 1332 Waiver Proposal..... | 4 |
| Executive Overview | 4 |
| Description of the Minnesota Premium Security Plan | 5 |
| Implementation of the MPSP | 6 |
| Additional State Responsibilities Related to the MPSP | 6 |
| Compliance | 7 |
| Summary of Proposal..... | 8 |
| Background | 8 |
| Goal of Waiver | 9 |
| Applicable Federal Regulations..... | 9 |
| Background on Minnesota’s Health Insurance Market..... | 9 |
| Waiver Proposal: Use of Savings..... | 13 |
| Waiver Funding Proposal Financial Effects..... | 14 |
| Description of Post-Waiver Marketplace | 15 |
| Individual Health Insurance Market | 15 |
| Small and Large Employers | 15 |
| Medicare | 15 |
| Medical Assistance, Minnesota’s Medicaid Program | 15 |
| MinnesotaCare..... | 15 |
| Number of Employers Offering Coverage Pre/Post Waiver | 15 |
| Impact on Insurance Coverage in the State..... | 16 |
| Administrative Burden | 16 |

| | |
|--|----|
| Waivers Requested | 17 |
| More on Minnesota Coverage of Services..... | 17 |
| 10-Year Waiver Budget (Budget Neutrality) | 28 |
| Ensuring Compliance, Reducing Waste and Fraud..... | 28 |
| Implementation Timeline and Process..... | 29 |
| Reporting Responsibilities | 29 |
| Waiver Development Process | 30 |
| Attachment A: New Legislation - 2017 Session Law, Chapter 13, House File 5, Article 1 | 32 |
| Attachment B: Existing Law - Minnesota Statutes Chapter 62E – Minnesota Comprehensive Health Association (MCHA)..... | 52 |
| Attachment C: Timeline | 61 |
| Attachment D: Public Comments..... | 63 |
| Attachment E: Slides From Public Hearings..... | 65 |
| Attachment F: Copy of Notice of Public Hearings | 73 |
| Attachment G: Reporting Targets..... | 75 |
| Scope of Coverage/Comparability..... | 75 |
| Affordability | 77 |
| Attachment H: Notice for Tribal Consultation Opportunity for Input..... | 81 |
| Attachment I: Written Response to Open Comment Period..... | 83 |

Minnesota 1332 Waiver Proposal

Affordable Care Act (ACA) Waiver for State Innovation

Executive Overview

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

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

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

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

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

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

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

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

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

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

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

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

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

Description of the Minnesota Premium Security Plan

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

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

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

Implementation of the MPSP

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

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

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

Additional State Responsibilities Related to the MPSP

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

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

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

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

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

Compliance

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

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

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

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

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

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

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

Summary of Proposal

Background

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

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

Goal of Waiver

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

The benefits of an approved waiver would include:

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

Applicable Federal Regulations

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

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

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

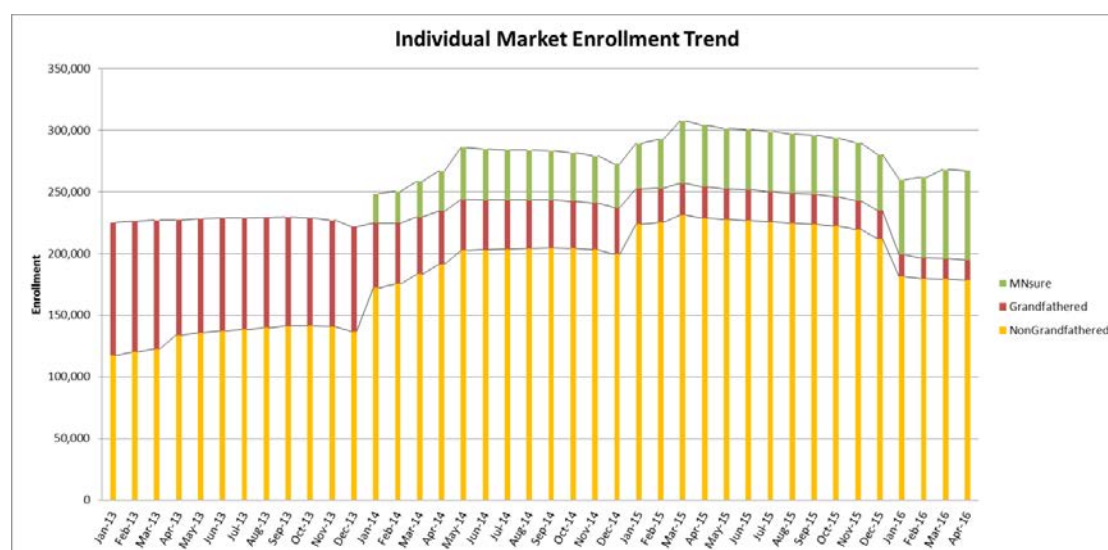
Background on Minnesota's Health Insurance Market

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

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

The ACA's guarantee issue requirements and preexisting condition prohibitions increased Minnesota's individual market enrollment in 2014 and 2015. This increase is somewhat understated when compared to other states, as Minnesota residents with incomes at or below 200 percent of the Federal Poverty Level (FPL) are enrolled in MinnesotaCare. Further expansion of Medicaid reduced Minnesota's uninsured rate to an all-time low (estimated at 4.3 percent) in 2015.⁴

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



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

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

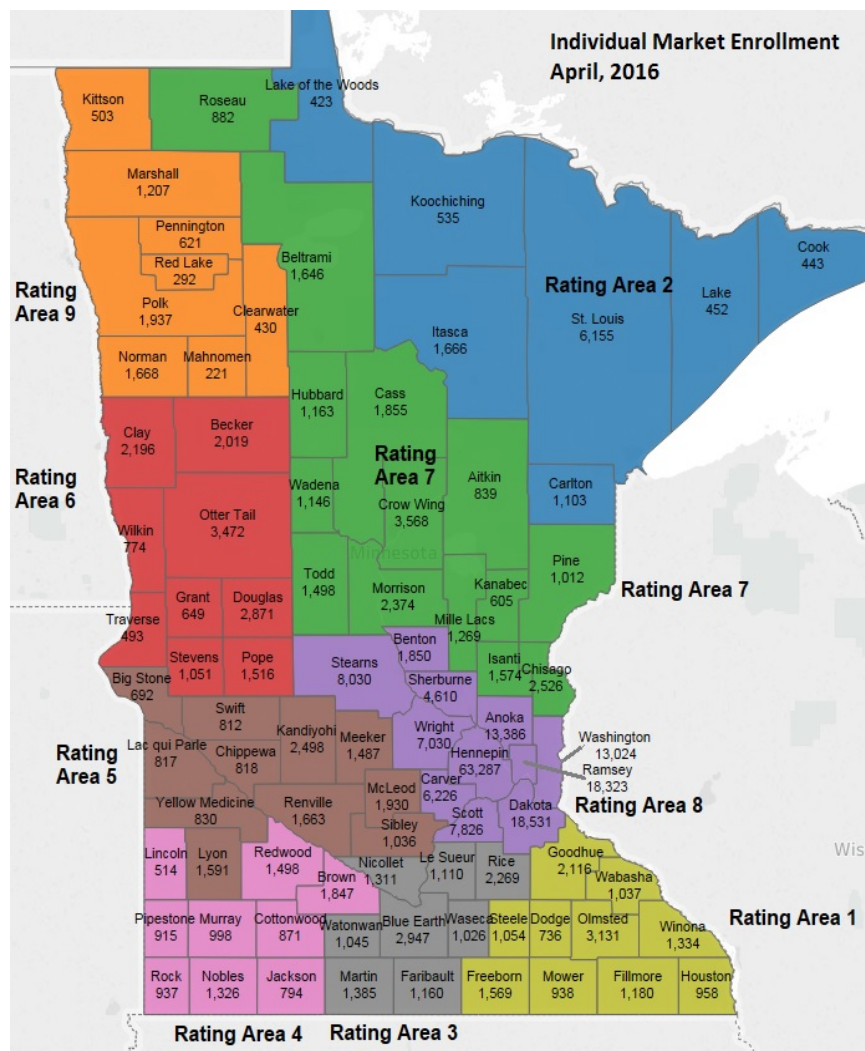
Many Minnesotans indicated that for 2017, they chose not to purchase health insurance at all. This significant decline is also evident through monitoring of enrollment, processed twice per week in order to monitor insurers' enrollment caps in place for 2017.

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

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

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

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

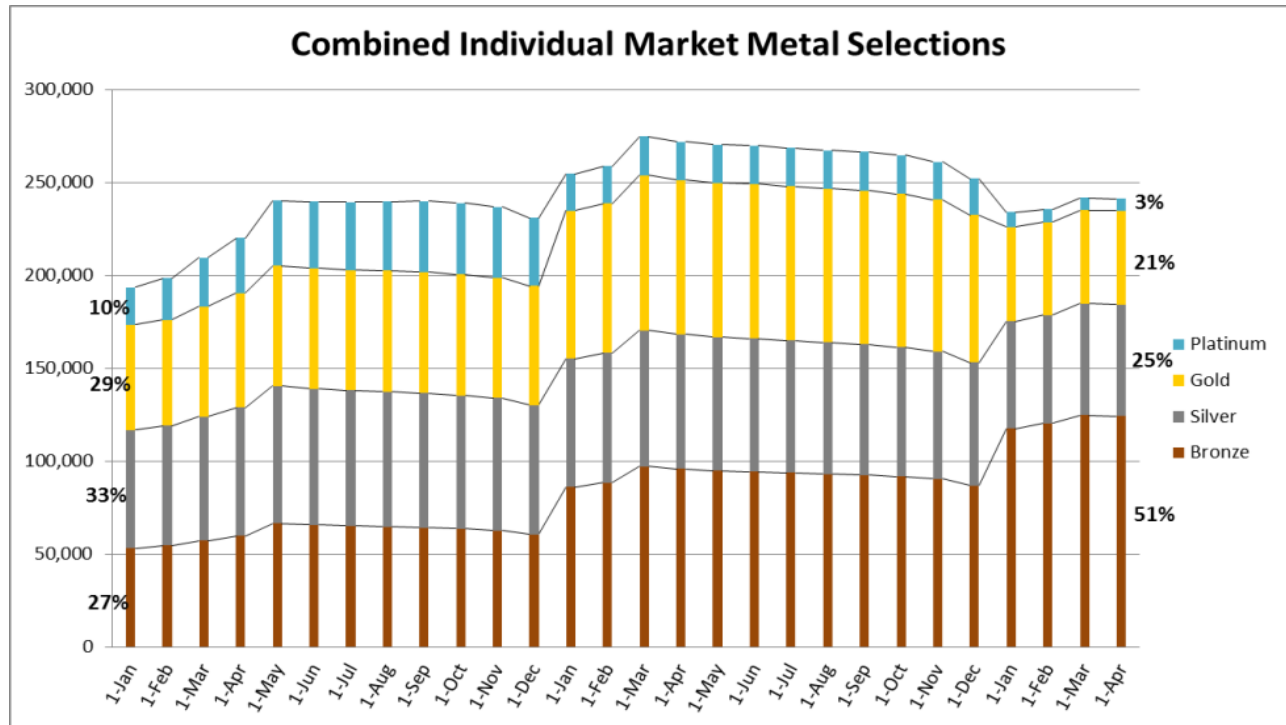


Individual market participants in rating area 1 (counties near Rochester, Minnesota, where the Mayo Clinic is headquartered) have had the highest rates in Minnesota, generally 20-35% higher than rates available elsewhere.

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

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

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



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

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

Waiver Proposal: Use of Savings

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

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

Minnesota proposes to receive federal savings as described in federal guidance issued on December 11, 2015.⁵ Federal waiver funding will contribute to reducing each issuer's individual market health insurance rates.

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

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

Waiver Funding Proposal Financial Effects

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

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

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

Description of Post-Waiver Marketplace

Individual Health Insurance Market

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

Small and Large Employers

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

Medicare

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

Medical Assistance, Minnesota's Medicaid Program

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

MinnesotaCare

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

Number of Employers Offering Coverage Pre/Post Waiver

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

Impact on Insurance Coverage in the State

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

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

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

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

Administrative Burden

Minnesota expects that the MPSP will result in a small increase in health insurers' administrative burden. Health insurers' actuarial, claims, and finance departments will need to report and account for high-cost claims, and many of the issuers will continue their participation on the MCHA Board. Health insurers will continue to manage rate filing requests, plan design and benefit set-up, enrollment, marketing, and claims administration in the same manner as they would without a waiver. Participation in the MPSP will be mandatory to participation in the non-grandfathered individual market.

Commerce will monitor the governance, solvency, and administration of MCHA, as well as review the actuarial work relating to the MCHA credit in issuer's rate filings. Actuarial staff participated in drafting this waiver request and actuarial study and are available for future inquiries from issuers, MCHA, or the federal government.

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

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

Waivers Requested

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

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

More on Minnesota Coverage of Services

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

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

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

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

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

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

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

These state-mandated benefits are summarized below:

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

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

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

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

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

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

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

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

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

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

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

10-Year Waiver Budget (Budget Neutrality)

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

Ensuring Compliance, Reducing Waste and Fraud

Commerce has the responsibility for regulating and ensuring the compliance and solvency of all issuers, performing market conduct analysis and examinations, investigations, and providing consumer outreach. The Minnesota Department of Health also regulates and ensures compliance for HMOs specifically, but monitors all issuers' accreditation, quality, and network adequacy.

The State of Minnesota, MCHA, and MinnesotaCare prepare financial statements and reports annually. Financial statements are audited annually, with the most recent audit completed for fiscal year ending

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

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

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

Implementation Timeline and Process

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

An implementation timeline is included as Attachment C.

Reporting Responsibilities

As required under 45 CFR 155.1308(f)(4), Commerce will submit quarterly, annual, and cumulative targets for the scope of coverage requirement, the affordability requirement, the comprehensive requirement, and the federal deficit requirement.

In addition, Commerce proposes to include the following information in the reports:

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

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

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

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

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

Waiver Development Process

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

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

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

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

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

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

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

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

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

HF5 FIFTH ENGROSSMENT

REVISOR

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H0005-5

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State of Minnesota
HOUSE OF REPRESENTATIVES
NINETIETH SESSION

H. F. No. 5

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

1.1 A bill for an act

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

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

1.4 provider system access; modifying premium subsidy program provisions;

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

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

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

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

1.9 Minnesota Statutes, chapter 62E.

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

1.11 ARTICLE 1

1.12 MINNESOTA PREMIUM SECURITY PLAN

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

1.14 Subd. 2. Board of directors; organization. The board of directors of the association
1.15 shall be made up of eleven 13 members as follows: six directors selected by contributing
1.16 members, subject to approval by the commissioner, one of which must be a health actuary;
1.17 two directors selected by the commissioner of human services, one of whom must represent
1.18 hospitals and one of whom must represent health care providers; five public directorsselected
1.19 by the commissioner, at least two of whom must be plan enrollees, two of whom are covered
1.20 under an individual plan subject to assessment under section 62E.11 or group plan offered
1.21 by an employer subject to assessment under section 62E.11, enrollees in the individual
1.22 market and one of whom must be a licensed insurance agent. At least two of the public
1.23 directors must reside outside of the seven-county metropolitan area. In determining voting
1.24 rights at members' meetings, each member shall be entitled to vote in person or proxy. The
1.25 vote shall be a weighted vote based upon the member's cost of self-insurance, accident and

Article 1 Section 1. 1

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

State of Minnesota This Document can be made available

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HOUSE OF REPRESENTATIVES

NINETIETH SESSION H. F. No. 5

01/05/2017 Authored by Davids, Hoppe, Gruenhagen, Halverson, Haley and others

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Services Finance

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03/08/2017 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

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

Read for the Second Time

03/13/2017 Calendar for the Day

Read for the Third Time

Passed by the House and transmitted to the Senate

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

Refused to concur and a Conference Committee was appointed

03/30/2017 Conference Committee Report Adopted

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

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

Presented to Governor

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

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

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

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

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

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

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

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

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

2.9 of the association.

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

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

2.12 defined in this section have the meanings given them.

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

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

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

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

2.17 Subd. 4. Benefit year. "Benefit year" means the calendar year for which an eligible
2.18 health carrier provides coverage through an individual health plan.
2.19 Subd. 5. Board. "Board" means the board of directors of the Minnesota Comprehensive
2.20 Health Association created under section 62E.10.
2.21 Subd. 6. Coinsurance rate. "Coinsurance rate" means the rate as provided in section
2.22 62E.23, subdivision 2, paragraph (c).
2.23 Subd. 7. Commissioner. "Commissioner" means the commissioner of commerce.
2.24 Subd. 8. Eligible health carrier. "Eligible health carrier" means all of the following
2.25 that offer individual health plans and incur claims costs for an individual enrollee's covered
2.26 benefits in the applicable benefit year:
2.27 (1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of
2.28 accident and sickness insurance as defined in section 62A.01;
2.29 (2) a nonprofit health service plan corporation operating under chapter 62C; or
2.30 (3) a health maintenance organization operating under chapter 62D.

Article 1 Sec. 2. 2

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

3.1 Subd. 9. Individual health plan. "Individual health plan" means a health plan as defined
3.2 in section 62A.011, subdivision 4, that is not a grandfathered plan as defined in section
3.3 62A.011, subdivision 1b.
3.4 Subd. 10. Individual market. "Individual market" has the meaning given in section
3.5 62A.011, subdivision 5.
3.6 Subd. 11. Minnesota Comprehensive Health Association or association. "Minnesota
3.7 Comprehensive Health Association" or "association" has the meaning given in section
3.8 62E.02, subdivision 14.
3.9 Subd. 12. Minnesota premium security plan or plan. "Minnesota premium security
3.10 plan" or "plan" means the state-based reinsurance program authorized under section 62E.23.

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

3.12 reinsurance cap, and coinsurance rate for the plan.

3.13 Subd. 14. Reinsurance cap. "Reinsurance cap" means the threshold amount as provided

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

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

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

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

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

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

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

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

3.22 part of the rate review.

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

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

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

3.26 security plan.

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

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

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

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

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

Article 1 Sec. 4. 3

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

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

4.3 subdivision 5, paragraph (c).

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

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

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

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

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

4.16 (1) will stabilize or reduce premium rates in the individual market;
4.17 (2) will increase participation in the individual market;
4.18 (3) will improve access to health care providers and services for those in the individual
4.19 market;
4.20 (4) mitigate the impact high-risk individuals have on premium rates in the individual
4.21 market;
4.22 (5) take into account any federal funding available for the plan; and
4.23 (6) take into account the total amount available to fund the plan.

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

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

4.30 an eligible health carrier for claims incurred for an enrolled individual's covered benefits
4.31 in a benefit year above the attachment point and below the reinsurance cap. The coinsurance
4.32 rate shall be set by the board at a rate between 50 and 80 percent.

Article 1 Sec. 4. 4

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

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

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

5.13 (b) If the amount in the premium security plan account in section 62E.25, subdivision
5.14 1, is not anticipated to be adequate to fully fund the approved payment parameters as of
5.15 July 1 of the year before the applicable benefit year, the board, in consultation with the
5.16 commissioner and the commissioner of management and budget, shall propose payment
5.17 parameters within the available appropriations. The commissioner must permit an eligible
5.18 health carrier to revise an applicable rate filing based on the final payment parameters for
5.19 the next benefit year.

5.20 Subd. 4. Calculation of reinsurance payments. (a) Each reinsurance payment must be
5.21 calculated with respect to an eligible health carrier's incurred claims costs for an individual

5.22 enrollee's covered benefits in the applicable benefit year. If the claims costs do not exceed
5.23 the attachment point, the reinsurance payment is \$0. If the claims costs exceed the attachment
5.24 point, the reinsurance payment shall be calculated as the product of the coinsurance rate
5.25 and the lesser of:
5.26 (1) the claims costs minus the attachment point; or
5.27 (2) the reinsurance cap minus the attachment point.
5.28 (b) The board must ensure that reinsurance payments made to eligible health carriers do
5.29 not exceed the total amount paid by the eligible health carrier for any eligible claim. "Total
5.30 amount paid of an eligible claim" means the amount paid by the eligible health carrier based
5.31 upon the allowed amount less any deductible, coinsurance, or co-payment, as of the time
5.32 the data are submitted or made accessible under subdivision 5, paragraph (c).

Article 1 Sec. 4. 5

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

6.1 Subd. 5. Eligible carrier requests for reinsurance payments. (a) An eligible health
6.2 carrier may request reinsurance payments from the association when the eligible health
6.3 carrier meets the requirements of this subdivision and subdivision 4.
6.4 (b) An eligible health carrier must make requests for reinsurance payments in accordance
6.5 with any requirements established by the board.
6.6 (c) An eligible health carrier must provide the association with access to the data within
6.7 the dedicated data environment established by the eligible health carrier under the federal
6.8 risk adjustment program under United States Code, title 42, section 18063. Eligible health
6.9 carriers must submit an attestation to the board asserting compliance with the dedicated
6.10 data environments, data requirements, establishment and usage of masked enrollee
6.11 identification numbers, and data submission deadlines.
6.12 (d) An eligible health carrier must provide the access described in paragraph (c) for the
6.13 applicable benefit year by April 30 of each year of the year following the end of the

6.14 applicable benefit year.

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

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

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

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

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

6.20 requests.

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

6.22 subdivision 2a.

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

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

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

6.26 section. If an audit results in a proposed finding of material weakness or significant deficiency

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

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

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

6.30 deficiency, the eligible health carrier must:

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

6.32 (2) implement the approved plan; and

Article 1 Sec. 4. 6

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

7.2 taken.

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

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

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

7.6 ASSOCIATION.

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

7.8 of all:

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

7.10 expenses;

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

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

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

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

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

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

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

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

7.19 applicable benefit year, whichever is later.

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

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

7.22 agents cooperate with the audit.

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

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

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

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

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

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

7.29 which to correct any such material weaknesses or deficiencies.

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

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

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

8.1 (2) identify to the commissioner any material weakness or significant deficiency identified
8.2 in the audit and address in writing to the commissioner how the board intends to correct
8.3 any such material weakness or significant deficiency in compliance with subdivision 5; and
8.4 (3) make public the results of the audit, to the extent the audit contains government data
8.5 that is public, including any material weakness or significant deficiency and how the board
8.6 intendsto correct the material weakness or significant deficiency, by posting the audit results
8.7 on the Minnesota Comprehensive Health Association Web site and making the audit results
8.8 otherwise available.

8.9 Subd. 5. Actions on audit findings. (a) If an audit results in a finding of material
8.10 weakness or significant deficiency with respect to compliance by the association with any
8.11 requirement under sections 62E.21 to 62E.25, the board must:

8.12 (1) provide a written corrective action plan to the commissioner for approval within 60
8.13 days of the completed audit;
8.14 (2) implement the corrective action plan; and
8.15 (3) provide the commissioner with written documentation of the corrective action taken.

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

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

8.21 Subdivision 1. Premium security plan account. The premium security plan account is
8.22 created in the special revenue fund of the state treasury. Funds in the account are appropriated
8.23 annually to the commissioner of commerce for grants to the Minnesota Comprehensive
8.24 Health Association for the operational and administrative costs and reinsurance payments

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

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

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

8.28 security plan account.

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

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

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

8.32 subdivision 1.

Article 1 Sec. 6. 8

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

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

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

9.4 health plan trust account in the federal fund.

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

9.6 Sec. 15. MINNESOTA COMPREHENSIVE HEALTH ASSOCIATION

9.7 TERMINATION.

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

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

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

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

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

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

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

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

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

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

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

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

9.20 Sec. 8. STATE INNOVATION WAIVER.

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

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

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

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

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

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

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

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

9.29 MNsure board.

9.30 Subd. 3. Application timelines; notification. The commissioner shall submit the waiver

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

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

Article 1 Sec. 8. 9

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

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

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

10.4 federal actions regarding the waiver request.

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

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

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

10.8 the act within the limits of existing appropriations.

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

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

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

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

10.13 carriers.

10.14 Sec. 11. PAYMENT PARAMETERS FOR 2018.

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

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

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

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

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

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

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

10.22 innovation waiver request in article 1, section 8.

10.23 Sec. 12. DEPOSIT OF FUNDS.

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

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

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

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

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

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

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

Article 1 Sec. 12. 10

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

11.1 Sec. 13. DISPOSITION AND SETTLEMENTS.

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

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

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

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

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

11.7 12; and

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

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

11.10 Sec. 14. LEGISLATIVE WORKING GROUP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.27 Sec. 15. MINNESOTA PREMIUM SECURITY PLAN FUNDING.

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

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

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

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

Article 1 Sec. 15. 11

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

12.1 (1) any federal funding available;

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

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

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

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

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

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

12.8 shall be deposited in the general fund.

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

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

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

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

12.13 16A.724.

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

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

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

12.17 Minnesota premium security plan.

12.18 Sec. 16. TRANSFERS.

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

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

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

12.22 is a onetime transfer.

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

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

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

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

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

12.28 revisor of statutes when federal approval is obtained.

Article 1 Sec. 16. 12

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

13.1 Sec. 17. TRANSFER; 2018.

13.2 The commissioner of management and budget shall transfer \$750,000 in fiscal year 2018

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

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

13.5 Sec. 18. APPROPRIATION.

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

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

13.8 Sec. 19. EFFECTIVE DATE.

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

13.10 ARTICLE 2

13.11 HEALTH POLICY

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

13.13 to read:

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

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

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

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

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

13.20 EFFECTIVE DATE. This section is effective January 1, 2018, and applies to individual

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

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

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

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

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

13.26 effective;

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

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

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

Article 2 Sec. 2. 13

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

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

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

14.4 to this subdivision.

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

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

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

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

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

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

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

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

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

14.14 read:

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

14.16 are permitted to share or disseminate data as follows:

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

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

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

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

14.21 budget; and

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

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

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

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

14.26 act.

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

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

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

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

14.31 subdivision.

Article 2 Sec. 4. 14

HF5 FIFTH ENGROSSMENT REVISOR PMM H0005-5

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

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

15.3 Sec. 3. AUDITS.

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

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

15.6 established in sections 1 and 2. The commissioner of human services shall provide data as
15.7 necessary to the legislative auditor to complete the audit. The commissioner shall withhold
15.8 or charge back payments to the health carriers to the extent they do not align with the criteria
15.9 established in sections 1 and 2, as determined by the audit.

15.10 (b) The legislative auditor shall audit the extent to which health carriers provided premium
15.11 subsidies to persons meeting the residency and other eligibility requirements specified in
15.12 section 1, subdivision 3. The legislative auditor shall report to the commissioner the amount
15.13 of premium subsidies provided by each health carrier to persons not eligible for a premium
15.14 subsidy. The commissioner, in consultation with the commissioners of commerce and health
15.15 human services, shall develop and implement a process to recover from health carriers the
15.16 amount of premium subsidies received for enrollees determined to be ineligible for premium
15.17 subsidies by the legislative auditor. The legislative auditor, when conducting the required
15.18 audit, and the commissioner, when determining the amount of premium subsidy to be
15.19 recovered, may take into account the extent to which a health carrier makes use of the
15.20 Minnesota eligibility system, as defined in Minnesota Statutes, section 62V.055, subdivision
15.21 1.

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

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

15.24 EFFECTIVE DATE. This section is effective 90 days following final enactment January
15.25 1, 2018, and applies to provider services provided on or after that date.

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

Article 2 Sec. 6. 15

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

CHAPTER 62E

COMPREHENSIVE HEALTH INSURANCE

62E.0162E.08 [Not applicable to the reinsurance program.]

62E.09 DUTIES OF COMMISSIONER.

The commissioner may:

- (a) formulate general policies to advance the purposes of sections 62E.01 to 62E.19;
- (b) supervise the creation of the Minnesota Comprehensive Health Association within the limits described in section 62E.10;
- (c) approve the selection of the writing carrier by the association, approve the association's contract with the writing carrier, and approve the state plan coverage;
- (d) appoint advisory committees;
- (e) conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association;
- (f) contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs;
- (g) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of sections 62E.01 to 62E.15, so that the residents of this state may best avail themselves of the health care benefits provided by these sections;
- (h) contract with insurers and others for administrative services; and
- (i) adopt, amend, suspend and repeal rules as reasonably necessary to carry out and make effective the provisions and purposes of sections 62E.01 to 62E.19.

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

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

62E.10 COMPREHENSIVE HEALTH ASSOCIATION.§

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

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

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

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

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

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

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

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

Subd. 5. [Repealed] [§](#)

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

Subd. 7.General powers. The association may:

- (a) Exercise the powers granted to insurers under the laws of this state;
- (b) Sue or be sued;
- (c) Enter into contracts with insurers, similar associations in other states or with other persons for the performance of administrative functions including the functions provided for in clauses (e) and (f);
- (d) Establish administrative and accounting procedures for the operation of the association;

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

- (1) individual qualified plans, excluding group conversions;
- (2) group conversions;
- (3) group qualified plans with fewer than 50 employees or members; and
- (4) major medical coverage.

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

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

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

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

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

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

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

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

- (1) develop a focused chronic disease management and case management program;
- (2) develop a comprehensive program of preventive care; and
- (3) implement a total drug formulary program.

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

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

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

62E.21 DEFINITIONS.

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

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

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

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

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

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

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

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

- (1) an insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01;
- (2) a nonprofit health service plan corporation operating under chapter 62C; or
- (3) a health maintenance organization operating under chapter 62D.

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

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

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

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

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

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

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

62E.22 DUTIES OF COMMISSIONER.

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

62E.23 MINNESOTA PREMIUM SECURITY PLAN.

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

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

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

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

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

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

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

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

- (1) will stabilize or reduce premium rates in the individual market;
- (2) will increase participation in the individual market;
- (3) will improve access to health care providers and services for those in the individual market;
- (4) mitigate the impact high-risk individuals have on premium rates in the individual market;
- (5) take into account any federal funding available for the plan; and
- (6) take into account the total amount available to fund the plan.

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

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

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

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

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

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

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

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

- (1) the claims costs minus the attachment point; or
- (2) the reinsurance cap minus the attachment point.

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

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

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

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

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

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

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

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

- (1) provide a written corrective action plan to the association for approval;
- (2) implement the approved plan; and
- (3) provide the association with written documentation of the corrective action once taken.

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

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

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

- (1) funds appropriated for reinsurance payments and administrative and operational expenses;
- (2) requests for reinsurance payments received from eligible health carriers;
- (3) reinsurance payments made to eligible health carriers; and
- (4) administrative and operational expenses incurred for the plan.

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

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

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

- (1) assess compliance with the requirements of sections 62E.21 to 62E.25; and
 - (2) identify any material weaknesses or significant deficiencies and address manners in which to correct any such material weaknesses or deficiencies.
- (b) The board, after receiving the completed audit, must:
- (1) provide the commissioner the results of the audit;
 - (2) identify to the commissioner any material weakness or significant deficiency identified in the audit and address in writing to the commissioner how the board intends to correct any such material weakness or significant deficiency in compliance with subdivision 5; and
 - (3) make public the results of the audit, to the extent the audit contains government data that is public, including any material weakness or significant deficiency and how the board intends to correct the material weakness or significant deficiency, by posting the audit results on the Minnesota Comprehensive Health Association Web site and making the audit results otherwise available.

Subd. 5. Actions on audit findings.

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

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

(2) implement the corrective action plan; and

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

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

62E.25 ACCOUNTS.

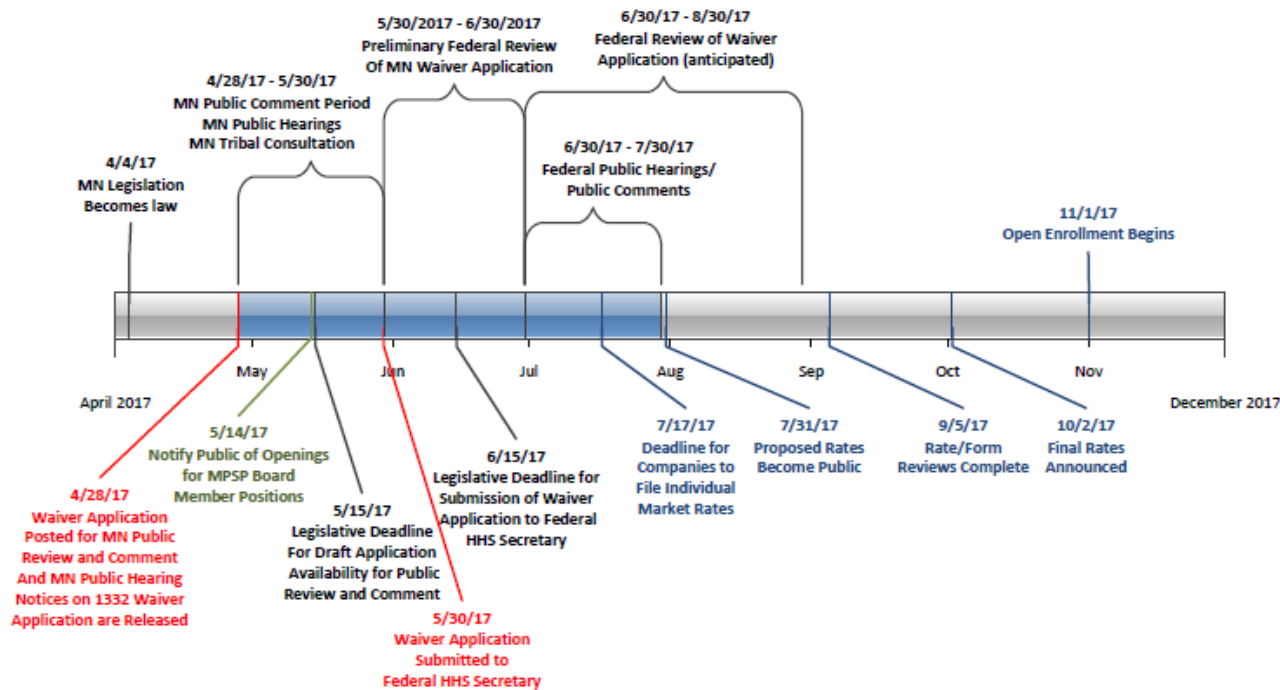
Subdivision 1. Premium security plan account. The premium security plan account is created in the special revenue fund of the state treasury. Funds in the account are appropriated annually to the commissioner of commerce for grants to the Minnesota Comprehensive Health Association for the operational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

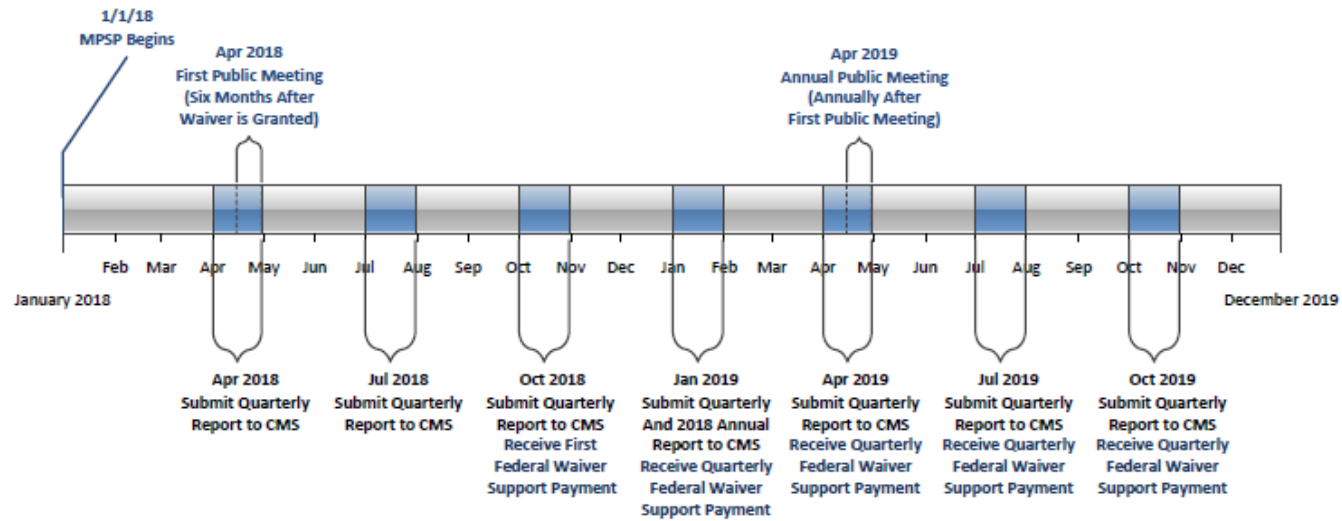
Subd. 2. Deposits. Except as provided in subdivision 3, funds received by the commissioner of commerce or other state agency pursuant to the state innovation waiver request in article 1, section 8, shall be deposited in the premium security plan account in subdivision 1.

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

Attachment C: Timeline

Best Estimate Timeline for 1332 Waiver Application





Attachment D: Public Comments

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

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

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

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

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

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

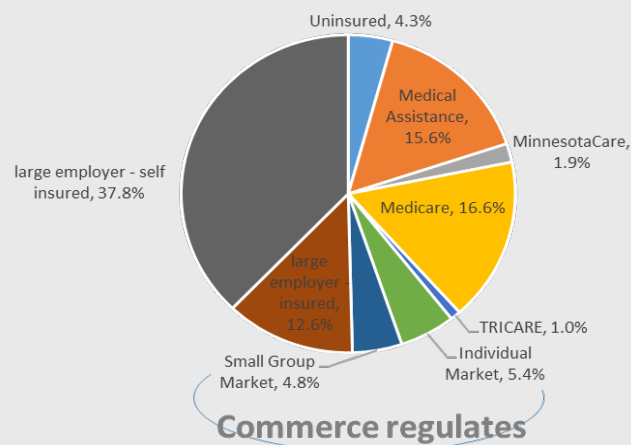
Attachment E: Slides From Public Hearings

Section 1332 Innovation Waiver Public Meeting Presentation



Minnesotans access health insurance in many ways

Minnesota Health Insurance by Market (2015)



2

Minnesotans who buy their own insurance need help

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

Rising costs have destabilized Minnesota's individual market

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

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4

National events also affected Minnesota's individual market

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

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5

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

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

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6

Minnesota is seeking a 1332 waiver

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

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7

The Federal government gives states the opportunity to innovate

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

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8

The MPSP will use Federal money to fund the reinsurance program

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

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9

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

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

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10

The amount of federal funding for the MPSP could be significant

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

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11

Impact on federal funding for MinnesotaCare

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

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12

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

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

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13

Timeline

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

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14

Questions?

- Questions or comments?

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15

Attachment F: Copy of Notice of Public Hearings



April 28, 2017

Notice of Public Comment Period and Information Meetings

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

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

Background

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

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

Draft Waiver Application

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

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

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

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

Public Comment

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

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

Public Information Meetings

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

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

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

Attachment G: Reporting Targets

Scope of Coverage/Comparability

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

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

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

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

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

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

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

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

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

Affordability

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

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

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

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

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

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

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

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

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

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

| | | | | | |
|----------------|-------|-------|-------|-------|---------|
| 2022 Projected | \$604 | \$697 | \$778 | \$872 | \$2,950 |
| 2022 Actual | | | | | |

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

Comprehensiveness

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

Proposed Report

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

Deficit Neutrality

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

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

Actual statistics will be monitored by a new quarterly report supplied by the exchange (MNsure).

Minnesota will not have access to final, reconciled actual PTC data, which is based on personal income tax filings.

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

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

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

Attachment H: Notice for Tribal Consultation Opportunity for Input



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

April 28, 2017

RE: Minnesota 1332 Waiver Request

Dear Tribal Leader:

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

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

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

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

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

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

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

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

Sincerely,

Danielle Oxendine Molliver

Department of Commerce, Tribal Liaison

Attachment I: Written Response to Open Comment Period



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

May 24, 2017

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

RE: Section 1332 State Innovation Waiver

Dear Commissioner Rothman:

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

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

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

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

Commissioner Rothman
May 24, 2017
Page 2

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

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

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Schowalter', with a stylized flourish at the end.

Jim Schowalter
President

**Blue Cross and Blue Shield of Minnesota
and Blue Plus**

P.O. Box 64560
St. Paul, MN 55164-0560
(651) 662-8000 / (800) 382-2000



May 24, 2017

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

Re: 1332 Waiver Draft Application

Dear Commissioner Rothman:

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

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

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

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

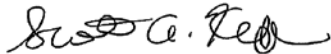
bluecrossmn.com

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

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

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

Sincerely,



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

HealthPartners
8170 33rd Avenue South
Bloomington, MN 55425

healthpartners.com

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



May 30, 2017

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

RE: Section 1332 State Innovation Waiver

Dear Commissioner Rothman:

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

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

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

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

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

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

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

Our mission is to improve health and well-being in partnership with our members, patients and community.

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

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

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

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

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

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

Sincerely,



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