

**Health Insurance Exchange – Finance Workgroup
Funding Options Worksheet**

Scenario – 2015 Net Operating Budget: \$40 million Member months: 3.333 million PMPM: \$12 Total Premiums: \$1,494,000,000
 2016 Net Operating Budget: \$50 million Member months: 5.55million PMPM: \$9 Total Premiums: \$2,628,000,000

Highest Degree of Funding Codes

- 1: Funding option could be considered to potentially fund all operating costs (being 100% of total funding source - only one funding source)
- 2: Funding option could be considered potentially to fund a significant portion (33% or more of total funding - 2 to 3 total funding sources) of all operating costs
- 3: Funding option could be considered to potentially fund a small portion (up to 30%) of operating costs
- 4: Funding option should not be considered/utilized as a potential funding source

Proportion of Funding Responses

Funding Option	Estimate Need if used for 100% 2015/2016	Proportion of Funding						Highest Degree	Mechanism of Collection	Comments
		A	B	C	D	E	F			
User Fee	\$12/9 PMPM	0-100 in conjunction with "other"	0 %	80 %	0 %	0 %	100 %	1 - **** 2- * 3- 4-*	<ul style="list-style-type: none"> • Mechanism on website to pay fee directly to the state upon purchasing • Billed/added to premiums • Separate line item on premium invoice 	<ul style="list-style-type: none"> • Benefits: Even a \$12/9 PMPM charge per enrollee should not be a financial disincentive to use the exchange if the exchange reduces premiums by 7.5 percent as asserted. There are no political obstacles to implementing this fee. It does not increase the cost of health insurance. It helps ensure the exchange remains accountable to consumers who will pay for its services. The administrative burden is minimal because the state can build collection into the website; this removes administrative burdens from the state and consumers already handling several administrative and compliance challenges with the ACA. • Preferred option as this would not cost shift to other market distribution channels. Matches who primarily benefits and who pays for it. • Users will ultimately foot bill of any of the funding mechanism, so should not have to pay a fee as well. • Other fee could include fee on small business that use the exchange to price and purchase policies for employees. The exchange would be serving a human resource function for these small businesses that they should pay for. This might be a user fee but limited to small businesses – this would account for a small amount of the total costs – less than 5%. • Should not exceed 3% of premium cost, only a replacement for portion of premium, should not be duplicated with portion of premium. The portion of premium or user fee should offset marketing costs that would be spent outside of the exchange. • <i>PRO: Aligns with task force recommendation of matching costs with those who benefit.</i> • <i>CON: May discourage participation in the Exchange. May not align with Task Force principle on health disparities. Could impact adverse selection. IF not part of premium, will not be part of APTC calculation.</i>
Portion of Premium inside Exchange	2.7/1.9% of premium revenue or \$12/9 PMPM	0	40 %	0 %	35 %	95 %	0%	1 - ** 2-*** 3- 4-*	<ul style="list-style-type: none"> • Carrier required to administer or added as fee via website and paid directly to state • Retain portion of premium • Added to premiums, new tax return? • Like Massachusetts • Withholds from premiums collected via Exchange or invoice and collect • Separate line item on premium invoice 	<ul style="list-style-type: none"> • Concern: Adverse selection; increased fees for fully-insured consumers who are the audience for exchange purchasing • Believe that health Exchange participants should pay for some portion of the costs to the degree fee does not impact on operations/viability of the product. • Good option but would require enabling legislation which could be challenging. A good second choice option. Rate setting needs to allow for this tax. • Should not exceed 3% of premium cost, only a replacement for user fee, should not be duplicated with user fee. The portion of premium or user fee should offset marketing costs that would be spent outside of the exchange. • <i>PRO: Aligns with task force recommendation of percent of premium mechanism and matching costs with who benefit (new member months from the uninsured, administrative relief, MLR, fund aggregation and reconciliation). If withhold part of premium, will not create disincentive to participate (higher premiums) or adverse selection issues.</i> • <i>CON: May discourage carriers from participating.</i>
Portion of Premium (Fully Insured Market)	.7/.8% of premium revenue	0	0	0	10 %	5 %	0%	1- * 2- * 3- * 4- **	<ul style="list-style-type: none"> • Likely administered through carriers who would determine value • Premium tax return • Tax health plans collect and pay exchange • Dedicated tax revenue to 	<ul style="list-style-type: none"> • Concern: The fully-insured market already pays high and rising premiums, the MCHA assessment, and the hefty impact of rich mandated benefits set. The early ACA years already provide greater uncertainty for fully insured market consumers. Benefits of an exchange extend beyond fully-insured market consumers. • Disruptive to the insured market when this market will already be incurring significant new ACA taxes at 2-4% • This could be a secondary source of revenue if the prior two items do not generate enough revenue to cover the cost of the exchange. • <i>PRO: Aligns with task force recommendation of percent of premium mechanism. Premiums inside and outside</i>

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									<ul style="list-style-type: none"> exchange Covered lives assessment on health plans, HMOs and TPAs. Separate line item on premium invoice 	<p><i>Exchange the same. Acknowledges broader benefit of the Exchange. Predictable.</i></p> <ul style="list-style-type: none"> CON: Reduces link between Exchange direct participants and revenue source.
Broad Based Health Care Tax (assume provider tax base)	.17/.20%	0%	0%	0%	25%	0%	0%	1 – 2- 3-**** 4-**	<ul style="list-style-type: none"> State administered tax Provider tax return Similar to MCHA and Provider tax collection Dedicated tax revenue to exchange 	<ul style="list-style-type: none"> Concern: Does this comport with the fund’s intended purpose? How will future provider tax changes impact the fund’s liquidity vis-à-vis other funding mechanisms? On whom will the administrative burden fall? How much will administration and collection cost? Would be politically challenging to get this passed. Health plans and the insured are the primary beneficiaries of the exchange and should be the entities that bear the cost of the exchange, not providers.
Sin Tax (with demonstrated public health benefit)	\$40/\$50 million	0%	10%	0%	0%	0%	0%	1- 2 - * 3- 4-***	<ul style="list-style-type: none"> State administered Appropriation Dedicated amount of collection or appropriation Dedicated tax revenue to exchange 	<ul style="list-style-type: none"> Concern: Political viability; the need to increase revenue when market-based alternatives may suffice. Benefit: improves overall public health in association. There is not a direct correlation between a sin tax and the beneficiaries of the service of the exchange. Sin taxes should be reserved for other purposes, like covering the costs of health care services needed because of the use of tobacco and other products impacted by the “sin”. Recommend changing to “evidenced based” public health benefit. See BCBS study
General Fund Operations	\$40/\$50 million	0%	40%	10%	30%	0%	0%	1 -* 2 – 3-** 4-**	<ul style="list-style-type: none"> Appropriation 	<ul style="list-style-type: none"> Concern: Political viability; stability over time Public program admin changes Should be used to cover any incremental cost over cap on user fee/portion of premium
Health Care Access Fund Appropriation	\$40/\$50 million	0%	0%	10%	0%	0%	0%	1- 2- 3- 4-***	<ul style="list-style-type: none"> Appropriation 	<ul style="list-style-type: none"> Concern: To what extent is the fund already slated for other programs/appropriations? Do we need to increase revenue when market-based alternatives may suffice? Reserve for funding BHP or wrap around services for population that will lose coverage under ACA but currently in MnCare Health plans and the insured are the primary beneficiaries of the exchange and should be the entities that bear the cost of the exchange, not providers
Other (grants, advertisement)	\$40/\$50 million	0-100 Maximize here; supplement remaining costs with a user fee.	10%	0%	0%	0%	0%	1 -** 2 – 3 -* 4-***	<ul style="list-style-type: none"> Exchange governance body would seek grants (pending governance structure); exchange staff would contract with advertisers and/or sell naming rights. Revenue via invoices/sales 	<ul style="list-style-type: none"> Concern: Lack of information presented for the work group to analyze. While the email excerpt sent to the work group is appreciated, it may not provide relevant information because it is a decade old and dealt with the state’s web portal, which is materially different from advertising on a health insurance exchange which has a natural audience for consumers (the portal does not) and advertisers. Benefits: This provides a link to brokers and agents. It ensures the consumer-value of the exchange by demonstrating that advertisers view the exchange as a valuable conduit to consumers. Grants exist that comport with the exchange’s mission, and because of the high profile nature of the project, it is likely major foundations would support the project. Recommend utilizing this funding source to the fullest extent possible and filling in the remaining cost by an adjusted PMPM user fee. Not sure we should plan for this right now Hard to estimate, but whatever can be raised could be put toward exchange operating costs Could generate some funding but may not generate enough to make it worth the administrative burden.