Health Insurance Exchange Finance Work Group

8/9/12

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Agenda

- Overview of prior work from work group
  - Timeline
  - Funding Pros and Cons
  - High level recommendations/principles
  - Benefit Analysis (who benefits from Exchange)
  - Review of “unknowns”
- Review Exchange budget model
  - Inputs, assumptions, output
- Discuss next steps for Work Group

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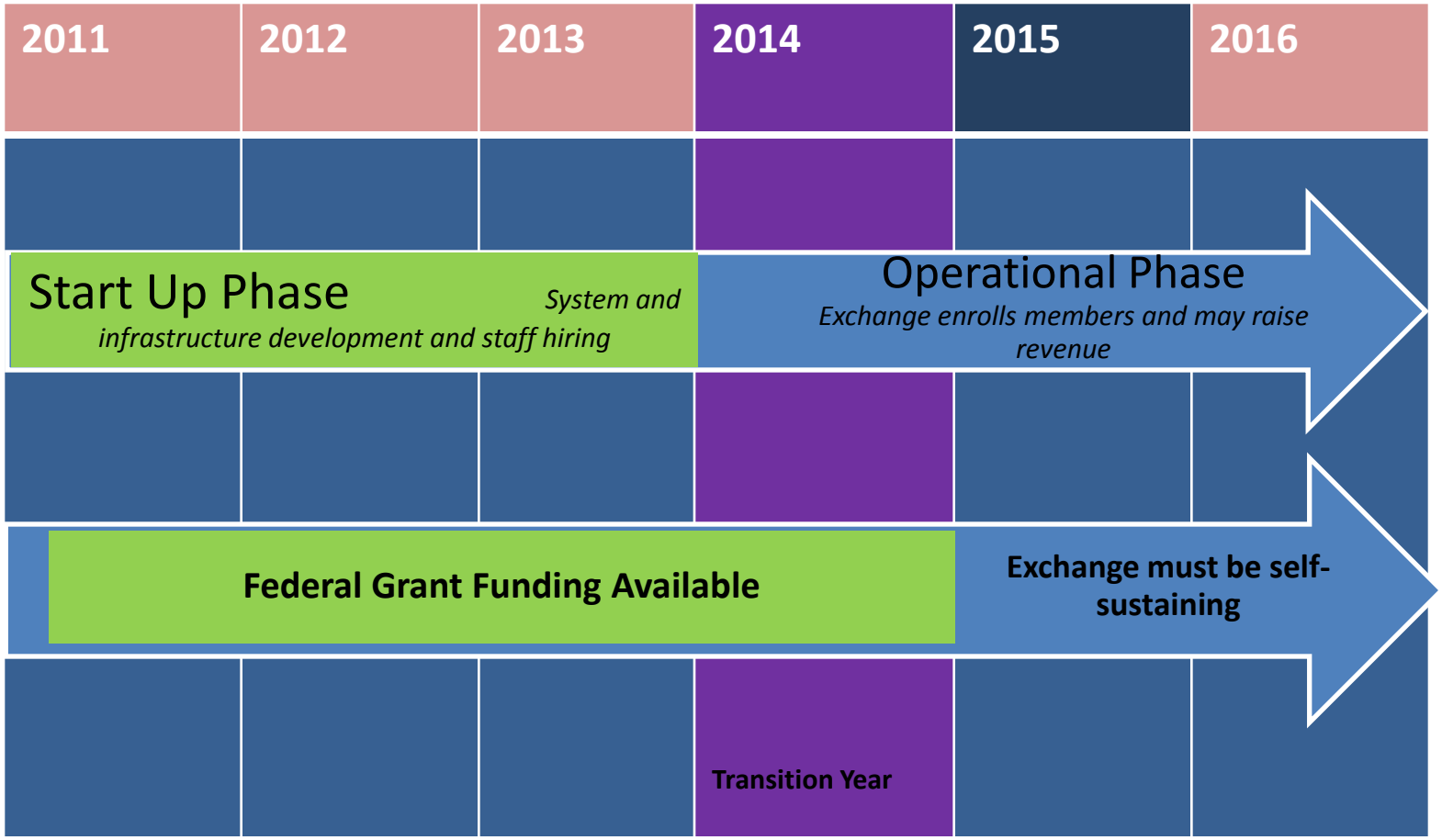
Exchange Financial Timeline



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Financing Options - User Fee

Assessment on products sold through the Exchange that is charged to enrollees. Essentially an add on to the premium.

Pros

- Works in all Governance structures
- Aligns costs to direct purchasers of insurance through the Exchange
- Transparent
- Scalable to enrollment
- Collection could occur at the Exchange via premiums

Cons

- Does not reflect all of the benefits an Exchange may provide to other consumers, insurers, providers and navigators/brokers

Cons

- May discourage participation in Exchange (dependant on cost level and transparency)
- Potentially invisible to consumer if rolled into premium and looks like added costs of product (Individual premiums inside the Exchange would be larger than outside)
- Tied to enrollment - Hard to predict first few years
- Per person costs vary with number of participants and the relation of fixed and variable costs
- If no mandate, participation may be reduced causing higher costs per person (further disincentive to participate)

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Financing Options - Portion of Premium

Exchange keeps some portion (percent and/or flat fee) of the total product premium.

PROS

- Works in all Governance Structures
- Would most closely relate exchange business operations and market relationships.
- Premiums same inside and outside Exchange, would not discourage individual participation
- Scalable to enrollment
- Collection could occur at the Exchange via premiums
- Medical Loss Ratio considerations (possible con)

Cons

- Acknowledges some but not all of the benefits an Exchange may provide to other consumers, insurers, providers and navigators/brokers
- May discourage carriers from participating in Exchange
- Tied to enrollment - Hard to predict first few years
- Per person costs vary with number of participants and the relation of fixed and variable costs
- If no mandate, participation may be reduced causing higher costs per person (further disincentive to participate)

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Financing Options: Fully Insured Market

Assessment on fully-insured products sold by insurers. Could be similar to the MCHA assessment or insurer premium tax. Could be a percentage of premium or flat fee per policy or enrollee.

PROS

- Acknowledges that some services benefit consumers that do not participate in the Exchange (risk adjustment, comparative information)
- Premiums inside and outside an Exchange the same and thus not discourage Exchange participation (individual or plan).
- Broader assessment, lower cost per person
- Predictable (known base, similar to current state revenues)
- Tied directly to estimated budget (not directly to enrollment)
- Reduced impact from Supreme Court decision on mandate
- Medical Loss Ratio considerations (possible con)

CONS

- Non-profit lack authority to assess non-participants
- Require appropriation
- Does not take into account consumers in self-funded plans and other stakeholders such as providers and navigators/brokers may also benefit from an Exchange
- Further reduces link between exchange business relationship and funding source
- Not transparent, cost shift
- Possibly creates competition between Exchange and other product distribution channels (brokers, plans, etc)
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.

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Financing Options: Broad Based Market Fee

An assessment like the provider tax or redirection of current health taxes and surcharges.

PROS

- Fully acknowledges Exchange may benefit a broad base of consumers and stakeholders.
- Reflects shift in marker as coverage expands (potential for increased revenue from current surcharges and taxes)
- Premiums the same inside and outside the Exchange
- Broad base – lower cost per person
- Predictable (known base - similar to current state surcharges and taxes)
- Tied directly to estimated budget (not directly to enrollment)
- Supreme court decision on mandate not impact revenue source.

CONS

- Non-profit lack authority to assess non-participants
- Require appropriation
- Further reduces link between exchange business relationship and funding source
- To extent a service is not covered within the Essential benefit set, service may still be included in assessment.
- Not transparent, cost shift
- Potential interaction with other processes (reinsurance, rate regulation, etc.) enhances uncertainties.
- Possibly creates competition between Exchange and other product distribution channels (brokers, plans, etc)
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.

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Financing Options: Sin tax/other broad tax

Use of a sin tax or other broad tax/fee that applies broadly to the population.

Pros

- Broad base – reduced costs per person
- Recognizes Exchange as a public good
- Spreads costs beyond health industry
- May have public health benefit
- Premiums not impacted
- Predictable – known base
- Tied directly to estimated budget (not directly to enrollment)
- Supreme court decision on mandate not impact.

Cons

- Non-profit lack authority to tax
- Further reduces link between exchange business relationship and funding source
- Amount increased for Exchange may not be large enough to impact behavior
- Require appropriation
- Raises taxes
- Not transparent, cost shift
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.

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Financing Options: General Fund

General fund: Appropriation to recapture of potential general fund savings

Pros

- Broad base – reduced costs per person
- Recognizes Exchange as a public good
- Spreads costs beyond health industry
- Premiums not impacted
- Appropriation is predictable
- Tied directly to estimated budget (not directly to enrollment)
- Supreme court decision on mandate not impact revenue source.

Cons

- Non-profit lack authority to tax
- Require appropriation
- Further reduces link between exchange business relationship and funding source
- Not transparent, cost shift
- Not tied to enrollment – fixed revenue may lead to under or over collections, not adjust for unexpected participation changes.
- Savings may be difficult to isolate and recapture

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Financing Options: Other

Raise revenue through other mechanisms such as naming rights, website advertising, grants, etc.

PROS

- Non-profit would be able to raise revenue
- Reduce or eliminate the need for fees and assessments on consumers and stakeholders.
- Exchange could directly collect revenues
- Supreme court decision on mandate not impact revenue source.

CONS

- Funding may not be predictable or stable.
- Questions on who could advertise, conflict of interest concerns.
- Exchange would need to compete and show value to attract funding.
- Could potentially harm the independent nature of an Exchange.
- Not tied to enrollment –not adjust for unexpected participation changes.

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Financing Options: Medicaid Match

Federal matching funds are available for activities necessary for Medicaid administration.

PROS

- Links costs of activities that benefit public programs to the public program (Outreach, eligibility determination, and managed care enrollment are generally accepted types of Medicaid administrative activities.)
- Reduces costs for other payers
- Premiums not impacted
- Predictable – tied to Medical Assistance enrollment
- Scalable to public assistance participation in the Exchange
- Cost allocation directly to Medical Assistance

CONS

- Non-federal share may include public funds appropriated or transferred to the Medicaid agency or certified by a local unit of government as a Medicaid expenditure. Private (non-profit) spending is not directly “matchable” by Medicaid.

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Financing Options: Combination

Combine existing revenues, cost allocation and new assessments

PROS

- Provide flexibility and stability for the exchange
- Recognizes business and public entity sides of the exchange.

CONS

- Increases complexity.

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Recommendation to Task Force

- 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.

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Benefits to Individuals

- 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

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Benefits to Individuals

- 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

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Benefits to Individuals

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

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Benefit to Carriers

- Insurers – direct benefit
  - 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

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Ancillary Benefits

- 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

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Workgroup "Unknowns" – January 2012 Presentation to Task Force

- **Unknowns**
  - Size of the ongoing operating budget for a Minnesota Health Insurance Exchange
  - Will federal funds be allowed to be used for navigators in 2014?
  - What public programs will be in Minnesota in 2014/2016 and what resources will be needed for them?
  - Decision on Exchange operations that impact finance options

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Wakely Budget Model

- Budget Model developed by Wakely Consulting Group
- Based on experience in Massachusetts
- Utilizes a PMPM benchmark based on 200,000 annual enrollees
- Assumes 55% fixed costs, 45% variable costs
- Model used for legislative fiscal note in March
- Model needs to be refined for Medicaid participation, Navigator/Broker compensation and to be determined operation plans

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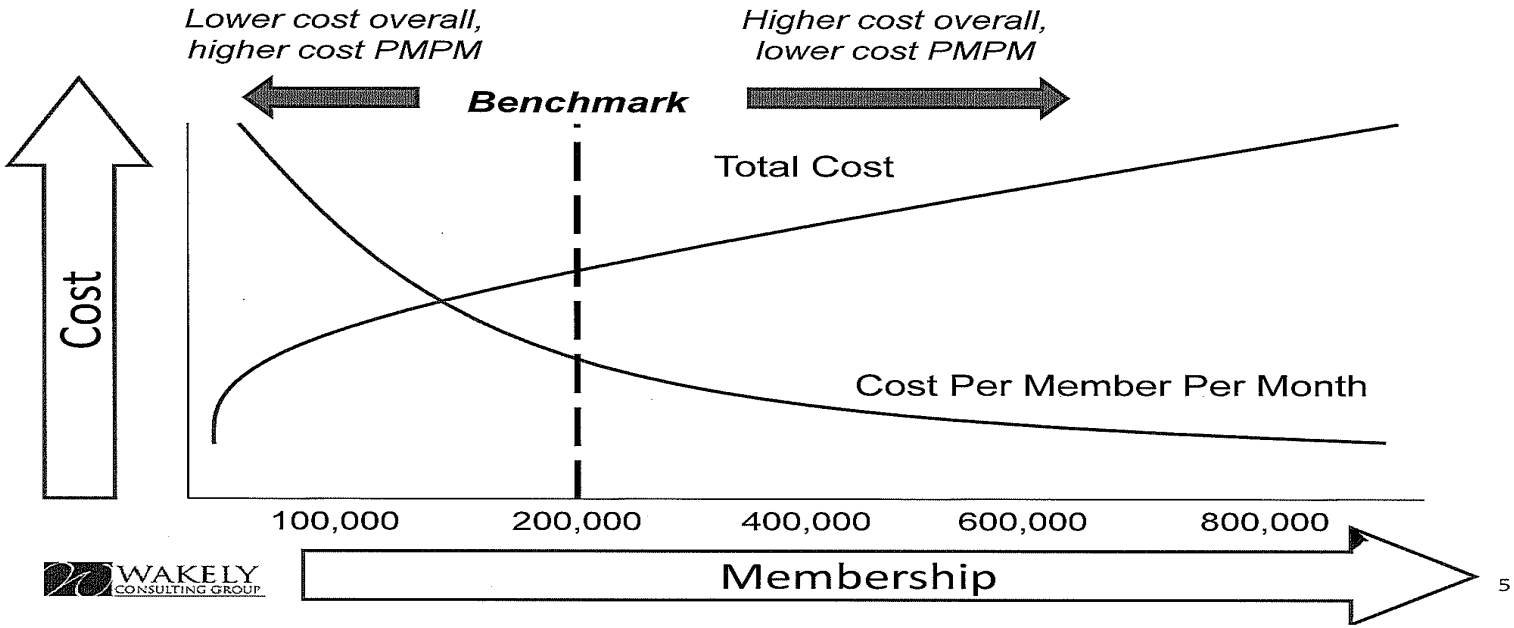
Funding Considerations

Benchmark Methodology (Cont.)

Exchange expenses are scalable based on enrollment and the relationship between fixed and variable costs.



WAKELY CONSULTING GROUP

MINNESOTA DEPARTMENT OF COMMERCE

Wakely Budget Model – Enrollment Projections

- Input - Projected Exchange Participation
  - 2016 participation estimates from Dr. Jonathon Gruber
  - Four scenarios with Medicaid MOE and BHP
  - Model run using Medicaid MOE at 275% and no BHP
  - See Table 1

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Wakely Budget Model – Enrollment Projections

- Assumption – Enrollment take up rate
  - By 2016 Exchange projected to have following take up rates (Table 1):
    - Individual – Subsidy Eligible – 100%
    - Individual – Non-Subsidy Eligible – 50%
    - Small Group – 35%
  - Assume low, medium and high penetration rate for CY 2014, 2015, 2016
  - See Table 2

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Wakely Budget Model – Enrollment Projections

- Output – Low, medium and high level calendar year enrollment estimates for 2014, 2015 and 2016 (Table 2)
  - Calculation of 2016 enrollment estimates times low, medium, high penetration rates for each calendar year.
  - Example, Individual – Subsidy Eligible
    - 280,000 *40% (CY 2014 low penetration rate estimate)= 112,000 participants in CY 2014.

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Wakely Budget Model – Member Month Projections

- Input – Fast, medium and slow take up rates for calendar year 2014 (Table 3)
- Assumption – Medium take up rate for calendar 2014 and 8.3% per month in calendar year 2015
- Output – Low, medium and high member months for calendar year 2014, 2015 and 2016 (Table 4)

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Wakely Budget Model – Premiums

- Individual Market
  - Input - 2016 estimated premiums for individual market from Dr. Jonathon Gruber and Bela Gorman ($5,687 average annual premium)
  - Assumptions – 5.5% reduction for each year for calendar year 2015 and 2014 (average increase from 2005 though 2009)
- Small Group
  - Input – 2009 average premiums
  - Assumptions – 5.1% annual inflation factor (average increase from 2005 through 2009)
- Output – Table 5

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Wakely Budget Model – Premiums

- Based on Model projected average individual and small group monthly premiums and Model projected member months (low, medium and high for each calendar year), a composite premium is calculated in the Model
- Model calculates total premiums based on composite premium times estimated member months
- Table 6 – Estimated revenue estimates based on premiums (similar to fiscal note calculations for budget projections).

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Wakely Budget Model – Annual Budget Estimates

- Input – benchmark PMPM costs for various cost categories including:
  - Eligibility and Enrollment
  - IT Website and Infrastructure
  - Customer Service (premium processing, call center, notices, appeals)
  - Outreach
  - Administration (Finance, HR, facilities, etc)
- Benchmark PMPM adjusted based on volume above or below 2.4 million member months

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Wakely Budget Model – Annual Budget Estimates

- Model Assumptions
  - 55% fixed costs and 45% variable
- Non- Model Assumption
  - Medicaid allocation from Model output to be about 15% (Model costs *50%*55%*55%)
    - 50% - estimated costs associated with Medicaid (non Medicaid costs = SHOP eligibility and enrollment, premium collection and aggregation, customer service operations depending on business operations between the Exchange and Medicaid)
    - 55% - fixed costs
    - 55% Medicaid participation
- Output
  - low, medium, high calendar 2014, 2015 and 2016 budget needs.
  - Calculation of percent of premium needed to meet estimated budget need
  - Table 7

Wakely Budget Model – Annual Budget Estimates

- Model provides budget range for first three budget years
- Need to refine and validate Model estimates including Navigator/Broker estimates
- Navigator/Broker workgroup evaluating compensation models
- Operational plans under development (call centers, appeals, premium processing, etc.)
- October/November timeframe for more refined projections

Wakely Budget Model – Other Revenue Calculations

- Input – annual estimated base for variety of current state health care revenues
- Output – Table 8

Next Steps

- Goal – detailed recommendation to task force on funding Exchange
- Workgroup discussion of tasks for next meeting (August 22).