

FINANCE WORK GROUP

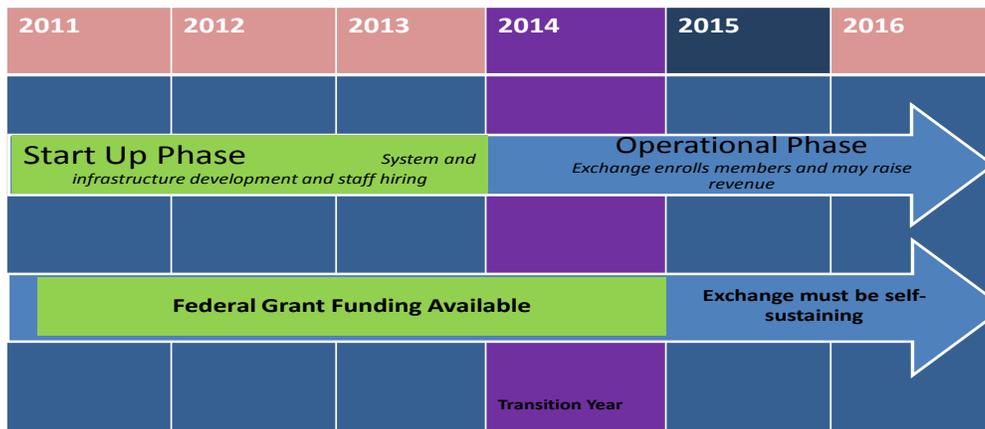
Health Insurance Exchange Report for Advisory Task Force October 24, 2012

Health Insurance Exchange Report to Advisory Task Force Finance Work Group

BACKGROUND

Per the Affordable Care Act Section 1311 (d) (5)(A), “In establishing an Exchange under this section, the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2015, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generating funding, to support its operations.” Federal funds are available for start up and the first year of operations.

Exchange Financial Timeline



In November of 2011, the Finance Work Group was formed. The purpose of the workgroup is to provide technical assistance and information on the options related to ongoing financing of a Minnesota Health Insurance Exchange. The workgroups task was to present to the Minnesota Exchange Advisory Task Force funding mechanism options, including pros and cons and principles, to consider for financing the Minnesota Health Insurance Exchange.

Members of the work group include:

- Barb Juelich, co-lead - HIX, Commerce
- Kurt Kaiser, co-lead– U of M Physicians (provider)
- Lisa Carlson – Sanford Health (Health Plans)
- Phil Cryan – Task Force Member (beginning August 2012)
- Elaine Cunningham – Children’s Defense Fund (Navigator)
- Dave Dziuk – Health Partners, (Health Plan)
- Stefan Gildemeister – Minnesota Department of Health
- Jim Golden – Department of Human Services
- Dave Greeman – Department of Health
- Chuck Johnson – Department of Human Services
- Kate Johansen – Minnesota Chamber of Commerce (small Business)

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- Margaret LeClair – Minnesota Assoc. of Health Underwriters (Broker)
- Andy McCoy – Fairview Hospital (provider)
- Matt Schafer – American Cancer Society (Consumer Representative)
- Nora Slawik – Legislator (through May, 2012)
- Angela Vogt/Ryan Baumtrog – Minnesota Management and Budget

The workgroup has met 9 times over the last year.

- November 30, 2011 – Review funding options and current health care taxes and surcharges
- December 9, 2011 – Discuss funding matrix, pros and cons
- December 14, 2011 – Finalize funding matrix; Discussion principles of Financing the Exchange
- February 8, 2012 – Discuss benefits/beneficiaries of an Exchange
- August 9, 2012 – Review Wakely Consulting Budget Model
- August 22, 2012 – Continued discussion on budget model and finance options
- September 5 – Review member survey results on finance options
- September 19 – Finalize funding options table and discuss workgroup principles/recommendations.

Recommendations and other work from the workgroup were presented to the task force three times

- **December 21, 2011** – Funding Options Matrix; Financing Principles; Funding Options Pros and Cons
- **January 10, 2012** – Funding Recommendations/Principles
- **March 30, 2012** – Presentation to Task Force on benefit/beneficiaries of an Exchange

Meeting minutes and documents can be found at

<http://mn.gov/commerce/insurance/topics/medical/exchange/Technical-Work-Groups/Finance-Group.jsp>

<http://mn.gov/commerce/insurance/topics/medical/exchange/Exchange-Advisory-Task-Force/index.jsp>

WORKGROUP ACTIVITY SUMMARY

Funding Options

The Finance Work Group reviewed nine funding options for potential sources to fund the Health Insurance Exchange. This included:

- Premium add-on or user fee
- Portion of premium for Qualified Health Plans sold in the Exchange
- Portion of premium for plans in the fully insured market
- Broad based health care market assessment
- Other broad based tax or sin tax with evidenced base health benefits
- General fund appropriation
- Health Care Access fund appropriation
- Other including advertisement, naming rights, and grants.

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- Medicaid cost allocation

Please note the non-Medicaid options are in an order from a narrow base to a broad base and do not reflect an order of preference of the group.

Principles

Four Basic Principles were adopted by the Advisory Task Force in January of 2012. These principles are:

- Funding mechanisms should be considered against the recommended principles of equity, transparency, sustainability and simplicity, as well as avoid negative impacts. Equity being the top principle.
- Funding mechanisms should not disproportionately burden one group over another, and as much as possible be proportionate to the benefit received by the paying group.
- Funding of the Exchange should include a combination of funding sources to ensure that those benefiting from an Exchange also support it, at a minimum include Medicaid or a percent of premium mechanism (to the extent it does not discourage participation or create adverse selection). Consideration of other resources should reflect overall budget needs, overall benefits of the Exchange and other decisions yet to be made.
- Funding mechanisms should be implemented in time to meet needs of Navigator program no later than July 1, 2013, as well as cash flow and reserve needs of the Exchange to be self-sustaining beginning in 2015.

Benefits of an Exchange

General benefits for all individuals using Exchange

- Provides Navigator/broker services for assistance
- Provides information to aid in selecting appropriate plan
- Provides easier transition between markets for public assistance, tax credit and employees of small firms from/into other markets
- Provides potential for reduced costs with risk pooling

Benefits for specific individuals

- Provides individual eligibility determination for Medical Assistance
- Provides individual eligibility determination and processing of advance premium tax credit
- Provides individual eligibility determination and processing of cost sharing reductions
- Provides potential for reduced costs with risk pooling, eligibility for advance premium tax credit and cost sharing reductions.
- Provides options for other individuals choosing to purchase through exchange
- Provides health plan choice and enrollment for employees of small business purchasing through exchange
- Provides option to pool resources for employees with multiple sources of payment

Benefits to small business owners

- Provides information to aid in selection appropriate plan(s)

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- Provides options for defined contribution
- Provides administrative relief in managing health plan choose and enrollment
- Provides Navigator/broker services for assistance
- Provides information on tax credit eligibility for certain small businesses

Benefits to Carriers

- Provides apples to apples comparison of products sold on Exchange
- Provides a distribution channel to sell products to certain groups (APTC individuals and small business)
- Provides member months purchased through Exchange
- Provides opportunity to reduce administrative costs
- Provides fund aggregation for members with multiple sources of payment

Benefits to general public

- Provides for general provider and plan information, cost and quality information
- Provides for potential state savings
- Provides for exception process to individual mandate
- Provides for transition between markets
 - Individual losing coverage due to job loss, reduction of hours, etc.
- Increased coverage potentially could lead to decreased uncompensated care, improved public health, and reduced health care costs overtime

The workgroups discussion of the non-Medicaid options is summarized in a set of funding options tables. The tables include:

- Pros and cons of each option,
- Links of Exchange benefits to the source of funding,
- Alignment with the principles of equity, neutrality to the market, transparency, flexibility and simplicity and
- Comments from work group members on the source funding mechanism.

The comments reflect the variety of opinions on each funding option. *See Funding Option Summary tables for more information.*

BUDGET PROJECTIONS

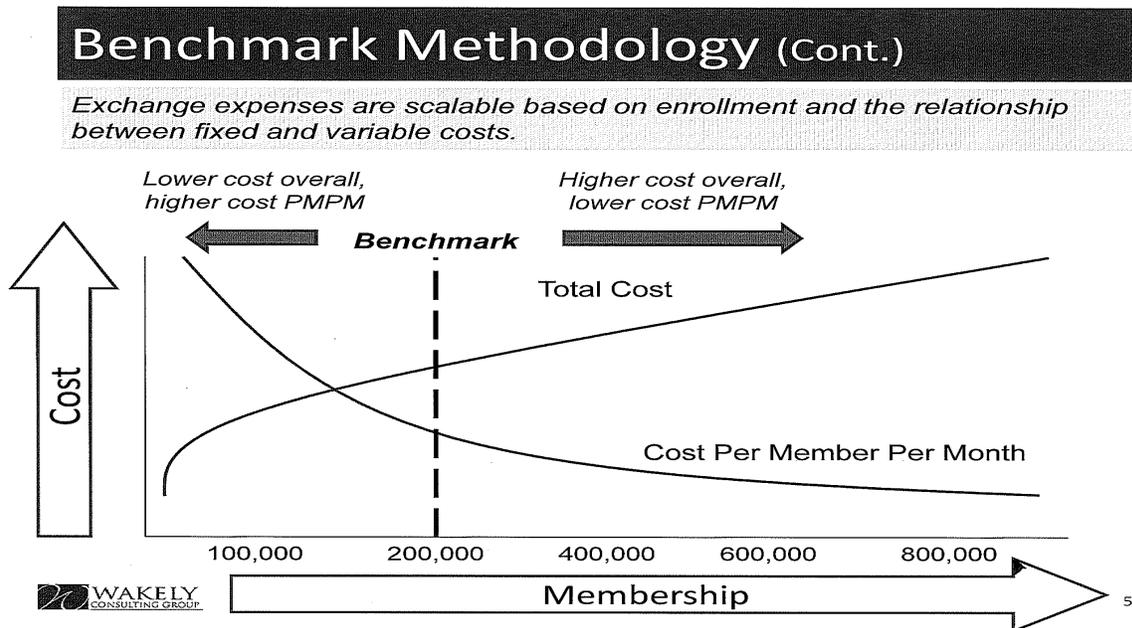
Wakely Consulting Group Model

The Health Insurance Exchange worked with the Wakely Consulting Group to establish a Self-Sustainability budget model. The model is based on the Massachusetts experience for Operating the Connector. The model utilizes a per member per month benchmark for operation categories based on 200,000 annual enrollees. The model assumes 55% of costs are fixed and 45% are variable. The Model was not designed for direct inclusion of Medicaid participants, however one can assume a percentage of fixed costs for certain categories would be allocated to Medicaid. While the model did include a

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calculation for Navigators and Brokers, that portion of the model is still compensation parameter input based on the work of the Broker/Navigator workgroup.

The graphic below shows the benchmark methodology the model is based on.



The model works on a number of inputs and assumptions for enrollment projections, member month projections, premiums and benchmark PMPM costs. Based on the inputs and assumptions of the model for these items, the model produces a low, medium and high enrollment and budget estimate for 2014 through 2016. The model also includes a calculation of revenue needed for a subset of the revenue options the workgroup looked at.

Wakely Model – Enrollment Projections

The enrollment projections are based on the Exchange participation estimates from Dr. Jonathon Gruber for calendar 2016. These estimates were originally presented to the Advisory Task Force in November 2011 and updated in April of 2012. The updated April numbers were utilized in the model. Dr. Gruber’s report included four scenarios for Exchange participation that were dependant on whether Minnesota created a Basic Health Plan (BHP) or not, and if Minnesota would be required to maintenance eligibility for children at 275% of the federal poverty guideline (FPG). The model is built to adjust for each of these scenarios, for the purpose of budget projections, the scenario of no BHP and a MOE of 275 PG for children was chosen.

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Table 1 - 2016 participation in the Exchange, No BHP, MOE at 275%

	Number of Individuals	Enrollment in Exchange	Assumed Take up Rate	Percent of HIX participation
Tax Credit Recipients	280,000	280,000	100%	22.76%
Non-Tax Credit Recipients in Reform Market	Up to 120,000	60,000	50%	4.88%
Enrollees in Firms <50 Receiving Tax Credit	70,000	70,000	100%	15.45%
Enrollees in Firms<50 not receiving tax credit	Up to 350,000	90,000	26%	
Enrollees in firms 50-99	Up to 120,000	30,000	25%	
Public Insurance	700,000	700,000	100%	56.91%
Total Exchange Enrollment		1,230,000		
Non-Public		530,000		43.09%
Public		700,000		56.91%

In order to project enrollment estimates for 2014 and 2015, the model utilizes a low, medium and high participation rate assumptions. For example, the model assumes that in 2014, 40% of the 280,000 individual's eligible for a subsidy estimated to participate in the Exchange in 2016 will participate in 2014. (280,000 x 40% = 112,000) These assumptions are outlined in Table 2. Highlighted cells in the table reflect the estimates for 2016 from the Gruber Report.

Table 2 – Enrollment Participation Rate Assumptions for the Exchange

	2014			2015			2016		
	Low	Med	High	Low	Med	High	Low	Med	High
Individual – Subsidy	40.00%	50.00%	60.00%	50.00%	70.00%	90.00%	60.00%	80.0%	100.00%
Individual – non subsidy	10.00%	20.00%	30.00%	20.00%	40.00%	60.00%	20.0%	50.00%	80.0%
Small Group	2.50%	5.00%	7.50%	5.00%	10.00%	15.00%	7.50%	15.00%	35.19%
Members (end of year)									
Individual – Subsidy	112,000	140,000	168,000	140,000	196,000	252,000	168,000	224,000	280,000
Individual – non subsidy	12,000	24,000	36,000	24,000	48,000	72,000	24,000	60,000	96,000
Small Group	13,500	27,000	40,500	27,000	54,000	81,000	40,500	81,000	190,000

Wakely Model – Member Month Projections

To finalize enrollment estimates, member months need to be calculated. The model allows for the use of fast, medium or slow take up rates for calendar 14. Based on workgroup discussion the model inputs

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for the fast rate was chosen and then modified to reflect higher take-up rates during the open enrollment months.

Table 3 – Model Take up rate estimates

2014	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Revised	25.0%	25.0%	18.0%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%
Fast	12.0%	18.0%	20.0%	18.0%	6.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.0%	3.0%
Med	8.0%	9.0%	10.0%	12.0%	13.0%	14.0%	8.0%	6.0%	6.0%	5.0%	5.0%	4.0%
Slow	6.0%	7.0%	8.0%	9.0%	10.0%	11.0%	11.0%	10.0%	9.0%	7.0%	6.0%	6.0%

Changed from medium scenario to “Revised” scenario. Revised scenario

2015	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Revised	60.9%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%	3.6%
Original	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%	8.3%

2016 – Original formula assumed participation growth from 2015 to 2016 averaged 8 months of enrollment. Revised scenario changes to new participants averaging 9.5 months enrollment to reflect similar growth in member months from 2014 to 2015.

Based on the take up rate assumptions in Table 3, members are calculated. Table 4 shows the model output for member month estimates.

Table 4 – Member month estimates

	2014			2015			2016		
	Low	Med	High	Low	Med	High	Low	Med	High
Individual	1,129,331	1,493,631	1,857,932	1,837,404	2,690,928	3,546,416	2,234,000	3,308,000	4,382,000
Sm. Group	122,951	245,903	368,854	302,499	595,533	886,604	452,250	904,500	2,007,500
Total	1,252,282	1,739,534	2,226,786	2,139,903	3,286,462	4,433,021	2,686,250	4,212,500	6,389,500

Wakely Model – Average Monthly Premium Projections

The Wakely Model includes premium revenue assumptions for participants in the Exchange. This is primarily used to analyze the revenue options tied to premiums within the Exchange such as a user fee or percent of premium within the change option. Inputs for the model include 2016 premium estimates for the individual market from Dr. Jonathon Gruber and Bela Gorman (5,687 average annual premium). The model takes the estimated 2016 rate and backs off 5.5% each year for 2015 and 2014 (assumes 5.5% premium growth per year) . For the small group market, the model utilizes the 2009 average premium and increases it each year by 5.1% which is the average increase from 2005 through 2009. Table 5 creates a composite premium for the individual and small group market based on estimated members per plan purchase and member months. Table 5 reflects the composite monthly premiums from the model.

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Table 5 – Estimated individual and small group premiums

	2014	2015	2016
Individual	423.22	447.85	473.92
Small Group	427.14	448.93	471.82

The model then creates total estimated premium revenue for Exchange participants by calculating member months times the composite premium. The results of the calculation are reflected in Table 6.

Table 6 – Estimated Premium Revenue

	2014			2015			2016		
	Low	Med	High	Low	Med	High	Low	Med	High
Total member mos (A)	1,252,282	1,739,534	2,226,786	2,139,903	3,286,462	4,433,021	2,686,250	4,212,500	6,389,500
Comp Prem (B)	\$423.60	\$423.77	\$423.87	\$448.00	\$448.05	\$448.07	\$473.57	\$473.48	\$473.29
Total Prem C = A*B	530,472,883	737,169,905	943,866,928	958,684,377	1,472,488,021	1,986,289,549	1,272,112,522	1,994,481,710	3,023,890,775
C*2% - \$	10,609,458	14,743,398	18,877,339	19,173,688	29,449,760	39,725,791	25,442,250	39,889,634	60,477,816
C*3% - \$	15,914,186	22,115,097	28,316,008	28,760,531	44,174,641	59,588,686	38,163,376	59,834,451	90,716,723
C* 4% - \$	21,218,915	29,486,796	37,754,677	38,347,375	58,899,521	79,451,582	50,884,501	79,779,268	120,955,631
* 5% - \$	26,523,644	36,858,495	47,193,346	47,934,219	73,624,401	99,314,477	63,605,626	99,724,085	151,194,539

Wakely Model – Budget Projections

Based on benchmark per member per month costs estimated from the Massachusetts experience for 200,000 participants, the model produces an estimated budget for the following categories:

- Eligibility determination and enrollment
 - IT Solution for eligibility and enrollment
 - Verification and other supports for eligibility determination
 - Communications on enrollment between Exchange and carrier.
- Website creation and maintenance
 - IT Solution for plan comparison, account management, case management, as well as design and maintenance of roles and responsibilities within the IT Solution (navigator, broker, assister, county worker, call center staff, carrier, provider)
- Customer Service
 - IT infrastructure and maintenance as well as transactional costs call center, notices and other customer service needs.
- Premium Billing
 - IT infrastructure and maintenance for fund aggregation, connection to e-payment and lockbox services including transactional/banking service costs for processing payments.
- IT infrastructure
 - Internal IT support such as equipment, desk-top support and internal operations infrastructure (network, etc).
 - Does not include IT infrastructure support of systems (included above)
- Marketing/Advertising/Outreach
 - Outreach, public awareness campaign and marketing activities

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- Consulting/Professional Contracts
 - Evaluation, auditing
 - QHP certification (Minnesota Department of Health and Commerce)
- Appeals
 - Appeals processing including hearings, adjudication, etc.
- General Administration (Personnel, facility, supplies, etc.)
 - Model assume 55 to 75 FTEs not including IT infrastructure to support systems

Table 7 shows the Model budget projections for 2015 and 2016 for the above categories, including areas that are optional and areas that may yield savings, either to the state, county or carriers. These numbers do not include navigator or broker compensation. They also do not include a Medicaid allocation for fixed costs that may benefit the Medicaid program. It is assumed that the Medicaid participation would be between 15 and 30% of the overall costs. For the purposes of this report a 20% Medicaid allocation is assume.

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Table 7 – Budget Projections – 2015 and 2016

		2015			2016			Description	Opt	Offset
		Low	Moderate	High	Low	Moderate	High			
Eligibility Determinations and Enrollment	0.19	7,208,897	8,693,523	10,130,683	7,878,740	9,866,519	12,653,083	IT infrastructure, Exchange eligibility and enrollment functionality (Module 1, 2 and 3) communications, verifications and other supports for eligibility and enrollment (\$1,177,518 = Module maintenance)	NO	State and County efficiencies
Website	0.05	1,760,952	2,123,609	2,474,671	1,924,578	2,410,142	3,090,830	IT infrastructure and maintenance for overall Exchange, plan comparison, account management (Module 4, 5 and 7) (\$878,507 = Module maintenance)	M5	
Customer Service	0.25	9,355,058	11,281,672	13,146,689	10,224,320	12,803,879	16,420,032	IT infrastructure and maintenance as well as transactional costs for call centers, notices, and other customer assistance services	NO	State and County efficiencies. Carrier offsets
Premium Billing	0.11	4,044,687	4,877,664	5,684,009	4,420,515	5,535,795	7,099,249	IT infrastructure and maintenance for fund aggregation (Module 6), connections to e-payment and lockbox services including transactional costs, (\$374,000 = Module maintenance).	Individual Prem	Carrier offsets
Subtotal: Systems Dvlpmnt and Support	0.60	22,369,594	26,976,468	31,436,052	24,448,152	30,616,335	39,263,194	\$2,430,025 – Annual Maintenance – Maximus, \$1.5 - \$2 million – IT infrastructure support, \$6 M Equipment maintenance, replacement, software licensing upgrades, etc. (20% of build)		
IT Infrastructure (internal)	0.02	797,931	962,260	1,121,335	872,074	1,092,096	1,400,532	IT support for HIX – includes internal IT infrastructure, user support, equipment, etc.	NO	
Marketing/Advertising/Outreach	0.13	4,849,029	5,847,656	6,814,354	5,299,596	6,636,665	8,511,034	Outreach, Public awareness campaigns, marketing, advertisement	Level is opt	
Consulting/Profession Contracts	0.06	2,146,160	2,588,148	3,016,005	2,345,579	2,937,361	3,766,948	Evaluation, auditing, Health and Commerce regulatory and enforcement. Risk Adjustment not included (optional)	RA – opt.	
Administrative (Personnel, Facility, General Admin)	0.15	6,222,504	7,620,401	8,003,234	7,493,068	8,045,796	9,473,927	55 to 75 FTEs not including IT infrastructure for systems support, regulatory and enforcement staff		
Appeals	0.04	1,348,229	1,625,888	1,894,670	1,473,505	1,845,265	2,366,416	Appeals process – hearings, adjudication, etc.	NO	St/Cty eff.
Subtotal – Program Operations	0.40	15,363,854	18,644,353	20,849,599	17,483,823	20,557,182	25,518,859			
Total Operating	1.00	37,733,448	45,620,821	52,285,651	41,931,975	51,173,517	64,782,053			
Estimate 20% MA		7,546,690	\$9,124,164	10,457,130	\$8,386,395	10,234,703	12,956,411			
Net		30,186,758	36,496,656	41,828,521	33,545,580	40,938,813	51,825,642			

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Wakely Model – Funding Option Analysis

The final part of the Wakely Model is an analysis of funding options against the estimated budget. Based on the Model and addition work from the finance work group, a number of funding scenarios was developed. They are summarized in Table 8.

Table 8 – Exchange Revenue Option Analysis (Wakely Model less 20% Medicaid allocation)

Revenue Options	Revenue Base	2014			2015			2016		
		Low	Med	High	Low	Med	High	Low	Med	High
Total costs as percent of Estimated Revenue										
User Fee	See above	3.87%	3.17%	2.78%	3.15%	2.48%	2.11%	2.64%	2.05%	1.71%
QHP/Premium withhold	See above	3.87%	3.17%	2.78%	3.15%	2.48%	2.11%	2.64%	2.05%	1.71%
Portion of Premium – Fully Insured	6,000,000,000*	0.34%	0.39%	0.44%	0.50%	0.61%	0.70%	0.56%	0.68%	0.86%
Broad Health Care Tax	23,350,000,000**	0.09%	0.10%	0.11%	0.13%	0.16%	0.18%	0.14%	0.18%	0.22%
HMO Premium Revenue	4,000,000,000**	0.51%	0.58%	0.66%	0.75%	0.91%	1.05%	0.84%	1.02%	1.30%
HMO, NFP Health Service Plan, Community Integrated Network Revenue	6,900,000,000 **	0.30%	0.34%	0.38%	0.44%	0.53%	0.61%	0.49%	0.59%	0.75%
Hospital Net Patient Revenue	7,788,500,000**	0.26%	0.30%	0.34%	0.39%	0.47%	0.54%	0.43%	0.53%	0.67%
MCHA Assessment Base	6,049,000,000 **	0.34%	0.39%	0.43%	0.50%	0.60%	0.69%	0.55%	0.68%	0.86%
Broad base – other tax (sin tax)		Dependant on the base of the tax								
General Fund /HCAF Appropriation		Options range from fund portion, select categories or 100%								
Other (grants, advertisement, naming rights)										

*Source: MDH Health Economics Program, 2009

**Source: Summary of Health Care Revenues for State fiscal year 2010-11

WORKGROUP CONCLUSIONS

While the workgroup agreed that Medicaid should be part of the funding solution for the Medicaid costs associated with the Exchange, the Workgroup could not come to agreement on a funding mechanism for the non-Medicaid portion. Without having decisions on a governance structure, a more defined budget estimate and the unknowns of other impacts from the Affordable Care Act, specific recommendations on funding options and other financial issues such as cash flow and reserve needs could not be made. One member described the workgroup being in “a nexus of uncertainty” and therefore unable to reach consensus.

While a specific recommendation on how to fund the Exchange was not agreed to, there was agreement that multiple options should be used. There was also a general consensus that any premium percentage or premium add-on (user fee) mechanism be used to meet the balance of costs not met by the other resources.

To the extent a percent of premium or a premium add-on is used to fund the Exchange, the workgroup members discussed two principles:

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- The funding mechanism should maximize federal participation by including the fee in the calculation of the Advanced Premium Tax Credit (APTC).
- The funding mechanism should not cause a cost shift into other parts of the market.

Alignment of these principles with each other is difficult to assess due to uncertainties around these options. It is not clear if a premium add-on could be included in the APTC calculation. It is not clear how the use of a premium add-on is impacted by the federal requirement for premiums inside and outside the Exchange be the same for the same product. If the only way to include the Exchange fee in the APTC calculation is to include it as part of the premium and the premiums inside and outside the Exchange must be the same, the two principles are in conflict with each other.

To the extent premiums inside and outside the Exchange need to be the same, the costs of a portion of premium funding option will likely be spread across products of the broader market, therefore a cost shift. To address these uncertainties, the following questions have been submitted to the federal Health and Human Services staff:

- 1.) If a state pursues an individual user fee that is administered as a add-on to the premium, would the add-on be allowed to be considered part of the premium for the purposes of APTC calculations.
- 2.) How would an add-on described in question 1 be viewed in relation to the requirement that premiums inside and outside the Exchange be the same for the same product.
- 3.) If a state pursues a carrier fee that is part of the premium, is that allowed to be part of the APTC calculation?
- 4.) If a state pursues a carrier fee or individual user fee administered through the premium, how will this assessment be viewed for provider tax purposes (caps, broad base rules, etc.)

In addition to the above potentially conflicting principles, the workgroup offers the following recommendations on other issues pertaining to the financing of the Exchange.

Transparency

- If premium options pursued, recommend including line item on invoice reflecting portion of premium or premium add-on that will be retained by the Exchange for Exchange operating costs.
- Recommend other markets show breakdown of premium costs to reflect proportion of administrative costs.
- Recommend annual audits and findings be posted on public website.

Accountability

- Recommend revenue sources created for Exchange only is used for Exchange purposes.
- Recommend Exchange track and report revenues and expenditures
- Recommend budgets presented to board and/or legislature for review (dependant on governance structure).

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Flexibility

- Recommend process be developed to adjust budget as necessary to meet changing budget needs against enrollment variances. Process will depend on governance structure.
- Recommend cash flow and reserve needs be met. Process of meeting cash flow and reserve needs will depend of Governance structure. Mechanisms to meet needs are different between a state entity and a non-profit.

Timing

- To the extent the funding mechanism includes a portion of premium (QHP or fully insured), it needs to be in place in time for rate filing.
- Legislative changes required to implement rate setting, cash flow or reserve needs and budgets should be implemented in the 2013 legislative session.

NEXT STEPS

The Health Insurance Exchange is continuing to refine its budget estimates.

Information Technology

As work with other IT Solution vendors continues, the IT infrastructure needs are becoming clearer. We are working with Mn.IT DHS and Mn.IT Central to validate the needs estimates which include standing up developing, testing and production environments or the Exchange. One-time costs include the purchase on hardware and software as well as installation services. Ongoing cost in this area includes ongoing maintenance and support costs and license renewal.

Staffing

Ongoing staffing needs are becoming clearer, as reflecting in the most recent grant application. We anticipate the need for about 50 to 60 non-IT staff for the Exchange to support program operations for SHOP, individual eligibility, plan management, provider information, customer service (call center, eligibility assistance, notification, appeals, premium billing and collection, etc) outreach as well as back office functions of finance, human resources and facilities management. Additional staff for information technology support is anticipated to be about 25 to 30 IT staff to support both the internal IT needs of the Exchange staff as well as overall IT infrastructure support for the systems.

Qualified Health Plan Certification

Cost for Department of Health and Commerce for QHP certification have been identified and outlined, but will need to be adjusted for actual experience.

Customer Service

While operating processes are still being defined, we can use the Wakely model to estimate costs such as eligibility in-take (in-person, mail, fax), eligibility verification and case management, in-person assisters, call center, notices, appeals and premium processes. Customer service activities continue to be defined, updated costs estimates can be made.

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Marketing and Outreach

Marketing and Outreach workgroup has been identifying audience profiles and outreach channels. Taking this analysis and combining it with the market research report and other research from state and national sources, the group will now assist in directing marketing dollars for optimum effectiveness in consumer outreach.

Navigator/Broker/Assistors

The Navigator/Broker program development and workgroup recommendations will assist in defining the budget needs in this area.