MPR Reference No.: 6392

MATHEMATICA
Policy Research, Inc.

Final Report: Health Insurance Exchange Study

March 27, 2008

Deborah Chollet
Su Liu
Kate Stewart
Alison Wellington
Allison Barrett
Mathematica Policy Research

Mila Kofman
Health Policy Institute
Georgetown University

Amy M. Lischko
Tufts University School of Medicine

Submitted to:

Minnesota Department of Health
Health Economics Program
85 East 7th Place, Suite 200
P.O. Box 64975
St. Paul, MN 55164-0975
Telephone: (651) 201-3561

Project Officer: Julie Sonier
Director, Health Economics Program

Submitted by:

Mathematica Policy Research, Inc.
600 Maryland Ave. S.W., Suite 550
Washington, DC 20024-2512
Telephone: (202) 484-9220
Facsimile: (202) 863-1763

Project Director: Deborah Chollet

This page has been intentionally left blank for double-sided copying.

ACKNOWLEDGMENTS

We are indebted to a number of individuals whose participation and assistance in developing this report have been essential.

Thomas Bell and Cynthia Saiontz-Martinez at Social and Scientific Systems provided expert consultation, data management, and programming to develop the microsimulation database.

Julie Sonier, Director of the Health Economics Program of the Minnesota Department of Health and project officer, provided guidance throughout, especially related to Minnesota's policy environment and the evolution of legislative interest in the proposed reforms. Stefan Gildemeister, a Senior Research Economist in the Health Economics Program of the Minnesota Department of Health, provided expert assistance in use of the Program's version of the 2004 Minnesota Health Insurance Access Survey and responded to myriad technical questions over the course of the project. Paul Wilson, Director of Tax Research in the Minnesota Department of Revenue, responded to many questions regarding Minnesota's personal income tax and insurance premium tax, and provided careful review of our draft fiscal impact estimates. George Hoffman, Reports and Forecasts Director of Finance and Management Operations in the Human Services Department provided Medicaid and MinnesotaCare projections of enrollment and expenditures.

At Mathematica Policy Research, Mary Grider provided technical review of the microsimulation programming language. Lynn Quincy developed the estimates of Minnesotans' effective state and federal marginal tax rates that were incorporated into the microsimulation model. Jackie McGee produced the report documents.

Of course, any shortcomings of the report remain the responsibility of the authors.

This page has been intentionally left blank for double-sided copying.

CONTENTS

Chapter		Page
	EXECUTIVE SUMMARY	xiii
I	INTRODUCTION	1
II	CURRENT AND PROJECTED COVERAGE WITHOUT POLICY CHANGE	3
	A. PROJECTION METHODS	3
	B. PROJECTED COVERAGE	4
III	ESTIMATION OF PROPOSED MARKET REFORMS	9
	A. GUARANTEED ISSUE AND COMMUNITY RATING IN THE SMALL GROUP AND INDIVIDUAL MARKETS	9
	B. AN INDIVIDUAL MANDATE FOR COVERAGE	11
	C. MANDATORY EMPLOYER OFFER OF SECTION 125 PLANS	12
IV	CHANGES IN COVERAGE	15
	A. SOURCES OF COVERAGE	15
	B. CHANGE IN THE UNINSURED POPULATION	17
V	CHANGES IN COST	21
	A. CHANGES IN THE COST OF PRIVATE INSURANCE	21
	B. CHANGES IN PUBLIC PROGRAM COSTS AND FINANCING	27

CONTENTS *(continued)*

Chapter **Page**

VI NET FISCAL IMPACT 31

A. CALCULATION OF REVENUE IMPACTS 31

B. NET FISCAL IMPACT AND INCIDENCE 33

VII IMPLEMENTATION ISSUES FOR AN EXCHANGE 37

A. OVERVIEW OF CONNECTICUT AND MASSACHUSETTS MODELS 37

1. Connecticut 37
2. Massachusetts 38

B. BLENDING THE SMALL GROUP AND INDIVIDUAL MARKETS 40

1. Advantages 41
2. Challenges 41
3. Recommendations 43

C. MINNESOTACARE IN THE EXCHANGE 43

1. Advantages 43
2. Challenges 44
3. Recommendations 44

D. OPTIONS FOR THE ADMINISTRATIVE ENTITY 45

1. Private Market Entity 45
2. Quasi Public-Private Entity 46
3. Fully Governmental Entity 47
4. Recommendations 47

E. OTHER IMPLEMENTATION AND OPERATIONAL ISSUES 48

1. Number of Plans 48
2. Choice and Risk Management 48
3. Eligibility 49
4. Role for Brokers 50

F. OPERATING COSTS 50

1. Initial Capitalization 50
2. Operating Budget 50

CONTENTS *(continued)*

Chapter **Page**

VIII LEGAL ISSUES FOR MINNESOTA 53

A. ERISA..55

B. HIPAA...56

1. Background..56
2. Application of HIPAA..57
3. Implications for State Policymakers.....................................59

C. COBRA 61

1. Background..61
2. Application and implementation 61
3. Implications for State Policymakers.....................................63

D. INTERNAL REVENUE CODE AND SECTION 125 PLANS 65

1. Who Can Sponsor a Section 125 Plan? 65
2. Who Can Participate? 65
3. Basic Requirements 65
4. Failure to Qualify as a Section 125 Plan 66
5. Implications for State Policymakers.....................................67

APPENDIX A: PROJECTION AND MICROSIMULATION METHODS

APPENDIX B: DETAILED ESTIMATES OF THE PROJECTED POPULATION WITHOUT POLICY CHANGE, FY2009 AND FY2011

APPENDIX C: DETAILED ESTIMATES OF THE PROJECTED COVERAGE IMPACTS OF MARKET REFORMS, FY2009

APPENDIX D: ESTIMATED MONTHLY PREMIUMS FOR SINGLE AND FAMILY COVERAGE: MINNESOTANS UNDER AGE 65 IN THE CURRENT CASE AND POLICY SIMULATIONS, FY2009

APPENDIX E: ESTIMATED ANNUAL STATE AND FEDERAL EXPENDITURES FOR PUBLIC PROGRAMS IN THE CURRENT CASE AND POLICY SIMULATIONS, FY2009

APPENDIX F: CALCULATION OF STATE REVENUE EFFECTS

This page has been intentionally left blank for double-sided copying.

TABLES

Table **Page**

II.1 MINNESOTANS UNDER AGE 65 WITH COVERAGE FROM SELECTED SOURCES OR UNINSURED: NUMBER AND PERCENT CHANGE, CY2004 AND PROJECTED FY2009-2011 4

II.2 MINNESOTANS UNDER AGE 65 WITH EMPLOYER-SPONSORED COVERAGE BY SIZE OF FIRM: NUMBER AND PERCENT CHANGE, CY2004 AND PROJECTED FY2009-2011 6

II.3 MINNESOTANS UNDER AGE 65 WITH EMPLOYER-SPONSORED COVERAGE FAMILY INCOME AS A PERCENT OF POVERTY: NUMBER AND PERCENT CHANGE, CY2004 AND PROJECTED FY2009-2011 7

III.1 PROPOSED AFFORDABILITY GUIDELINES FOR AN INDIVIDUAL MANDATE 12

IV.1 ESTIMATED NUMBER OF MINNESOTANS UNDER AGE 65 BY SELECTED SOURCES OF COVERAGE AND PERCENT CHANGE FROM THE CURRENT CASE, FY2009 16

IV.2 ESTIMATED NUMBER AND PERCENT OF UNINSURED MINNESOTANS UNDER AGE 65 ELIGIBLE FOR PUBLIC COVERAGE, FY2009 19

IV.3 ESTIMATED PERCENT OF UNINSURED MINNESOTANS BY SELECTED PERSONAL CHARACTERISTICS, FY2009 20

V.1 ESTIMATED PERCENT OF MINNESOTANS IN GROUP AND INDIVIDUAL PRIVATE COVERAGE BY SELECTED PERSONAL CHARACTERISTICS, FY2009 22

V.2 ESTIMATED PREMIUMS IN GROUP AND INDIVIDUAL COVERAGE AND PERCENT CHANGE FROM THE CURRENT CASE, FY2009 23

V.3 ESTIMATED EMPLOYER CONTRIBUTIONS TO COVERAGE BY SIZE OF FIRM AND CHANGE FROM THE CURRENT CASE, FY2009 26

V.4 ESTIMATED STATE AND FEDERAL EXPENDITURES, AND ENROLLEE PREMIUM PAYMENTS FOR PUBLIC PROGRAMS: CURRENT CASE AND POLICY SIMULATIONS, FY2009 29

VI.1 ESTIMATED NET FISCAL IMPACT OF SELECTED REFORMS: REVENUE AND COST COMPONENTS, FY2009 34

TABLES (*continued*)

Table **Page**

VI.2 INCIDENCE OF THE ESTIMATED CHANGE IN INDIVIDUAL INCOME TAX RECEIPTS AND EXPENDITURES FOR THE MINNESOTA WORKING FAMILY CREDIT AND AFFORDABILITY SUBSIDIES, FY2009 36

VII.1 START-UP COSTS FOR COMMONWEALTH CONNECTOR AUTHORITY, FY2007 50

VII.2 ONGOING REVENUE AND EXPENSES FOR CONNECTOR 51

VIII.1 SUMMARY: APPLICATION OF FEDERAL HIPAA AND COBRA UNDER ERISA AND IRC 63

FIGURES

Figure **Page**

II.1 PERCENT OF MINNESOTANS UNDER AGE 65 WITH COVERAGE FROM SELECTED SOURCES OR UNINSURED, CY2004 AND PROJECTED FY2009-2011 5

IV.1 ESTIMATED PERCENT OF MINNESOTANS UNDER AGE 65 WHO ARE UNINSURED: CURRENT CASE AND POLICY SIMULATIONS, FY2009 17

V.1 ESTIMATED PERCENT OF INSURED MINNESOTANS UNDER AGE 65 WITH PREMIUM CONTRIBUTIONS THAT EXCEED 10 PERCENT OF FAMILY INCOME, FY2009 25

VI.1 VALUE OF THE FEDERAL EARNED INCOME TAX CREDIT AND THE MINNESOTA WORKING FAMILY TAX CREDIT FOR A MARRIED COUPLE WITH TWO CHILDREN 32

VI.2 PERSONAL INCOME TAX LIABILITY NET OF THE MINNESOTA WORKING FAMILY CREDIT FOR A MARRIED COUPLE WITH TWO CHILDREN 33

This page has been intentionally left blank for double-sided copying.

EXECUTIVE SUMMARY

In 2007, the Legislature of the State of Minnesota required the Department of Health to report on the possibility of establishing a Health Insurance Exchange. The Exchange would serve small groups and individuals, facilitating access to coverage, choice among insurance products, portability of coverage, and affordability. It would not negotiate health insurance premiums, nor would it act as a regulator independent of the state's current regulatory authority.

The Minnesota Department of Health contracted with Mathematica Policy Research to undertake a study of the coverage, cost, and fiscal impacts of a series of reforms that might occur coincident with the implementation of an Exchange serving small groups and individuals who buy coverage directly:

- Guaranteed issue and community rating of both small group and individual products, maintaining separate risk pooling of small-group and individual lives.
- An individual mandate, requiring all Minnesotans to obtain coverage.
- A requirement that all employers with 11 or more employees offer a Section 125 (or "cafeteria") plan, enabling workers to pay either contributions to group coverage or premiums for individual coverage with pre-tax dollars.

We estimated the impacts of these reforms alone and in combination, and also considered variants of an individual mandate—alternatively (1) exempting Minnesotans from the mandate if their contribution to premiums would exceed an affordability standard that would be established by the state; and (2) providing subsidies to Minnesotans, so that available coverage would be affordable, consistent with the affordability standard. In addition, we explored the range of implementation and legal issues that policy makers in Minnesota would need to address in order to develop an Exchange.

CURRENT AND PROJECTED COVERAGE WITHOUT POLICY CHANGE

To develop estimates of change associated with the proposed reforms, it was necessary first to develop an estimate of health insurance coverage in the current case—specifically, coverage in state fiscal year (FY) 2009 among Minnesotans under age 65 who are not currently enrolled in Medicare. Projected to FY 2009 and 2011, the number of Minnesotans with private coverage is expected to continue to erode. Most of the projected erosion of private coverage is associated with a net loss of employer-sponsored coverage. Compared to 2004, approximately 52,000 fewer Minnesotans are projected to have private coverage by FY 2009, 1.5 percent fewer than in 2004.

At least in part due to the erosion of private coverage, the number of Minnesotans under age 65 enrolled in public coverage—Medicaid, GAMC, or MinnesotaCare—is projected to increase 41 percent by FY2009 relative to 2004 enrollment—an additional 185,000 persons. Similarly,

the number of uninsured Minnesotans is projected to increase 30 percent (by 113,000 persons) relative to the number in 2004, with 486,000 persons uninsured by FY2009.

CHANGES IN COVERAGE UNDER THE PROPOSED REFORMS

As a consequence of each reform or combination of reforms, uninsured Minnesotans would obtain coverage. However, those who are currently insured may also change their source of coverage.

Community Rating in the Small-Group Market

Because this reform would produce rate increases for more workers and dependents than it produces rate decreases, some workers and dependents would drop small-group coverage. Most would move to individual coverage, where they are able to obtain a lower age-rated premium, although perhaps for less coverage than was available to them in their small group plan. A small proportion of workers who would face higher small group premiums would enroll in MinnesotaCare or become uninsured. The rate of uninsured Minnesotans under age 65 would decline slightly—from an estimated 10.6 percent in the current case, to 10.1 percent with small-group and individual guaranteed issue and community rating (Figure 1).

Individual Mandate

Even if those for whom coverage is deemed unaffordable were exempted, an individual mandate would reduce the number of uninsured Minnesotans dramatically—by an estimated 57 percent. The number of workers and dependents with employer-sponsored coverage would increase approximately 5 percent, and the number of Minnesotans with individual coverage would increase 12 percent—both under current market rules regarding issue and rating of coverage in these markets. Many Minnesotans now eligible for public coverage would enroll, increasing the number enrolled in public coverage by 15 percent. Fewer than 5 percent of Minnesotans under age 65 would remain uninsured.

With subsidies to support an individual mandate, the number of uninsured would drop much more—by 77 percent. Some workers with an offer of group coverage would enroll, increasing the estimated number of employer-covered workers and dependents by 7 percent, while the estimated number of Minnesotans with individual coverage would rise nearly 20 percent. With further subsidies available to those eligible for MinnesotaCare, the number of Minnesotans with public coverage would increase 16 percent. Just 2.5 percent of Minnesotans under age 65 would remain uninsured.

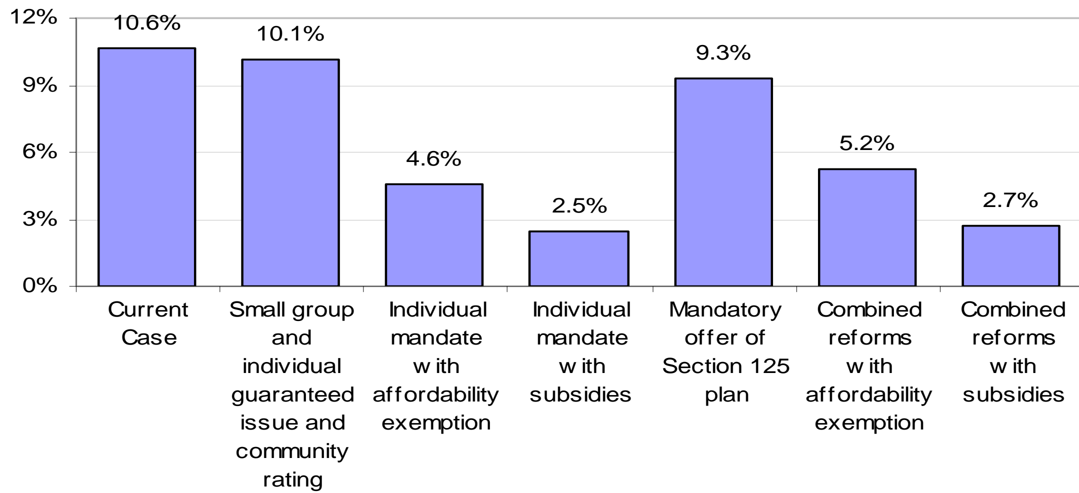
Mandatory Offer of a Section 125 Plan

While the availability of a Section 125 plan to all workers in firms with 11 or more employees also would increase coverage, coverage would remain voluntary and after-tax premiums would remain high for some workers. With a Section 125 plan more widely available to workers, group coverage would increase slightly (1 percent) and individual coverage would

rise by about 6 percent. The percentage of Minnesotans who remain uninsured would decline to 9.3 percent of the population under age 65.

FIGURE 1

ESTIMATED PERCENT OF MINNESOTANS UNDER AGE 65 WHO ARE UNINSURED: CURRENT CASE AND SIMULATIONS, FY2009



Source: Mathematica Policy Research.

Combined Reforms

The coverage results of the combined reforms are largely driven by the individual mandate. With an affordability exemption, the number of Minnesotans with group coverage would increase 3 percent net of coverage losses, reflecting the large number of workers who would experience rate increases with community rating. The number with individual coverage and those enrolled in public programs also would increase (each by about 17 percent), but the net gain in coverage overall would be somewhat less than with the mandate alone. With subsidies, the gain in group coverage would be slightly greater (5 percent), as would the gain in public coverage (19 percent). The gain in individual coverage would be much greater (33 percent)—but again, the overall net gain in coverage would not be greater than with the mandate and subsidies alone.

CHANGES IN PRIVATE INSURANCE COST

Because the proposed reforms would change the composition of the insured population in each insurance market, the average cost experience in each market also would change. The demographic and health-status composition of the estimated population with private group insurance (including small-group and large-group) would change relatively little with any of the reforms—although with subsidies, a larger proportion would be low-income. In contrast, the composition of the population enrolled in individual coverage would change, although modestly. Specifically, the individual market would cover relatively more adults, and Minnesotans in good,

fair, or poor health would constitute a larger share of the market. Both changes would affect the expected cost of individual coverage in a reformed market.

- Community rating in the small group and individual markets would increase average premiums, as Minnesotans with health problems obtain coverage in greater numbers. This increase is especially noticeable for single coverage—where adults predominate. Average premiums for single coverage in small groups would increase 9 percent, and average individual premiums for single coverage would increase 14 percent.

- An individual mandate would reduce average premium levels in the small-group market, especially for single coverage, as larger numbers of young workers took coverage. With an affordability exemption from the individual mandate, average premiums for single coverage in small groups would decline as much as 7 percent. With subsidies to support an individual mandate, premiums for single coverage in small groups would decline approximately 10 percent. In the individual market, the availability of subsidies would bring sufficient numbers of younger and healthier Minnesotans into the market such that premiums ultimately might change very little: we estimate an increase of just 1 percent for single coverage and a reduction of 3 percent for family coverage.

- Mandatory employer offer of section 125 plans would have the greatest effect on large-group premiums, as workers newly offered section 125 plans begin to take it up. Estimated average premiums would decline 12 to 13 percent for single or family coverage in large groups, but would have no appreciable effect on premiums in small groups. Changes in the population covered in the individual market would drive a reduction of 5 to 6 percent in individual premiums for single or family coverage.

- The combined reforms generally would result in lower average group premiums than either the current case or each reform alone. However, this is not the case with respect to individual coverage. Of all the reforms, mandatory offer of a Section 125 plan would drive the lowest average level of premiums in the individual market for single coverage—although, with coverage remaining voluntary, it would still not produce the highest level of coverage. The combined reforms with subsidies would drive the lowest average level of individual premiums for family coverage, reducing premiums for family coverage by 9 percent compared with the current case.

Under each of the reforms, employers' costs for coverage could change because the number of workers who take coverage would increase, average premiums would change, or both. Such changes are estimated to occur in both large and small firms:

- With the combined reforms and subsidies, the number of covered workers in large groups would increase 6 percent, while average employer contributions per worker would increase 11 percent for single premiums. Total large-employer contributions to coverage would increase an estimated 5 percent.

- The change for small employers under each reform would be substantially greater than for large employers. The greatest increase would result not from the combined

reforms, but from the individual mandate alone when coupled with subsidies. With an individual mandate and subsidies, enrollment in small-group coverage would increase 22 percent, and small-employer contributions to coverage would increase 23 percent. The magnitude of such changes suggests that policymakers should pay some attention to risk management in the small group market if reforms are implemented.

CHANGES IN PUBLIC PROGRAM COSTS AND FINANCING

Estimated increases in expenditures for public programs associated with each of the reforms would be paid in part from state funds, but also from federal funds—and to a small extent, from enrollee premiums. The estimated increase in state expenditures for public programs associated with the reforms ranges from less than 1 percent (for guaranteed issue and community rating of individual and small-group coverage) to approximately 28 percent (for the combined reforms with a subsidy). Only the offer of a mandatory Section 125 plan would entail no increase in state expenditure (although it would entail fiscal impacts as described in the next chapter).

The state would pay approximately 55 percent of the public-program costs associated with each of the reforms. Reflecting the small expected change in public program enrollment associated with guaranteed issue and community rating of individual and small group coverage, public program financing would change little, and would be distributed among the state, federal government, and enrollees in very nearly the same way as in the current case. With an individual mandate and subsidies, the magnitude of the subsidy payments are not so great as to change the distribution of payers significantly. When the reforms are combined and paired with subsidies, the state would pay 57 percent of the cost—an estimated $3.5 billion; federal matching payments would total $2.6 billion.

NET FISCAL IMPACT

The fiscal impacts of market reforms include the impacts on both state expenditures and revenues. For each of the reforms, state revenues could change as a result of changes in individual income tax receipts, changes in receipts from Minnesota's excise tax on health insurance premiums, or both. The net fiscal impact is calculated as the sum of the change in state revenue minus the change in state expenditures.

Each of the proposed reforms would affect the state's revenue and expenditure outlook. The lowest net fiscal impact would be associated with guaranteed issue and community rating in the small group and individual markets. While this reform would generate increased state revenues from premium taxes, state expenditures for Medicaid and MinnesotaCare would increase as some workers and dependents eligible for public coverage would be motivated to enroll when confronted with a premium increase for private coverage. On net, the estimated fiscal impact would be negative, approximately -$2.2 million.

Each of the other reforms, either alone or in combination, would have a much greater net fiscal impact, ranging from an estimated reduction of $84 million (with mandatory offer of Section 125) to an estimated reduction of approximately $853 million (with the combined reforms and subsidies). The fiscal impact of a Section 125 requirement would be due nearly

entirely to a loss of state income tax revenue—in large part among Minnesotans who are now insured but paying contributions to coverage post-tax.

Not surprisingly, a mandate with subsidies is estimated to have a larger net fiscal impact than a mandate with affordability exemption. The estimated net fiscal impact of a mandate with exemptions (-$520 million) would be 24 percent less than that of a mandate with subsidies (-$683 million). The percentage difference between net fiscal impact of the combined reforms with exemptions (-$661 million) and the combined reforms with subsidies (-$853 million) is similar, but of course the magnitude of the difference is greater. However, calculation of the net fiscal impact per person estimated to gain coverage suggests that consideration of subsidies may in fact be the more cost-effective option. Among those who would gain coverage (net of any coverage loss), the per-person net fiscal impact of a mandate with subsidies (alone) is about 3 percent less than that of a mandate with an affordability exemption. In combination with other reforms, per-person net fiscal impact of a mandate with subsidies is 14 percent less than that of a mandate with an affordability exemption.

IMPLEMENTATION ISSUES FOR AN EXCHANGE

Exchanges have been conceptualized and developed as platforms to improve access for small employers and individuals who do not have access to coverage that are portable, choice-based, tax-advantaged, and easy to access. Exchanges can be attractive alternatives for small employers, part-time employees that work for large employers, temporary and seasonal employees, and people purchasing in the non-group market.

At present, there are two statewide Exchanges in operation:

- The Connecticut Business and Industry Association Health Connections is a private-sector purchasing mechanism. Operated as a division of the Connecticut Business and Industry Association (CBIA) for more than 12 years, Health Connections was one of the first statewide, multi-vendor health insurance purchasing alliances in the country. It serves employers with three to 100 employees and provides choice among plans offered by four participating health insurance companies. Currently, more than 6,000 businesses with 88,000 covered lives participate.
- The Commonwealth Health Insurance Connector Authority (the Connector) was established in 2006 as an important part of system-wide reform in Massachusetts. The Connector is an independent, quasi-governmental entity designed to help eligible individuals and small groups purchase health insurance at affordable prices. The Connector began offering subsidized products in October 2006 and private products in April 2007. The Connector certified for sale seven plans offered by six carriers, signaling to consumers that the approved plans were both comprehensive and affordable.

Both Exchanges offer potentially useful lessons for Minnesota.

Blending the Small Group and Individual Markets

With the exception of self-insured (also called self-funded) employers, an Exchange ideally would provide access to affordable choice-based coverage for all residents of a state—either through a small employer or on a direct-pay basis. CBIA does not provide access to very small firms or individuals, but there is nothing to preclude CBIA doing so, although it would need to consider the differences between Connecticut's rating rules in the small group and individual markets. In Massachusetts, the small group and individual markets were merged as part of the reform plan. It followed that the Connector would sell the same products to both small groups and individuals. Both decisions were made somewhat easier by the fact that rating factors in both markets were almost identical.

There are at least two major advantages to providing access to both small group and individual coverage through an Exchange. First, an Exchange must enroll a significant number of covered lives to be a financially viable organization, and greater enrollment is achieved more easily if the Exchange provides services to both individuals and small employers. Second, having the exchange available to both small group and individual purchasers helps workers to move between employment and self-employment more easily—a strong advantage in a dynamic economy.

However, states face a number of challenges in implementing an Exchange:

- Brokers, if not also carriers, may resist the idea of an Exchange, especially if the Exchange is designed to provide an alternative system for selling coverage to small employers. Experience in both Connecticut and Massachusetts (and in other states where similar purchasing pools have failed) has shown that states need to work with brokers and carriers to successfully implement an Exchange. The Exchanges in both Connecticut and Massachusetts have financial arrangements with brokers.
- If the Exchange were the exclusive source of individual coverage, the state might be forced to include all carriers and products that are currently available in the non-group market—not only those that the Exchange would endorse as "good value." However, if individuals were required to purchase through an Exchange that limits product choices, they might perceive it as limiting choice. The Exchanges in both Connecticut and Massachusetts limit the number and types of products they offer, and in both states individuals and employers can purchase a non-Exchange product in the regular market.
- In Minnesota, the rating rules are different in the non-group and small group markets. While it is easier to blend markets when the rating rules are the same for individuals and businesses—and there are a number of reasons that Minnesota might wish to have the same rules to support an Exchange, identical rating rules are not essential.

Recommendations: If the desire is to sell to both individuals and small groups through the Exchange, then Minnesota should begin by allowing individuals and small groups to purchase from the Exchange, but not requiring either to do so. The Exchange would offer affordable options and choice of plans to employers who want to contribute towards their employees' health

insurance, and it would be easier for employers to move from a noncontributory status to a contributory status without affecting their employees' enrollment in a health plan. Conversely, if only individuals purchase through the Exchange, it is unclear how it would be very different from the current non-group market.

MinnesotaCare in the Exchange

Policymakers in Minnesota would like to facilitate pre-tax payment of premiums for MinnesotaCare beneficiaries. To do this, the beneficiary would need to work for an employer who sponsors a Section 125 plan; he or she could not be self-employed. The employer would deduct dollars from eligible employees' paychecks and send them to the single state agency. There is no need for this to be run through the Exchange; it could be implemented today.

The biggest operational challenge to pre-tax payment of MinnesotaCare premiums would be the administrative complexity for firms that employ beneficiaries. Individuals are eligible for MinnesotaCare only if they do not have access to employer-sponsored health insurance for which the employer pays at least half of the premium. Consequently, most MinnesotaCare enrollees, if working, either are not offered employer-based coverage or they are not eligible for the coverage when offered.

Employers that do not sponsor coverage can nevertheless set up a Section 125 plan for their employees, whether full-time or part-time. When a MinnesotaCare beneficiary works in a firm that offers coverage, but belongs to an employment class (for example, part-time workers) that is ineligible, the employer could set up a Section 125 plan for this class of employees. However, setting up either a new Section 125 plan or a Section 125 plan for a currently ineligible class of employees could be perceived as additional administrative burden, and the state would most likely need to mandate that employers do so. The initiative would make more sense if it were coupled with a requirement that employers offer Section 125 plans to all employees—not only MinnesotaCare beneficiaries—for the purpose of pre-tax payment of premiums.

Minnesota authorities would need to set up a means to accept premium payments from employers. An Exchange would not make these administrative tasks easier: either a state agency or an Exchange would need to build the same functionality. However, an Exchange could accept pre-tax payments for all employees (MinnesotaCare and non-MinnesotaCare), easing the burden especially on employers that offer noncontributory Section 125 plans and coordinating with the single state agency for eligibility processing.

Recommendations: To include MinnesotaCare enrollees in the Exchange, it would be important for Minnesota policymakers to move forward with a plan to require employers of a certain size to offer Section 125 plans to their employees. Since relatively few Minnesota employers currently offer Section 125 plans, it might be advisable to phase-in such a requirement. Minnesota would need to legislate a requirement that employers also make available their Section 125 plan for payment of MinnesotaCare premiums by beneficiaries who are not enrolled in the employers' group health plan.

Options for the Administrative Entity

The Exchange will need the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, confirming eligibility, billing premiums, monitoring employer contribution, reconciling payments, developing and maintaining a website, payment of commissions, broker training, ongoing marketing and outreach, and electronic interface. The Exchange may either make or buy these capacities, or it may partner with state agencies. These decisions will depend in large part on the administrative option that Minnesota chooses, available funding and the timetable for implementation.

There are potentially three administrative options for Minnesota to consider:

- **A private market entity**, such as that in Connecticut. Small businesses would likely trust an entity that already works with them. It could offer additional insurance options such as life, disability, worker's compensation insurance, and dental insurance. In addition, it could offer administrative assistance in meeting requirements related to Section 125, COBRA, and IRS provisions related to health savings accounts (HSAs) or health reimbursement accounts (HRAs). In short, it could provide one-stop shopping for small business human resources functionality, similar to CBIA. However, the State have very little, if any, say in how decisions were made regarding eligibility, what products would be offered, and how much choice would be allowed. If the priorities of a private-sector organization do not align well with those of policymakers, it is more difficult to integrate roles that are viewed as state responsibilities, such as including MinnesotaCare in the Exchange. For the same reason, a private-sector model might not be ideal if Minnesota envisions a subsidy program at some later date, although it would not be prohibitive.

- **A quasi public-private entity**, such as in Massachusetts—although arguably the Massachusetts model became more public than private in the course of its development. A quasi public-private structure could provide the balance between decision-making and responsibility that Minnesota would like to have: It might be perceived as sufficiently outside the state system to be more agile and business-friendly, and it could maintain some independence while still attending to the State's priorities. However, a quasi public-private structure would require an infusion of funding for start-up, and the state could be responsible should the entity become unsustainable going forward. Moreover, no single agency can be fully responsible for both meeting the business needs of the Exchange and pursuing the policy goals of the state.

- **A fully governmental entity**. In Minnesota, this may be an appealing approach, in part because of the knowledge and administrative capacity around managing health insurance purchases for state employees. The start-up costs of an Exchange would be lower if it was built upon an existing infrastructure, and (in the Department of Employee Relations, DOER) some capacity to operate an Exchange already exists. In addition, the state could take credit for the initiative and easily build other reforms onto it. However, if DOER operated the Exchange, there could be pressure to blend the Exchange and state employee risk pools. The Exchange is not a purchasing pool *per se*, but unless all small employers purchased through the Exchange, bifurcating

the market in this way could cause problems. Furthermore, the DOER has no experience working with the small business community that would either indicate a natural fit or support trust. Finally, some of the skills required to set up a "business" may not exist within state government, and adequately managing a contract to obtain such skills might not be possible.

Recommendations: Minnesota's history of state involvement with health care reform efforts is not dissimilar from Massachusetts. Massachusetts struggled with the decision of governance and ultimately decided on a quasi private-public structure. Minnesota, too, might find a quasi private-public structure for the Exchange to be the best fit. However, Minnesota policymakers will need to determine how much policy-making responsibility should reside in the Exchange. Policy decisions regarding eligibility or product design could be laid out in legislation or assigned to a governmental agency such as the Department of Health to decide. In addition, it will be important for Minnesota to consider what expertise and input the Exchange needs to make the decisions assigned to it, and develop a selection process for Board members and staff to meet those needs.

Other Implementation and Operational Issues

The operation of an Exchange will entail a number of first-order decisions, including the number of plans that will be available through the Exchange, how to manage risk and risk selection among plans, eligibility to purchase through the Exchange, and the role of agents and brokers.

- **Number of plans.** Both Connecticut and Massachusetts restrict the number of plans participating in their respective Exchanges. To promote competition and reduce confusion in the marketplace, it makes sense to limit available plans to those with meaningful differences in cost sharing, network design and/or formularies. Minnesota policymakers also will need to determine whether, and the extent to which, Exchange products will be standardized. To a certain extent, both Connecticut and Massachusetts have standardized plans their Exchanges in order to balance the objective of providing choice with the challenge of managing risk selection.
- **Choice and risk management.** Neither Connecticut nor Massachusetts allow carriers to pool individuals and small groups inside the Exchange separately from those outside the Exchange: the rating rules for products sold in the Exchange are the same as for those outside, and products sold both in the Exchange and outside pool risk across both markets. To mitigate risk selection, having the same rating rules and mandatory benefits for products both inside and outside the Exchange is essential. Establishing new rules for products offered through the Exchange—for example, allowing products offered through the Exchange to exclude mandatory benefits—will ultimately lead to fragmentation of the small group market and create selection issues. If coverage through the Exchange is voluntary, it may help to have some standardization of plans to avoid risk selection within the Exchange, and potentially also a mandatory reinsurance risk pool or system of risk adjustment. Finally, limiting small-group employee choice to selection within a suite of plans (as in both

Connecticut and Massachusetts) would help to ensure that younger, healthier lives do not enroll predominantly in high-deductible plans (leaving sicker, higher-risk enrollees predominantly in more comprehensive plans)—although it does not provide for as much choice as some policymakers desire.

- **Eligibility.** Minnesota policymakers will need to decide whether certain types of employers or individuals may be required to purchase through the Exchange or, conversely, whether some are ineligible to do so. Recognizing that the Exchange must achieve a sustainable size, the eligibility criteria should correspond to the problems Minnesota is trying to solve and the populations it is attempting to reach. Decisions about risk selection and crowd-out should depend on the objectives of reform.

- **Role for brokers.** Brokers may view an Exchange as competition for the services they provide to businesses. However, in many cases, it is hard to identify what businesses pay for these services. In most states, a broker fee is built into the small group premium rate that small employers pay, whether or not a broker is used. While an Exchange probably would require a similar fee for administrative services, it would deliver greater value—offering small-group employers a choice of plans for employees, the ability to budget their contributions, assistance with Section 125 plan administration, and other services. The Exchanges in Connecticut and Massachusetts pay brokers a commission for bringing them business but keep most of the fee for administration of the account. Thus, the broker transaction and fee are fully transparent. Over time, brokers' fees could be separated from the rate, with the market determining the cost of their services.

LEGAL ISSUES FOR MINNESOTA

While states are the principal regulators of health insurance coverage, a number of federal laws and standards apply. Unless reforms are carefully structured, state efforts may be challenged as being preempted and/or have unintended federal tax consequences for employers and workers, or both.

Some major federal laws to consider in crafting private market reforms include the Employee Retirement Income Security Act of 1974 (ERISA); the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related health amendments to ERISA, the Internal Revenue Code (Code), and the Public Health Service Act (PHSA); the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amendments to ERISA and the Code; and the Code (Section 125 Plans and the tax consequences). Generally, these federal laws establish certain minimum standards for health coverage and employee benefits through a job. Some standards apply even when state insurance laws regulate coverage. In addition to minimum standards, one federal law—ERISA—limits the scope of state-based health coverage reforms. If not properly addressed, ERISA and HIPAA amendments to ERISA, especially, may give rise to preemption challenges to state reforms.

To avoid a preemption challenge under HIPAA, policymakers should ensure that state insurance laws are at least as protective of consumers as those under HIPAA for job-based and individual coverage. For employers, HIPAA's requirements are triggered when there is a group

health plan. Generally, employer contributions result in a group health plan, even when there are separate individual contracts issued to workers. Even in the absence of employer contributions there may be a group health plan if the employer has more than mere minimal involvement. The courts (in the course of a lawsuit, the U.S. Department of Labor (DOL) or the IRS) can review the facts and make a finding that there is a group health plan. Additionally, insurers selling coverage must comply with applicable requirements (enforced by the state's insurance regulators).

Potential vulnerabilities to preemption include standards for: (1) non-discrimination in access and rates; (2) portability including preexisting condition exclusions; (3) special enrollment rights; and (4) other state standards applicable to individual health insurance policies that would be considered "group health plan" coverage under federal law. In Minnesota, HIPAA non-discrimination standards seem most likely to be triggered. For example, HIPAA prohibits keeping an employee out of the plan because of a health condition and prohibits charging sicker employees higher premiums. Currently in Minnesota's individual market (like in many other states), insurers can deny coverage to sick people and, when coverage is issued, charge premiums based on health factors. Absent modifications to Minnesota's individual market standards, new reforms may be challenged as preempted by HIPAA if an employer contributes to individual health insurance that is underwritten for either access or rates. Although Minnesota's individual market standards for preexisting conditions appear consistent with HIPAA's requirements for group health plans, to ensure consistency with other standards applicable to group health plans (for example, special enrollment rights), further modifications to individual health insurance products would be needed. Without standards that are at least as protective of consumers as HIPAA, the state would be exposed to a potential preemption challenge.

In addition, Minnesota policymakers should seek ways to minimize the risk that the IRS would find employers in violation of the HIPAA or COBRA provisions in the Code. Because the Code defines a "group health plan" more broadly than ERISA, it is possible to have a group health plan under the Code but not under ERISA. For instance, when an employer offers a Section 125 Plan, an employer's obligations under COBRA may be triggered depending on the size of the employer. Absent a Section 125 Plan, such violations may occur when an employer's contribution to individual coverage or other involvement results in a group health plan, triggering HIPAA and COBRA obligations. An employer that violates the Code could face significant financial penalties. One way to minimize the risk of unintentional violations would be to assume that HIPAA and COBRA obligations would exist, and to modify state law to reflect HIPAA and COBRA standards.

Finally, policymakers should consider federal tax implications relating to the use of pre-tax dollars to pay for health insurance premiums. When Section 125 Plans are incorporated into state-based health care reforms as a way to make health insurance premiums less expensive by funding premiums with pre-tax dollars, efforts should be made to minimize the risk of non-compliance with the Code. For example, considering the complex technical requirements and the resource constraints for some businesses (especially small businesses), state policymakers might consider providing model plan documents. In addition, policymakers might consider ways to help ensure that employers actually adhere to plan documents in administering the Section 125 Plan.

I. INTRODUCTION

In 2007, the Legislature of the State of Minnesota required the Department of Health to report on the possibility of establishing a Health Insurance Exchange. The purpose of an Exchange would be to improve individuals' access to coverage, choice among insurance products, portability of coverage, and affordability. Similar to the Connector, which Massachusetts implemented last year, Minnesota's Exchange would serve small groups and individuals, facilitating access to coverage for both. It would not negotiate health insurance premiums, nor would it act as a regulator independent of the state's current regulatory authority.

The Minnesota Department of Health contracted with Mathematica Policy Research to undertake a study of the impacts of such an Exchange. Specifically, we were asked to look at the coverage, cost, and fiscal impacts of a series of reforms that might occur coincident with the implementation of an Exchange serving small groups and individuals who buy coverage directly. These reforms included:

- Guaranteed issue and community rating of both small group and individual products, maintaining separate risk pooling of small-group and individual lives.
- An individual mandate, requiring all Minnesotans to obtain coverage.
- A requirement that all employers with 11 or more employees offer a Section 125 (or "cafeteria") plan, enabling workers to pay either contributions to group coverage or premiums for individual coverage with pre-tax dollars.

We were asked to estimate the impacts of these reforms alone and in combination, and also to consider variants of an individual mandate—alternatively (1) exempting Minnesotans from the mandate if their contribution to premiums would exceed an affordability standard that would be established by the state; and (2) providing subsidies to Minnesotans, so that available coverage would be affordable, consistent with the affordability standard. In addition, we were asked to explore and present the range of implementation and legal issues that policy makers in Minnesota would need to address in order to develop an Exchange.

At least two caveats with respect to the estimates presented in this report are in order. There is not yet significant experience with an Exchange in any state on which to gauge how differently employers, consumers, and carriers might behave in such a new market environment. Our estimates of the coverage, cost, and fiscal impacts of the various reforms are based on analysis of Minnesota household survey data, which reflect employer and consumer behavior in the current market. If an Exchange made individual coverage much more accessible than in the current market, reduced the administrative cost implicit in premiums, or made it easier for small employers to offer group coverage, more Minnesotans might obtain coverage than is estimated. In this case, the remaining number of uninsured—while estimated to be low as a result of the reforms—might be still lower.

In addition, we assume that the Exchange would either incorporate the entire small group and individual markets, or it would be implemented with safeguards (as in Massachusetts) to prevent adverse selection in the Exchange relative to the outside market. If the Exchange were designed in a way that allowed for adverse selection, the coverage impacts probably would be different than is estimated.

This report is organized as follows. In Chapter II, the insurance market reforms that were modeled are described and key assumptions that underlie the estimates are presented. In Chapter III, coverage estimates in the current case (that is, without reforms) are presented, projected to fiscal year (FY) 2009 and 2011. The impacts of each reform are estimated against the projected current case—in effect, comparing alternative visions of the future with and without change. In Chapter IV, estimates of the coverage impacts of market reforms are presented. The number and characteristics of the remaining uninsured (specifically, age and health status) are described, as are the characteristics of Minnesotans who would, in each simulation, populate the group and individual health insurance markets in Minnesota.

In Chapter V, estimated costs for each of the reforms are presented—including the amount of premiums paid by consumers relative to income, costs to employers associated with greater take-up of group coverage, and costs to the state associated with greater enrollment in public programs. In Chapter VI, estimates of net fiscal impact are reported, including changes in state revenues from individual income and premium taxes, and changes in state outlays to fund current public programs and future subsidies to support an individual mandate.

In Chapter VII, implementation issues for an Exchange are discussed with specific reference to the implementation features of two existing and alternative Exchange models, in Connecticut and Massachusetts, respectively. Finally, in Chapter VIII, legal issues for an Exchange are explored. This chapter focuses on the federal laws that govern employee benefit plans, and safeguards to avoid unintended consequences for employers, employees, and the State.

II. CURRENT AND PROJECTED COVERAGE WITHOUT POLICY CHANGE

To develop estimates of change associated with the proposed reforms, it was necessary first to develop an estimate of health insurance coverage in the current case—specifically, coverage in 2009 among Minnesotans under age 65 who are not currently enrolled in Medicare. Reflecting the focus of the reforms (as well as available survey data), persons who reside in institutions (such as military barracks, long-term care facilities or prisons) are excluded.

To develop the current case, available data reflecting coverage among Minnesotans in 2004 were projected to state fiscal years (FY) 2009 and 2011, based on apparent trends in survey data fielded since 2004. Concurrent with this effort, the 2007 Minnesota Health Access Survey (MNHA) was fielded, and preliminary results of that survey are now available. In contrast to apparent trends in earlier data, preliminary estimates from the 2007 MNHA show no statistically significant increase in the uninsured since 2004.[1]

However, our estimates project an additional 2.5 to 4.5 years, to FY2009 and FY2011 respectively. They are based on trends in coverage by firm size, demographic trends, and assumed proportionate growth in employment by firm size (all projected from calendar year 2004). We project further erosion of employer-based coverage by FY2009, continuing into FY2011, with a substantial increase in both the number and percentage of Minnesotans who are uninsured.

A. PROJECTION METHODS

Current coverage is projected from the 2004 MNHA. To "age" the this survey to FY2009 and FY2011, respectively, the MNHA target weights were adjusted to match a series of benchmarks developed from the Minnesota samples of the American Community Survey (ACS) and the Current Population Survey (CPS), as well as population projections from the Minnesota State Demographic Center and public program projections from the Reports and Forecasts Division of Minnesota Department of Human Services.

At the end of the data aging process, the projected current-case estimates of coverage for FY2009 and FY2011 reflect Minnesota-specific projections among the non-institutionalized population under age 65 in terms of:

[1] Preliminary results from the 2007 Minnesota Health Access Survey indicate that coverage in Minnesota was generally stable from 2004 to 2007, at least in part due to relatively fast growth in large-firm employment and, consequently, relative stability in the rate of employer-sponsored coverage (Julie Sonier, personal communication, February 28, 2008). Calculated as a percent of the total state population (including persons over age 65, in contrast to our estimates), 62.5 percent of Minnesotans had group coverage or coverage through an employer, an estimated rate that is statistically unchanged from 2004, when 62.6 percent of Minnesotans were estimated to have group coverage (http://health.state.mn.us/divs/hpsc/hep/publications/ coverage/inscovprelim2007.pdf, accessed February 28, 2008).

- The demographic distribution of the population by age, race/ethnicity and urban/rural location;

- The percentage in poverty by race and location;

- The distribution of employment by firm size; and

- Sources of health insurance coverage—including employer-sponsored insurance, non-group (individual) coverage (including MCHA), military health benefits, Medicaid (including GAMC), MinnesotaCare—and the uninsured.

Estimates of projected coverage in FY2009 and FY2011 are reported in the following section. A more detailed presentation of the methods used to develop both the coverage projections and the simulation estimates is provided in Appendix A. More detailed estimates of the projected population are provided in Appendix B.

B. PROJECTED COVERAGE

Projected to FY 2009 and 2011, the number of Minnesotans with private coverage is expected to continue to erode. Most of the projected erosion of private coverage is associated with a net loss of employer-sponsored coverage. Compared to 2004, approximately 52,000 and 96,000 fewer Minnesotans are projected to have private coverage by FY2009 and FY2011, respectively. (Table II.1).

TABLE II.1

MINNESOTANS UNDER AGE 65 WITH COVERAGE FROM SELECTED SOURCES OR UNINSURED: NUMBER AND PERCENT CHANGE, CY2004 AND PROJECTED FY2009-2011

	Number (000s)			Projected Change (000s)		Percent Change	
	CY2004	FY2009	FY2011	CY2004-FY2009	CY2004-FY2011	CY2004-FY2009	CY2004-FY2011
Total, Private Coverage	3,431.4	3,379.3	3,335.0	-52.1	-96.4	-1.5%	-2.8%
Employer-sponsored	3,173.1	3,128.5	3,088.8	-44.6	-84.2	-1.4%	-2.7%
Individual	258.3	250.9	246.1	-7.5	-12.2	-2.9%	-4.7%
Public Programs	453.8	639.2	662.8	a	a	a	a
Military	73.6	78.5	79.7	4.9	6.1	6.6%	8.3%
Uninsured	373.4	486.5	543.5	113.0	170.0	30.3%	45.5%

Source: Mathematica Policy Research.

Notes: CY2004 estimates were derived from the Minnesota Health Access Survey (MNHA), as used by the Health Economics Program, and are not benchmarked to actual enrollment to correct for under-reporting of public program coverage. FY2009 and FY2011 estimates are benchmarked to state projections.

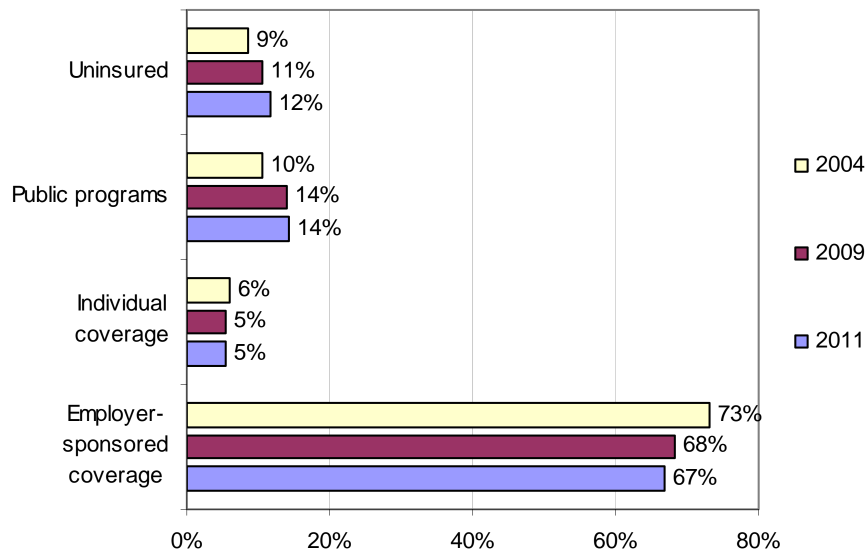
[a] Estimated change from CY2004 cannot be calculated (see notes).

The expected erosion of private coverage is relatively small in percentage terms: compared with 2004 estimates, 1.5 percent fewer Minnesotans are projected to have private coverage in 2009, and 2.8 percent fewer are projected to have private coverage in 2011. However, at least in part due to the erosion of private coverage, the number of Minnesotans under age 65 who are uninsured is projected to increase by 30 percent (113,000 persons) relative to the number in 2004, with 486,000 persons uninsured by FY2009. By FY2011, the uninsured population is projected to increase by 170,000 persons (46 percent compared to 2004), totaling 543,000 uninsured persons.

The projected percentage of Minnesotans with coverage from alternative sources is depicted in Figure II.1. In 2009, 68 percent of the population under age 65 is projected to have coverage from an employer-sponsored plan, falling to 67 percent in FY2011—compared with an estimated 73 percent of Minnesotans with employer-sponsored coverage in 2004. The population with individual coverage is projected to decline by about 1 percentage point—from 6 percent in 2004 to about 5 percent in 2009 and 2011. Public programs are projected to cover 14 percent of Minnesotans under age 65 in both 2009 and 2011, while the share of Minnesotans who are uninsured is projected to rise to 11 and 12 percent of the population under age 65 by FY2009 and FY2011, respectively, compared with 9 percent in 2004.

FIGURE II.1

PERCENT OF MINNESOTANS UNDER AGE 65 WITH COVERAGE FROM SELECTED SOURCES OR UNINSURED, CY2004 AND PROJECTED FY2009-2011



Source: Mathematica Policy Research.

Notes: Figure excludes persons with military coverage. Public program enrollment in CY2004 is estimated from household survey data and is not comparable to estimates for FY2009 and FY2011, which are benchmarked to state projections.

The projected loss of employer-sponsored coverage in Minnesota is largely associated with small and medium-sized firms. Compared with 2004 estimates, coverage of workers and dependents in small firms with fewer than 50 employees is projected to decline 11 percent by FY2009, and nearly 13 percent by FY2011 (Table II.2). Coverage in medium-sized firms is projected to decline even faster. Compared with 2004 estimates, the number of workers and dependents with employer-sponsored coverage from firms with 51 to 100 workers is projected to decline nearly 18 percent by FY2009 and more than 20 percent by FY2011. Employer-sponsored coverage is projected to rise in the largest firm sizes (with 100 employees or more) and among (combined) federal, state, and local government employees.

TABLE II.2

MINNESOTANS UNDER AGE 65 WITH EMPLOYER-SPONSORED COVERAGE BY SIZE OF FIRM: NUMBER AND PERCENT CHANGE, CY2004 AND PROJECTED FY2009-2011

	Number (000s)			Percent Change	
	CY2004	FY2009	FY2011	CY2004-FY2009	CY2004-FY2011
Self-Employed	45.8	38.1	38.1	-16.8%	-16.7%
Firms with 2-50 Employees	567.0	503.2	495.3	-11.2%	-12.7%
2-10 employees	216.2	207.2	202.4	-4.1%	-6.4%
11-50 employees	350.8	296.0	292.9	-15.6%	-16.5%
Firms with 51-100 Employees	267.2	219.7	213.5	-17.8%	-20.1%
Firms with 101 or More Employees	1,653.5	1,725.4	1,708.4	4.3%	3.3%
Government Employee Plans	480.6	516.8	509.2	7.5%	5.9%
COBRA	57.5	49.1	49.5	-14.6%	-13.9%

Source: Mathematica Policy Research.

Notes: Government employee plans include federal, state, and local government employee plans. COBRA refers to continued group coverage purchased by qualified former employees and dependents, as authorized by the federal Consolidated Omnibus Reconciliation Act (COBRA) of 1986.

Minnesotans with income between zero and 275 percent of the federal poverty level (FPL) are more likely to lose private coverage over time compared to residents with higher income (Table II.3). In particular, by FY2009 and FY2011, the number of low-income workers and dependents with employer-sponsored coverage is projected to drop by more than 20 percent—from 752,000 to fewer than 600,000—while employer coverage among higher-income Minnesotans is projected to increase by three percent.

Despite some expansion of public coverage, the uninsured population is projected to grow significantly relative to the estimated number of uninsured Minnesotans in 2004.[2] Among low-income Minnesotans, the number of uninsured is projected to increase 22 percent by FY2009, and nearly 40 percent by FY2011. Among Minnesotans with higher income, the number of uninsured is much lower, but it is projected to increase more steeply—growing 55 percent by FY2009 and 64 percent by FY2011.

TABLE II.3

MINNESOTANS UNDER AGE 65 WITH EMPLOYER-SPONSORED COVERAGE FAMILY INCOME AS A PERCENT OF POVERTY: NUMBER AND PERCENT CHANGE, CY2004 AND PROJECTED FY2009-2011

	Number (000s)			Percent Change	
	CY2004	FY2009	FY2011	CY2004-FY2009	CY2004-FY2011
Total Population					
0-275% FPL	1,534.7	1,592.7	1,673.2	3.8%	9.0%
Over 275% FPL	2,707.8	2,902.1	2,859.8	7.2%	5.6%
Employer-Sponsored Coverage					
0-275% FPL	752.5	598.8	596.3	-20.4%	-20.8%
Over 275% FPL	2,405.8	2,520.1	2,484.8	4.8%	3.3%
Individual Coverage					
0-275% FPL	115.1	107.0	108.7	-7.1%	-5.6%
Over 275% FPL	143.2	143.9	137.4	0.5%	-4.0%
Public Coverage					
0-275% FPL	389.2	547.2	579.4	a	a
Over 275% FPL	64.6	92.0	83.4	a	a
Uninsured					
0-275% FPL	277.9	339.8	388.8	22.2%	39.9%
Over 275% FPL	94.2	146.0	154.1	55.0%	63.6%

Source: Mathematica Policy Research.

Notes: Estimates exclude persons with unknown income in 2004. Public program enrollment in CY2004 is estimated from household survey data and is not comparable to estimates for FY2009 and FY2011, which are benchmarked to state projections.

[a] Estimated change from CY2004 cannot be calculated (see notes).

[2] The Minnesota Human Services Department projects continued modest growth of enrollment through FY2009 and FY2011 (data not shown). These estimates cannot be compared to the CY2004 estimates reported here, which are based the Minnesota Health Access (MNHA) household survey data as used by the Department's Health Economics Program, and are not adjusted for likely underreporting of public program enrollment.

This page has been intentionally left blank for double-sided copying.

III. ESTIMATION OF PROPOSED MARKET REFORMS

This chapter describes the three proposals for market reform that were modeled. The market reforms are, respectively: (a) guaranteed issue and community rating in the small group and individual markets; (b) an individual mandate for coverage; (c) a requirement that all employers with at least 11 employees offer a Section 125 plan to help employees purchase group or individual coverage with pre-tax dollars.

Estimates of coverage, premiums, and cost for each reform are derived from the application of behavioral parameters that were estimated from the 2004 MNHA.[3] Based on these parameters, changes in premiums drive changes in employer offer of coverage, employee take-up when offered, individual purchase of coverage, and enrollment in public programs. However, estimation of the results of each reform entails a number of assumptions specific to the reform, as described below. The assumptions that underlie the estimates for each reform are applied together to produce estimates for the combined reforms.

A. GUARANTEED ISSUE AND COMMUNITY RATING IN THE SMALL GROUP AND INDIVIDUAL MARKETS

Under current law, carriers in Minnesota may rate small groups to reflect the health status and claims experience of their workers. State regulation constrains the extent of rate variation associated with health status or claims experience: when coverage is first issued, small groups that include workers or dependents with health problems may not be charged more than 167 percent of the premium charged to the lowest-risk small groups.[4] At renewal, carriers may rate small group coverage on the basis of duration—the number of years that the group has renewed the policy—to account for the erosion of initial underwriting.

In the individual market, carriers may deny coverage to applicants for coverage based on their health status. In addition, when carriers issue individual coverage, they may charge individuals with health problems higher premiums (sometimes called a "rate up"). Individuals who are either denied coverage or rated up may obtain coverage from the state high-risk pool—the Minnesota Comprehensive Health Association (MCHA), where premiums are set at approximately 125 percent of the standard rate for similar coverage in the commercial market. Expenses that are not covered by enrollee premiums are paid for through an assessment on group and individual health insurance premiums in Minnesota's fully insured market.[5]

---

[3] The microsimulation model and underlying estimates are described in Appendix A.

[4] Rate bands are set at plus or minus 25 percent of the carrier's standard rate.

[5] Among the high-risk pools that most states operate, MCHA is by far the largest. In 2004, MCHA covered approximately 10 percent of all Minnesotans under age 65 with individual coverage.

We simulated a proposal to replace this current system with one in which all carriers in the individual market would be required to issue coverage to any applicant (called guaranteed issue). In addition, carriers would no longer rate either small group or individual coverage on the basis of health status or claims experience. The intent of such rules is to force carriers to spread risk more broadly, improve the affordability of coverage to higher-risk workers, dependents, and individuals, and improve mobility in both small-group and individual markets, but the latter especially—where individuals who develop health problems are in effect locked into their current coverage or may have to enroll in MCHA.

The simulation of guaranteed issue and community rating in both the small group and individual markets entailed a number of assumptions, as follow:

- Small employers that currently offer coverage continue to do so, even when their premium is increased.[6]
- Small employers may newly offer coverage, when the community rated premium is lower than that available to them in the current market.[7]
- Workers pay part of any increase or decrease in small-group premiums, maintaining current contributions as a percent of total premium. Employees may discontinue take-up of group coverage in response to an increase in their contribution to premiums.
- In either the small-group or individual market, persons who drop coverage in response to a premium increase will consider accepting either large-group coverage (if available through a parent or their spouse) or public coverage (if eligible), but they may become uninsured.[8]
- Individuals will consider buying individual coverage only after they have declined group and public coverage, when either is available.
- Individuals who face no change in premiums continue with their current coverage, reflecting their revealed preference, even if a lower-cost option is available to them.

---

[6] Neither large-group premiums nor, therefore, large-employer offer of coverage would change.

[7] It is reasonable to expect that observed small-group premiums are systematically lower than the premiums available to small employers that do not offer coverage, all else being equal. Based on the research literature, we assumed that premiums for small-firm workers and dependents who are not offered coverage prior to the market reform are 20 percent higher (controlling for worker and firm characteristics) than the premiums available to workers and dependents that are offered coverage. See: Jack Hadley and James Reschovsky, Small Firms' Demand for Health Insurance: The Decision to Offer Health Insurance. *Inquiry*, vol. 39, 2002, pp. 118-137.

[8] In Minnesota, dependents to age 25 are eligible for coverage from a parent's group policy.

- All individuals enrolled in MCHA continue to buy coverage, but move into the community rated individual market.[9] MCHA funding is retained to offset the cost impact of these individuals in the market; in effect, this is equivalent to assuming that MCHA provides full reinsurance for former MCHA enrollees.

B. AN INDIVIDUAL MANDATE FOR COVERAGE

At present, only one state—Massachusetts—requires all residents to maintain creditable health insurance coverage, effective January 2008. Premium assistance is available to residents with income as high as 300 percent FPL, but affordability remains an issue.[10] An estimated 20 percent of residents have been exempted from the coverage mandate based on the level of the least costly creditable coverage available to them relative to their income.[11]

In considering an individual mandate, Minnesota has proposed developing guidelines for affordability. Residents for whom available coverage would be unaffordable would either be exempted from the mandate (as in Massachusetts) or would be offered premium subsidies sufficient to make coverage affordable to them within the guidelines. We simulated the impact from the proposed affordability guidelines for residents with income up to 400 percent FPL that ranged from 7 to 10 percent of gross family income, as shown in Table III.1. Residents with income below 275 percent FPL would be eligible for public coverage; however, if they also have an insurance offer from employer, we assume that the state would subsidize their participation in group coverage up to the level at which it would be more cost-effective to enroll them in the public program. All residents with income above 400 percent FPL would be required to comply with the mandate and would be ineligible for premium assistance. In addition, lower-income residents who are already insured (in the current case) would be required to continue coverage, but would be ineligible for premium assistance.

To simulate responses to an individual mandate, we assumed that the presence of a mandate would increase the likelihood of individuals taking any group, individual, or public coverage that is available to them. However, no experience from which to estimate likely compliance with an individual mandate (such as in Massachusetts) is yet available. Therefore, we assumed (arbitrarily) that the imposition of a mandate would increase individuals' likelihood of enrolling in available coverage by 60 percent.

---

[9] The 2004 Minnesota Health Access Survey did not obtain premium information for MCHA enrollees. To estimate MCHA premiums, we predicted premiums for all individual-market enrollees based on their personal characteristics and inflated the predicted premium for MCHA enrollees by a factor of 1.25. The premiums available to uninsured targets were assumed to by systematically higher (by a factor of 1 to 1.25) than those reported by persons enrolled in individual coverage with the same personal characteristics.

[10] See: Health Care Access and Affordability Conference Committee Report (http://www.mass.gov/legis/summary.pdf, accessed February 28, 2008).

[11] Alice Dembner (April 12, 2007), Health Plan May Exempt 20% of the Uninsured. The Boston Globe (http://www.boston.com/yourlife/health/other/articles/2007/04/12/health_plan_may_exempt_20_of_the_uninsured/, accessed February 20, 2008).

TABLE III.1

PROPOSED AFFORDABILITY GUIDELINES FOR
AN INDIVIDUAL MANDATE

Family Income as a Percent of Poverty	Affordable Percent of Income for Payment of Premiums
At or Below 300%	7.0%
301 - 310%	7.3%
311 - 320%	7.6%
321 - 330%	7.9%
331 - 340%	8.2%
341 - 350%	8.5%
351 - 360%	8.8%
361 - 370%	9.1%
371 - 380%	9.4%
381 - 390%	9.7%
391 - 400%	10.0%

Source: Health Economics Program, Division of Health Policy, Minnesota Department of Health.

C. MANDATORY EMPLOYER OFFER OF SECTION 125 PLANS

Section 125 plans are employee benefit plans that allow workers to pay their contributions to qualified benefits—such as health insurance—on a pre-tax basis. These plans sometimes are called cafeteria plans, and when used solely for the purpose of paying health insurance premiums, they may be called premium-only plans.

Payment of health insurance premiums on a pre-tax basis reduces the amount of the employee's income that is taxable, in effect reducing the amount of the premium payment by the amount of tax savings. In addition, because the federal earned income tax credit (EITC) and the Minnesota Working Families Credit (MWFC)—both refundable tax credits—are calculated on the family's adjusted gross income, working families with very modest incomes can benefit from sheltering premium contributions in a Section 125 plan even when they have no tax liability.[12] (The relationship of the MWFC to taxable income is described in Chapter VII.)

Under federal law, employees may direct earned income to a Section 125 plan to pay contributions to either group coverage or individual coverage. As explored in Chapter VIII, use of Section 125 plans to finance individual coverage can have significant implications for how

[12] For example, in 2008, single filers without dependents pay no federal income tax if their adjusted gross income (AGI) is below $8,950; families with two adults and three children pay no federal income tax if their AGI is below $28,400.

employers administer the plan if they do not otherwise wish to sponsor a group health plan. However, our analysis assumes that employers comply with these rules, and that income sheltered in Section 125 plans for the purpose of paying premiums is fully tax exempt.

We estimated the impacts of a proposal that would require all employers with at least 11 employees to offer their workers a Section 125 plan to pay all contributions to premiums on a pretax basis, even if the employer does not offer a health insurance plan. To estimate the value of a Section 125 plan to Minnesota working families, we developed a spreadsheet model to calculate the marginal tax rates (including the federal income tax, the Minnesota state income tax, and federal payroll taxes) for families of different sizes and at different levels of income.

These calculations (for 2009) use income tax rules for 2008, and incorporate a number of simplifying assumptions:

- Data limitations made it necessary to assume that all income is from wages and that the family takes the standard deduction.[13] Based on these assumptions, the calculated marginal tax rates for higher-income families may overstate their actual marginal rates. However, because marginal tax rates are flat over wide ranges of income, the impact of this problem on our estimates is expected to be modest.
- We assume that families claim the EITC and MWFC when eligible, but do not claim the Child and Dependent Care tax credit.[14] These assumptions are intended to reflect the likely filing behavior of low-income households.
- While Minnesota residents with income that is too low for them to owe taxes may still benefit from paying premiums with pre-tax dollars, they cannot realize most of this benefit until the following year—when they file their taxes. Therefore, families with very limited cash flow may have much less incentive to enroll in coverage than their marginal tax rate (after receipt of the EITC and MWFC) would imply. For families with no income tax liability, we set the effective rate of change in premium due to use of a new Section 125 plan equal to their payroll tax rate (7.65 percent)—reflecting the savings that are immediately available to them. For families with income tax liability, the effective rate of change in premium due to use of a new

[13] The Minnesota Health Access Survey does not ask about total family income, but not sources of income. It does not offer sufficient information to support adequate assumptions about different sources of taxable income.

[14] Because the Child and Dependent Care tax credit is not a refundable credit, families that do not owe taxes cannot benefit from it. Also, to claim the credit, the family must use a childcare provider with a tax identification number, so that the transaction is "on the books." For both reasons, it is believed that low-income families rarely take the credit—either because their income is too low for them to have tax liability or because they have childcare arrangements that do not qualify for the credit. Claiming the dependent care credit, if eligible, would further lower marginal federal income tax rates for workers at incomes of approximately 150 to 200 percent FPL. See: Stacy Dickert-Conlin, Katie Fitzpatrick, and Andrew Hanson, Utilization of Income Tax Credits by Low-Income Individuals. National Tax Journal, December 2005 58(4), p743-785.

Section 125 plan was set equal to their estimated combined federal and state marginal tax rate after receipt of the EITC and MWFC, if eligible.

- Finally, while workers could use Section 125 plans to pay for either individual or group premiums, we assume that they could not be used to pay premiums for MinnesotaCare.

Estimates of the coverage, cost, and fiscal impacts for each reform, and for all of the reforms in combination, are presented in the chapters that follow.

IV. CHANGES IN COVERAGE

This chapter presents estimates of the change in coverage associated with each of the three proposals for market reform—guaranteed issue and community rating in the small group and individual markets, an individual mandate for coverage, and a requirement that employers with 11 or more employees offer a Section 125 plan. With respect to the individual mandate, we modeled two approaches to the issue of affordability, alternatively exempting Minnesotans whose income would make the purchase of coverage unaffordable and providing subsidies to ensure affordability. Estimates of compliance with mandate are provided under both approaches, for the reform with individual mandate alone as well as for the combined reforms. Additional detail for each set of simulation results is provided in Appendix C, including a "change matrix" (Table C.3) that identifies movement of individuals among sources of coverage under each of the proposed reforms.

A. SOURCES OF COVERAGE

Simulated changes in coverage that result from the implementation of each of these reforms individually and in combination are reported in Table IV.1. As a consequence of each reform or combination of reforms, currently uninsured Minnesotans would obtain coverage. However, those who are currently insured may also change their source of coverage. The principal coverage results of each reform are summarized below:

- Community rating in the small group market produces rate increases for more workers and dependents than it produces rate decreases. As a result, some workers and dependents would drop small-group coverage. Most of these workers would move to individual coverage—where they may be able to obtain a lower age-rated premium, although perhaps for less coverage than was available to them in their small group plan. We estimate that a small proportion of workers who would face higher small group premiums would enroll in MinnesotaCare or become uninsured.

- With an individual mandate that exempts coverage is deemed unaffordable the number of uninsured Minnesotans by an estimated 57 percent. The number of workers and dependents with employer-sponsored coverage would increase approximately 5 percent, and the number of Minnesotans with individual coverage would increase 12 percent—both under current market rules regarding issue and rating of coverage in these markets. A substantial number of Minnesotans now eligible for public coverage would enroll, increasing the number enrolled in public coverage by 15 percent.

TABLE IV.1

ESTIMATED NUMBER OF MINNESOTANS UNDER AGE 65 BY SELECTED SOURCES OF COVERAGE AND PERCENT CHANGE FROM THE CURRENT CASE, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
Number (000's):							
Employer sponsored insurance	3,128.5	3,092.7	3,279.4	3,347.6	3,172.9	3,226.8	3,291.2
Individual private insurance	250.9	304.2	281.7	300.1	266.6	293.7	333.7
Public program	639.2	645.2	733.3	743.7	639.2	745.8	757.9
Uninsured	486.5	463.0	210.6	113.7	426.3	238.7	122.3
Percent Change from Current Case:							
Employer sponsored insurance	–	-1.1%	4.8%	7.0%	1.4%	3.1%	5.2%
Individual private insurance	–	21.3%	12.3%	19.6%	6.3%	17.1%	33.0%
Public program	–	0.9%	14.7%	16.3%	0.0%	16.7%	18.6%
Uninsured	–	-4.8%	-56.7%	-76.6%	-12.4%	-50.9%	-74.9%

Source: Mathematica Policy Research.

Notes: Minnesotans with coverage from a military plan are omitted. Individual coverage includes MCHA enrollees. Public program enrollees include GAMC, Medical Assistance, and MinnesotaCare enrollees.

- With subsidies to support an individual mandate, the number of uninsured would drop substantially more—by 77 percent. Some workers with an offer of group coverage would enroll, increasing the estimated number of workers and dependents with group coverage by 7 percent; the estimated number of Minnesotans with individual coverage would rise nearly 20 percent. Similarly, more of uninsured persons eligible for MinnesotaCare would enroll when further subsidized, increasing the number of Minnesotans with public coverage by 16 percent.

- With a Section 125 plan more widely available to workers, group coverage would increase slightly (1 percent) and individual coverage would rise by about 6 percent. However, because coverage would remain voluntary and after-tax premiums would remain high for some workers, the estimated impact would be much less than with an individual mandate and direct subsidies to limit premium payments relative to income. Assuming that individual MinnesotaCare premiums would not be payable from Section 125 plans, there would be no change in public coverage.

- The coverage results of the combined reforms are largely driven by the individual mandate. With an affordability exemption, the number of Minnesotans with group coverage would increase 3 percent net of coverage losses, reflecting the large number of workers who would experience rate increases with community rating. The number with individual coverage and those enrolled in public programs also would increase (each by about 17 percent), but the net gain in coverage overall would be somewhat less than with the mandate alone. With subsidies, the gain in group coverage would be slightly greater (5 percent), as would the gain in public coverage (19 percent). The gain in individual coverage would be much greater (33 percent)—but again, the overall net gain in coverage would not be greater than with the mandate and subsidies alone.

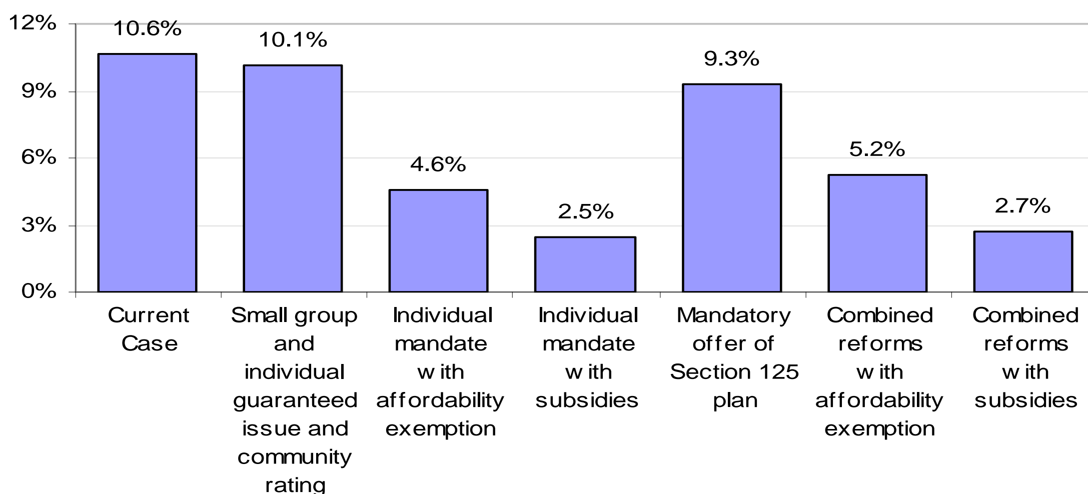
B. CHANGE IN THE UNINSURED POPULATION

Each of the reforms would result in substantially fewer Minnesotans being uninsured. However, the reforms in combination would not necessarily reduce the number of uninsured below that which would result from a mandate alone.

With small-group and individual guaranteed issue and community rating, the rate of uninsured Minnesotans under age 65 would decline slightly—from an estimated 10.6 percent in the current case, to 10.1 percent with small-group and individual guaranteed issue and community rating (Figure IV.1). If employers with 11 or more employees were required to offer a Section 125 plan, the percentage of Minnesotans who remain uninsured would decline somewhat more—to 9.3 percent of the population under age 65.

FIGURE IV.1

ESTIMATED PERCENT OF MINNESOTANS UNDER AGE 65 WHO ARE UNINSURED: CURRENT CASE AND POLICY SIMULATIONS, FY2009



Source: Mathematica Policy Research.

In contrast, the impact of an individual mandate would be far greater than either rate reforms or mandatory offer of Section 125 alone. Even with exemptions for affordability, fewer than 5 percent of Minnesotans under age 65 would remain uninsured with an individual mandate. With subsidies to support an individual mandate, just 2.5 percent of Minnesotans under age 65 would remain uninsured.

If the reforms were implemented in combination with an affordability exemption from the individual mandate, an estimated 5.2 percent of Minnesotans would remain uninsured—compared with 4.6 percent who would remain uninsured if rating and issue in the small group and individual markets were unchanged and employers were not required to offer a Section 125 plan. This result reflects a number of low- and moderate-income Minnesotans who are currently insured and, with the combined reforms, would receive a rate increase in the community rated markets. Exempted from the mandate, some would become uninsured—although many fewer than if the markets were community-rated without an individual mandate. The reduction in after-tax premiums associated with greater availability of Section 125 plans is not sufficient to offset this effect fully.

For similar reasons, the effect of the combined reforms with subsidies to ensure affordability is less than the effect of an individual mandate alone with subsidies. That is, some individuals who would not qualify for a subsidy—because they either have relatively high income or already are insured—would experience an increase in their community-rated premium and would drop coverage. Again, the availability of a Section 125 plan does not fully offset this effect. Consequently the combined reforms with subsidies would leave 2.7 percent of Minnesotans uninsured, compared with 2.5 percent who would remain uninsured with only an individual mandate and subsidies.

In the simulations that assume an individual mandate, the number of Minnesotans who would remain uninsured is our estimate of noncompliance. Recall that we assumed that an individual mandate would increase the likelihood that individuals would obtain coverage, but some who have very low demand for coverage would remain relatively unlikely to comply. Assuming 60-percent increase in the probability of obtaining coverage in response to a mandate, an estimated 2 to 5 percent of Minnesotans would be noncompliant. Of these, approximately one-half would be eligible for public coverage (either Medicaid or MinnesotaCare) and might be either auto-enrolled or enrolled with additional outreach efforts (Table IV.2). The balance of the population that would remain uninsured—an estimated 1.3 to 2.4 percent of the population under age 65—would be ineligible for public program coverage.

Each of the reforms would alter the composition of the uninsured population. Each of the reforms would alter the composition of the uninsured population. Coverage would change most with an individual mandate, and the composition of the remaining uninsured also would change the most under this reform (Table IV.3). An individual mandate with an affordability exemption would result in many fewer uninsured than the current case, but low-income adults would comprise a greater percentage of those who remain uninsured (72 percent versus 54 percent in the current case). Conversely, children would comprise a smaller percentage of the uninsured (9 percent, versus 19 percent in the current case).

With an individual mandate and subsidies to ensure affordability, fewer Minnesotans would remain uninsured, and a lower proportion would be low-income. If subsidies were available,

low-income adults would account for an estimated 60 percent of the remaining uninsured, compared with 54 percent in the current case and 72 percent with an exemption from the individual mandate. Children would account for less than 7 percent of the uninsured.

Finally, although an individual mandate would greatly reduce the number of uninsured and, therefore, the burden of uncompensated care, the health status of those who would remain uninsured under an individual mandate—either alone or in combination with other reforms—suggests noncompliance would pose some ongoing uncompensated care burden for providers. While many fewer Minnesotans would remain uninsured, those with good, fair, or poor health status would represent a larger share of the uninsured (47 percent, compared with 37 percent in the current case and 25 percent with an affordability exemption). Even combined with other reforms, those in relatively poor health would become a somewhat larger share of the uninsured (39 percent with exemption and 43 percent with subsidies) compared with the current case (37 percent).

TABLE IV.2

ESTIMATED NUMBER AND PERCENT OF UNINSURED MINNESOTANS UNDER AGE 65 ELIGIBLE FOR PUBLIC COVERAGE, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
Total Uninsured:							
Number (000's)	486.5	463.0	210.6	113.7	426.3	238.7	122.3
Percent of population under age 65	10.6%	10.1%	4.6%	2.5%	9.3%	5.2%	2.7%
Uninsured Eligible for Public Coverage:							
Number (000's)	245.8	242.5	110.7	52.0	230.7	129.4	60.6
Percent of uninsured	50.5%	52.4%	52.6%	45.7%	54.1%	54.2%	49.5%
Percent of population under age 65	5.4%	5.3%	2.4%	1.1%	5.0%	2.8%	1.3%
Uninsured not Eligible for Public Coverage:							
Number (000's)	240.7	220.5	99.9	61.7	195.6	109.3	61.7
Percent	49.5%	47.6%	47.4%	54.3%	45.9%	45.8%	50.5%
Percent of population under age 65	5.3%	4.8%	2.2%	1.3%	4.3%	2.4%	1.3%

Source: Mathematica Policy Research.

TABLE IV.3

ESTIMATED PERCENT OF UNINSURED MINNESOTANS BY SELECTED PERSONAL CHARACTERISTICS, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption) (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
Adults Age 18-64	80.8%	79.7%	91.3%	93.4%	80.1%	91.8%	93.5%
0-275% FPL	53.5%	54.3%	71.5%	60.4%	55.7%	72.6%	62.8%
276% FPL or more	27.3%	25.4%	19.8%	32.9%	24.4%	19.2%	30.7%
Children Age 0-17	19.2%	20.3%	8.7%	6.6%	19.9%	8.2%	6.5%
0-275% FPL	16.3%	17.1%	8.2%	5.8%	16.7%	7.8%	5.6%
276% FPL or more	2.8%	3.2%	0.4%	0.8%	3.2%	0.4%	0.9%
Region							
North	24.3%	24.5%	24.6%	24.9%	25.0%	24.5%	26.9%
Central	13.2%	12.7%	15.8%	13.2%	12.7%	15.0%	13.2%
Twin Cities	46.1%	46.2%	46.6%	52.3%	45.1%	41.6%	45.2%
South	16.4%	16.6%	13.1%	9.6%	17.2%	18.9%	14.8%
Health Status							
Excellent-very good	61.6%	64.0%	58.3%	52.0%	61.9%	61.2%	56.4%
Good, fair or poor	37.0%	34.6%	41.3%	47.4%	36.6%	38.5%	42.9%
Unknown	1.3%	1.4%	0.4%	0.6%	1.5%	0.4%	0.6%

Source: Mathematica Policy Research.

V. CHANGES IN COST

Similar to the process of projecting coverage estimates, we projected private insurance premiums and public program expenditures to FY2009.[15] These projections extrapolated experience in Minnesota in private coverage and public programs, respectively. Private insurance premiums were benchmarked and projected to FY2009 based on average per member per month (pmpm) private insurance premiums and medical losses in large-group, small-group and individual health plans, respectively, as reported by major carriers in Minnesota from 2001 to 2006. Public program costs (by age group, gender, and location) were benchmarked and projected to FY2009 based on average pmpm expenditures in Medicaid and GAMC (combined), and in MinnesotaCare.

Together, projected premiums and program expenditures represent total third-party medical expenditures and private administrative cost in the current case. These projections assume that changes in the level of consumer cost-sharing relative to total expenditures are consistent with experience from 2001 to 2006. That is, to the extent that carriers' medical losses slowed as a result of greater cost sharing (and consumer out of pocket expenditures increased), that trend is implicitly assumed to continue to FY2009.

In this chapter, we report estimated changes in private insurance premiums (including both the employer and employee share) that would result from the implementation of the proposed reforms alone and in combination. Estimated changes in public program cost and financing are then presented in Chapter VI.

A. CHANGES IN THE COST OF PRIVATE INSURANCE

Because the proposed reforms would change the composition of the population who would participate in each insurance market, the average cost experience in each market also would change.

In Table V.1, various characteristics of the population with private group or individual coverage are summarized, both in the current case and the reform simulations. The demographic and health-status composition of the estimated population with private group insurance (including small-group and large-group) would change relatively little with any of the reforms, either alone or in combination—although with subsidies, a larger proportion would be low-income. As in the current case, approximately 24 percent of the group-insured Minnesotans would be children, and 21 percent would be in good, fair, or poor health status.

In contrast, the composition of the population enrolled in individual coverage would change, although modestly. Compared with the current case, the individual market would cover relatively more adults, and Minnesotans in good, fair, or poor health would constitute a larger

[15] Data sources and methods used to develop the cost projections are described in detail in Appendix A.

share of the market. Both changes would affect the expected cost of individual coverage in a reformed market.

TABLE V.1

ESTIMATED PERCENT OF MINNESOTANS IN GROUP AND INDIVIDUAL PRIVATE COVERAGE BY SELECTED PERSONAL CHARACTERISTICS, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
Group Coverage							
Adults age 18-64	75.4%	75.4%	75.6%	75.9%	75.5%	75.5%	75.7%
0-275% FPL	13.1%	13.0%	14.0%	15.5%	13.4%	13.5%	14.9%
276% FPL or more	62.4%	62.4%	61.6%	60.4%	62.1%	62.0%	60.8%
Children age 0-17	24.6%	24.6%	24.4%	24.1%	24.5%	24.5%	24.3%
0-275% FPL	6.1%	6.0%	6.4%	6.5%	6.2%	6.3%	6.4%
276% FPL or more	18.5%	18.6%	18.0%	17.6%	18.2%	18.2%	17.9%
Health Status							
Good, fair or poor	21.0%	20.8%	21.5%	21.8%	21.3%	21.4%	21.6%
Excellent or very good	78.9%	79.1%	78.4%	78.1%	78.6%	78.5%	78.3%
Individual Coverage							
Adults age 18-64	76.3%	79.7%	77.2%	78.4%	77.6%	78.2%	80.4%
0-275% FPL	32.1%	31.5%	29.7%	32.9%	32.3%	27.2%	33.4%
276% FPL or more	44.2%	48.3%	47.6%	45.4%	45.2%	51.0%	47.0%
Children age 0-17	23.7%	20.3%	22.8%	21.6%	22.4%	21.8%	19.6%
0-275% FPL	10.6%	8.8%	10.6%	10.2%	10.1%	9.8%	9.1%
276% FPL or more	13.1%	11.5%	12.2%	11.4%	12.4%	12.0%	10.6%
Health Status							
Good, fair or poor	20.2%	27.4%	21.2%	21.6%	20.7%	22.3%	24.6%
Excellent or very good	79.8%	72.6%	78.8%	78.4%	79.3%	77.7%	75.4%

Source: Mathematica Policy Research.

These changes in the covered populations drive changes in premiums, as reported in Table V.2. Of course, estimated premium changes are greatest for small group and individual coverage—the insurance markets that the reforms target—but they also occur in large group coverage (firms with more than 50 employees), as workers accept offers of employer coverage that they had not accepted prior to reform.

TABLE V.2

ESTIMATED PREMIUMS IN GROUP AND INDIVIDUAL COVERAGE AND PERCENT CHANGE FROM THE CURRENT CASE, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
Premiums per Member per Month							
Large Group Coverage							
Single	$123	$122	$122	$120	$108	$108	$107
Family	$262	$262	$262	$260	$228	$231	$230
Small Group Coverage							
Single	$118	$129	$110	$106	$118	$107	$106
Family	$181	$185	$177	$177	$180	$164	$164
Individual							
Single	$215	$246	$221	$217	$202	$215	$206
Family	$340	$353	$338	$330	$322	$322	$309
Percent Change from the Current Case							
Large Group Coverage							
Single	---	-0.8%	-0.8%	-2.4%	-12.2%	-12.2%	-13.0%
Family	---	0.0%	0.0%	-0.8%	-13.0%	-11.8%	-12.2%
Small Group Coverage							
Single	---	9.3%	-6.8%	-10.2%	0.0%	-9.3%	-10.2%
Family	---	2.2%	-2.2%	-2.2%	-0.6%	-9.4%	-9.4%
Individual Coverage							
Single	---	14.4%	2.8%	0.9%	-6.0%	0.0%	-4.2%
Family	---	3.8%	-0.6%	-2.9%	-5.3%	-5.3%	-9.1%

Source: Mathematica Policy Research.

Notes: Group coverage includes both insured and self-insured plans. Large groups are defined as those with more than 50 employees.

The principal results of each reform with respect to estimated premium levels are summarized below:

- Community rating in the small group and individual markets would increase average premiums, as Minnesotans with health problems obtain coverage in greater numbers. This increase is especially noticeable for single coverage—where adults predominate. Average premiums for single coverage in small groups would increase approximately

9 percent, while average individual premiums for single coverage would increase 14 percent.

- An individual mandate would reduce average premium levels in the small-group market, especially for single coverage, as larger numbers of young workers took coverage. With an affordability exemption from the individual mandate, average premiums for single coverage in small groups would decline approximately 7 percent. With subsidies to support an individual mandate, premiums for single coverage in small groups would decline approximately 10 percent. In the individual market, though currently uninsured people in relatively poor health would obtain coverage, the availability of subsidies would bring sufficient numbers of younger and healthier Minnesotans into the market such that premiums ultimately might change very little: we estimate an increase of just 1 percent for single coverage and a reduction of 3 percent for family coverage.

- Mandatory employer offer of section 125 plans would have the greatest effect on large-group premiums, as workers newly offered section 125 plans begin to take it up. Estimated average premiums would decline 12 to 13 percent for single or family coverage in large groups. Reflecting higher take-up of small group coverage (when offered) in the current case and the exemption of the smallest employers from the requirement, a mandatory Section 125 plan in small groups is expected to have no appreciable effect on premiums. However, changes in the population covered in the individual market would drive premium changes there, reducing individual premiums for single or family coverage by 5 to 6 percent.

- The combined reforms generally would result in lower average group premiums than either the current case or each reform alone. However, this is not the case with respect to individual coverage. Of all the reforms, mandatory offer of a Section 125 plan would drive the lowest average level of premiums in the individual market for single coverage—although, with coverage remaining voluntary, it would still not produce the highest level of coverage. The combined reforms with subsidies would drive the lowest average level of individual premiums for family coverage, reducing premiums for family coverage by 9 percent compared with the current case.

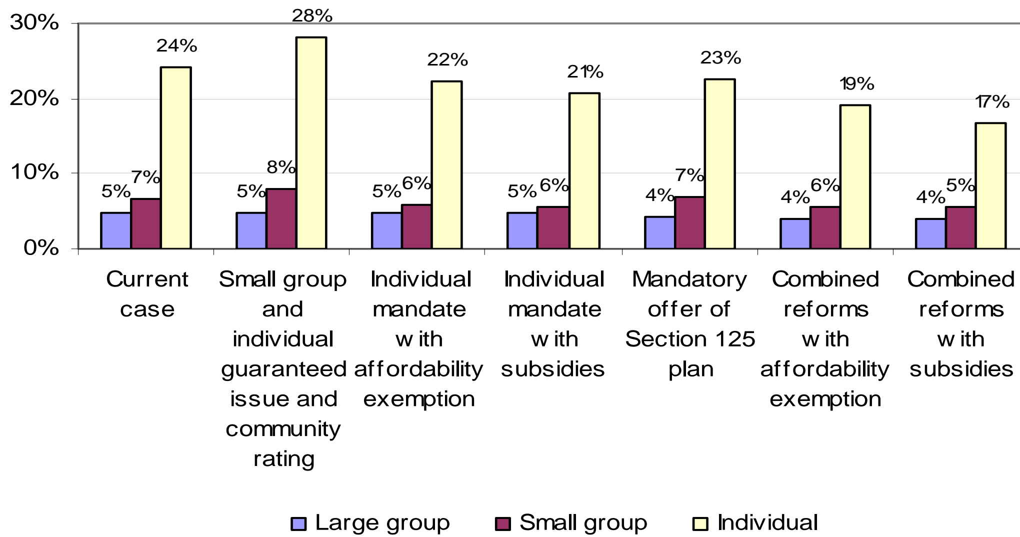
These premium changes are expected to affect the affordability of coverage for Minnesotans—both those who are insured in the current case and those who might become insured. We estimated the percent of family income that insured Minnesotans would pay in each simulation; results are summarized in Figure V.1, and reported in greater detail in Appendix D.

As expected, Minnesotans would see more change in the affordability of individual coverage than group coverage. In the current case, approximately 24 percent of Minnesotans would pay more than 10 percent of family income as a contribution to employer-sponsored coverage or as a direct premium payment for individual coverage. Only in one reform simulation—with community rating and guaranteed issue of small group and individual coverage—would a higher percentage of Minnesotans pay a more than 10 percent of family income for individual coverage—as many as 28 percent.

Note that while the combined reforms would not necessarily produce the lowest average premiums, they would produce premiums that are affordable to the most people. With the combined reforms and an affordability exemption, 19 percent of Minnesotans with individual coverage would face a premium that exceeds 10 percent of family income. With subsidies, just 17 percent—those who are above 400 percent FPL or are currently insured—would face such a high premium for individual coverage.

FIGURE V.1

ESTIMATED PERCENT OF INSURED MINNESOTANS UNDER AGE 65 WITH PREMIUM CONTRIBUTIONS THAT EXCEED 10 PERCENT OF FAMILY INCOME, FY2009



Source: Mathematica Policy Research.

Under each of the reforms, employers' costs for coverage would change for two reasons: First, the number of workers who take up employer-sponsored insurance would increase under each reform, in both small and large groups—entailing higher total employer cost. Second, average premiums would change, affecting the amount of employer contribution per worker, if (as is assumed) employers maintain the same percentage contribution to premiums.[16]

The number of covered workers and average pmpm employer cost under each reform is reported in Table V.3. For large groups, the average cost for single coverage would increase under each reform, as number of covered workers increased and the composition of the group changed. With the combined reforms and subsidies, the number of covered workers in large groups would increase 6 percent, while average employer contributions per worker would increase 11 percent for single premiums. Total cost for large employers also would increase the most relative to other reform scenarios—total large-employer contributions to coverage would increase an estimated 5 percent.

[16] Of course, employers might ultimately shift increases in cost to workers in the form of lower wages or other compensation while maintaining contributions to coverage at approximately the same percentage of premium.

TABLE V.3

ESTIMATED EMPLOYER CONTRIBUTIONS TO COVERAGE BY SIZE OF FIRM AND CHANGE FROM THE CURRENT CASE, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
FY 2009 Projected							
Large Firms							
Number of covered workers (000's)	2,443	2,447	2,505	2,550	2,482	2,535	2,577
Employer contribution pmpm:							
Single coverage	$180	$181	$189	$198	$187	$193	$200
Family coverage	$381	$381	$380	$380	$380	$380	$379
Total employer cost (millions)	$865	$866	$884	$898	$877	$892	$905
Small Firms							
Number of covered workers (000's)	520	527	609	632	526	576	598
Employer contribution pmpm:							
Single coverage	$232	$257	$283	$285	$235	$291	$317
Family coverage	$390	$384	$392	$393	$390	$383	$383
Total employer cost (millions)	$187	$189	$222	$230	$190	$208	$218
Percent Change from the Current Case							
Large Firms							
Number of covered workers	---	0.2%	2.5%	4.4%	1.6%	3.7%	5.5%
Employer contribution pmpm:							
Single coverage	---	0.2%	4.9%	9.7%	3.7%	6.9%	11.1%
Family coverage	---	0.0%	-0.2%	-0.3%	-0.1%	-0.3%	-0.3%
Total employer cost (millions)	---	0.1%	2.2%	3.8%	1.4%	3.1%	4.6%
Small Firms							
Number of covered workers	---	1.3%	17.1%	21.6%	1.1%	10.8%	15.1%
Employer contribution pmpm:							
Single coverage	---	10.9%	22.1%	22.9%	1.2%	25.4%	36.5%
Family coverage	---	-1.7%	0.5%	0.6%	0.0%	-1.9%	-2.0%
Total employer cost (millions)	---	1.1%	18.7%	23.0%	1.6%	11.2%	16.6%

Source: Mathematica Policy Research.

The change for small employers under each reform would be substantially greater than for large employers, related to the much larger percentage of small-firm workers without coverage in the current case. The greatest increase would result not from the combined reforms, but from the individual mandate alone when coupled with subsidies. With an individual mandate and subsidies, estimated enrollment in small-group coverage would increase 22 percent. Small-

employer contributions to coverage would increase 23 percent—more than for any of the other proposed reforms.

If the reforms were combined and coupled with subsidies, small firms would see a somewhat smaller increase in the number of covered workers (15 percent) than with a mandate and subsidies alone. At current contribution rates, employer contributions (pmpm) to single coverage would increase more steeply (37 percent), but the increase in total small-employer contributions (17 percent) would be lower compared with a mandate and subsidies alone.

The magnitude of these changes for small groups suggests that policymakers should pay some attention to risk management in the small group market if reforms are implemented. Given the magnitude of change that the reforms would cause, the estimated average increase in employer cost is not surprising. However, some employers could experience enrollment and premium changes that would be much greater than the average.

Finally, many small employers might seek to reduce their contributions as a percent of premium, at least initially, to offset the increased costs from greater enrollment, increased premiums, or both. If employers reduced their percentage contribution to manage their costs of offering coverage, small group take-up of employer-sponsored coverage would be smaller, take-up of individual coverage (under a mandate) would be larger, and the cost to the state of providing subsidies would increase.

B. CHANGES IN PUBLIC PROGRAM COSTS AND FINANCING

Estimated increases in expenditures for public programs associated with each of the reforms would be paid in part from state funds, but also from federal funds—and to a small extent, from enrollee premiums. The estimated increase in expenditures for public programs associated with each of the reform proposals is reported by source of funding in Table V.4 (additional detail is provided in Appendix E). The proportion of cost that the state would pay reflects the federal matching rate for Minnesota's Medicaid and SCHIP enrollees, as well as the absence of federal matching for GAMC and adults without children in MinnesotaCare.

Our estimates of MinnesotaCare financing differ from the state's forecasts in at least two important ways. First, our projections include a higher percentage of enrollees with income above 300 percent FPL and lower percentage with income below poverty. Second, we estimated that a greater number of parents and children would enroll relative to adults without children. We adjusted our estimates of MinnesotaCare premiums for the first discrepancy—so that projected premium income to the program approximates the state's projections.

However, we did not reduce our higher estimate of enrolled families with children (with lower average per capita spending, and for whom the state draws federal match) relative to adults without children (with higher average per capita spending, and for whom the state does not draw federal match). Consequently, our estimate of total MinnesotaCare expenditures in the current case is lower than the state's projections and should be viewed as a lower-bound estimate of program expenditures with no policy change. Conversely, our estimate of federal funding in the current case is somewhat higher than the state's projections and should be viewed as an upper bound estimate of potential federal funding for the program with no policy change.

Relative to state projections, our projected current-case distribution of adults without children and families with children also has important implications for estimates of expenditure growth associated with policy change. Specifically, if the state's projected distribution of enrollment is correct, our estimates of expenditure growth may be somewhat higher than would actually occur with policy change. That is, in our projections, adults without children newly enter the program in somewhat higher numbers than they would if (as the state projects) the current case already included so many adults without children. Conversely, federal funding for new enrollees would be greater than we have projected—as new enrollees would be somewhat more likely to be families with children, and to draw federal match.

The estimated increases in state expenditures for public programs associated with the reforms range from less than 1 percent (for guaranteed issue and community rating of individual and small-group coverage) to approximately 28 percent (for the combined reforms with a subsidy). Only the offer of a mandatory Section 125 plan would entail no increase in state expenditure (although it would entail fiscal impacts as described in the next chapter).

The state would pay approximately 55 percent of the public-program costs associated with each of the reforms. Reflecting the small expected change in public program enrollment associated with guaranteed issue and community rating of individual and small group coverage, public program financing would change little, and would be distributed among the state, federal government, and enrollees in very nearly the same way as in the current case. With an individual mandate and subsidies, the magnitude of the subsidy payments are not so great as to change the distribution of payers significantly. When the reforms are combined and paired with subsidies, the state would pay 57 percent of the cost—an estimated $3.5 billion; federal matching payments would total $2.6 billion.

TABLE V.4

ESTIMATED STATE AND FEDERAL EXPENDITURES, AND ENROLLEE PREMIUM PAYMENTS FOR PUBLIC PROGRAMS: CURRENT CASE AND POLICY SIMULATIONS, FY2009

	Current Case	Small Group and Individual Guaranteed Issue and Community Rating (1)	Individual Mandate with Affordability Exemption (2a)	Individual Mandate with Subsidies (2b)	Mandatory Offer of Section 125 Plan (3)	Combined Reforms with Affordability Exemption (1+2a+3)	Combined Reforms with Subsidies (1+2b+3)
Total Expenditures (billions)							
State	$2.699	$2.703	$3.220	$3.383	$2.699	$3.269	$3.460
Medical Assistance and GAMC	$2.450	$2.450	$2.960	$2.990	$2.450	$3.000	$3.050
MinnesotaCare	$0.249	$0.253	$0.260	$0.268	$0.249	$0.269	$0.277
Affordability subsidies	N/A	N/A	N/A	$0.125	N/A	N/A	$0.133
Federal	$2.114	$2.128	$2.536	$2.573	$2.114	$2.578	$2.615
Medical Assistance and GAMC	$1.990	$2.000	$2.410	$2.440	$1.990	$2.450	$2.480
MinnesotaCare	$0.124	$0.128	$0.126	$0.133	$0.124	$0.128	$0.135
Enrollees							
Enrollee premiums	$0.032	$0.033	$0.033	$0.034	$0.032	$0.034	$0.035
Percent of Total							
State	55.7%	55.6%	55.6%	56.5%	55.7%	55.6%	56.6%
Federal	43.6%	43.8%	43.8%	43.0%	43.6%	43.8%	42.8%
Enrollees	0.7%	0.7%	0.6%	0.6%	0.7%	0.6%	0.6%
Percent Change from the Current Case							
State	---	0.1%	19.3%	25.3%	0.0%	21.1%	28.2%
Federal	---	0.7%	20.0%	21.7%	0.0%	21.9%	23.7%
Enrollees	---	3.1%	3.1%	6.3%	0.0%	6.3%	9.4%

Source: Mathematica Policy Research.

This page has been intentionally left blank for double-sided copying.

VI. NET FISCAL IMPACT

The fiscal impacts of market reforms include the impacts on both state expenditures (as described in the previous chapter) and revenues. State revenues can change as a result of changes in tax receipts from both individuals and insurance carriers. Changes in individual income tax receipts can occur with changes in pretax payment of premiums. Changes in receipts from Minnesota's excise tax on health insurance premiums can result from changes in premium volume.

The net fiscal impact is the sum of the change in state revenue minus the change in state expenditures. While most of the proposed market reforms would drive some increase in state expenditures, state revenues after payment of the MWFC could either increase or decrease.

A. CALCULATION OF REVENUE IMPACTS

Changes in the premium levels, the offer of health coverage, and the use of Section 125 plans could result in consistent or opposing effects on state revenues. For example:

- A change in premiums for workers who already use pre-tax dollars to pay for insurance would affect their taxable income, increasing or reducing it by the amount of the change in pre-tax contributions to coverage.
- A new offer of employer coverage will drive increased purchase of health insurance, and may also drive pre-tax payment of premiums, reducing workers' taxable income.
- The offer of a Section 125 plan to workers who before were paying either group or individual premiums post-tax would reduce their taxable income.

In addition, for some low-income workers, a change in pre-tax payment of premiums will affect whether they qualify for the Minnesota Working Family Credit (MWFC) and how much they receive—changing their tax liability net of the MWFC.[17] An increase in the number of families who qualify for the MWFC would reduce state revenues; these families would begin to receive a credit from the state, lowering their tax bill.

However, among families that already receive the MWFC, the amount of the credit could either increase or decrease with pretax payment of premiums, depending on the amount of their adjusted gross income (AGI). At the lowest levels of income, the MWFC (as well as the federal earned income tax credit, the EITC) increases as earned income increases. Conversely, both credits would decline as adjusted gross income is reduced via use of Section 125 accounts. Therefore, it is reasonable to expect that individuals at this level of income would not reasonably

[17] The MWFC is a refundable credit. Therefore, families can receive a net payment if their tax liability is less than the credit, so that their net tax liability is in effect negative.

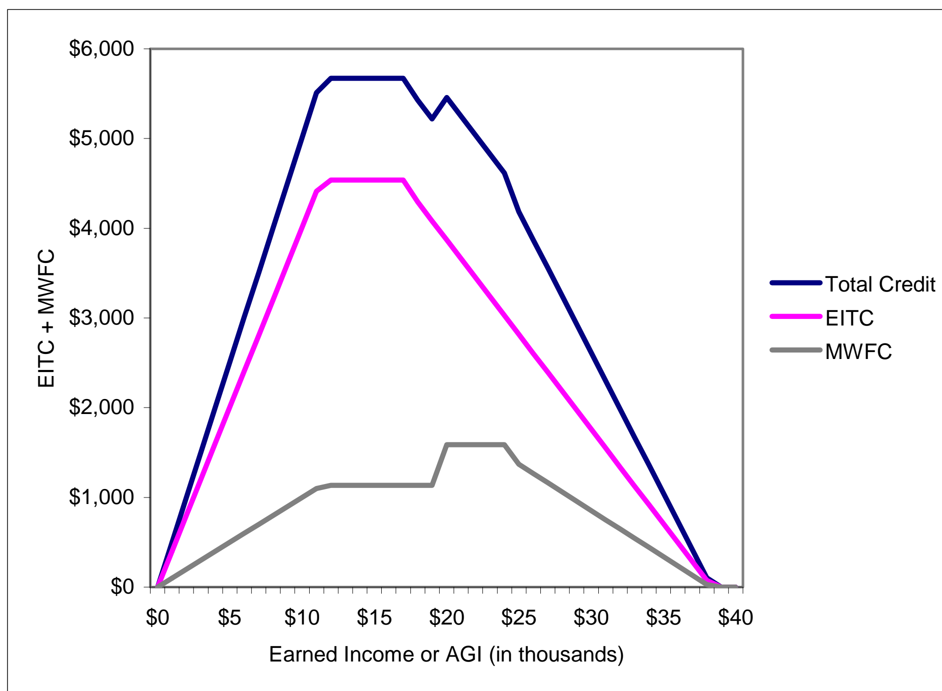
use Section 125 accounts, since the after-tax price of insurance would increase as their reported gross income (net of Section 125 contributions) declines.

At somewhat higher levels of income, the credit increases in steps, such that it is flat over a range of income, rises with additional income, and then is flat again over a range of income. At still higher levels of income, the MWFC (and the EITC) decline with increases in income, and finally both are phased out.

The structure of the MWFC and EITC for a family of two adults and two children is depicted in Figure VI.1. For other family types, the tax credit structure is generally similar, although the inflection points differ. The structure of the MWFC generates a pattern of income tax liability that falls and then rises, as family income rises (Figure VI.2).

FIGURE VI.1

VALUE OF THE FEDERAL EARNED INCOME TAX CREDIT AND THE MINNESOTA WORKING FAMILY TAX CREDIT FOR A MARRIED COUPLE WITH TWO CHILDREN

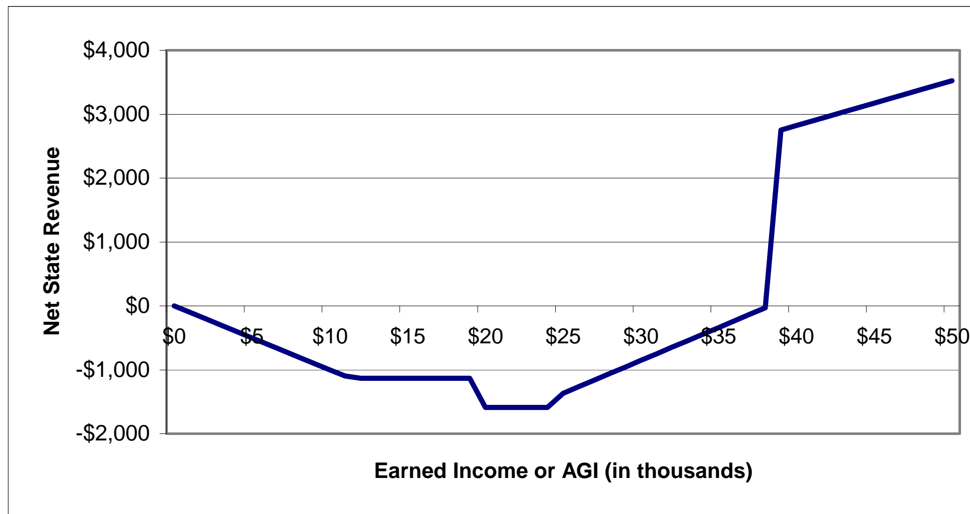


Source: Mathematica Policy Research.

Notes: Estimates reflect 2006 marginal tax and MWFC rates. Simulations are based on 2007 EITC rates and projected 2009 MWFC rates

FIGURE VI.2

PERSONAL INCOME TAX LIABILITY NET OF THE MINNESOTA WORKING FAMILY CREDIT FOR A MARRIED COUPLE WITH TWO CHILDREN



Source: Mathematica Policy Research.

Notes: Estimates reflect 2006 marginal tax and MWFC rates. Simulations are based on 2007 EITC rates and projected 2009 MWFC rates.

Finally, changes in either the level of coverage or total premiums can generate changes in state revenue from premium taxes. Minnesota's premium tax rate varies for various components of the premium tax base—namely, stop loss premiums; premiums of HMOs, nonprofit health service plan corporations and community integrated service networks; and other health insurance premiums. Our method of calculating of changes in total premium tax revenues—as well as changes in individual income taxes and the MWFC—is described in detail in Appendix F.

B. NET FISCAL IMPACT AND INCIDENCE

Each of the proposed reforms would affect the state's revenue and expenditure outlook. The lowest net fiscal impact would be associated with a move to guaranteed issue and community rating in the small group and individual markets. While this reform would generate increased state revenues from premium taxes, state expenditures for Medicaid and MinnesotaCare would increase as some workers and dependents eligible for public coverage would be motivated to enroll when confronted with a premium increase for private coverage. On net, the fiscal estimated impact would be negative, approximately -$2.2 million (Table VI.1).

Each of the other reforms, either alone or in combination, would have a much greater net fiscal impact, ranging from an estimated reduction of $84 million (with mandatory offer of Section 125) to an estimated reduction of approximately $853 million (with the combined reforms and subsidies). The fiscal impact of a Section 125 requirement would be due nearly entirely to a loss of state income tax revenue—in large part among Minnesotans who are now insured but paying contributions to coverage post-tax.

TABLE VI.1

ESTIMATED NET FISCAL IMPACT OF SELECTED REFORMS: REVENUE AND COST COMPONENTS, FY2009
(Dollars in millions)

	Small Group and Individual Guaranteed Issue and Community Rating	Individual Mandate with Affordability Exemption	Individual Mandate with Subsidies	Mandatory Offer of Section 125 Plan	Combined Reforms with Affordability Exemption	Combined Reforms with Subsidies
	(1)	(2a)	(2b)	(3)	(1+2a+3)	(1+2b+3)
Change in State Tax Revenues	**$1.8**	**$0.6**	**$1.3**	**-$83.7**	**-$90.6**	**-$91.5**
Change in individual income tax receipts	$0.0	-$4.8	-$7.3	-$84.7	-$94.2	-$98.6
Change in taxable income	$0.0	-$4.5	-$6.3	-$81.9	-$91.1	-$94.4
Change in income tax receipts from or refunds to MWFC recipients	$0.0	-$0.3	-$1.0	-$2.8	-$3.1	-$4.2
Change in receipts from insurance providers	$1.8	$5.3	$8.6	$1.0	$3.6	$7.1
Change in State Expenditures	**$4.0**	**$521.0**	**$684.0**	**$0.0**	**$570.0**	**$761.0**
Medicaid, GAMC, and MinnesotaCare	$4.0	$521.0	$559.0	$0.0	$570.0	$628.0
Affordability subsidies	N/A	N/A	$125.0	N/A	N/A	$133.0
Net Fiscal Impact	**-$2.2**	**-$520.4**	**-$682.7**	**-$83.7**	**-$660.6**	**-$852.5**
Estimated net fiscal impact per person newly insured (dollars)	*-$94*	*-$1,886*	*-$1,831*	*-$1,390*	*-$2,666*	*-$2,341*

Source: Mathematica Policy Research.

Notes: Net fiscal impact is calculated as the change in State tax revenues minus the change in State expenditures. The number of newly insured persons is estimated as the change in the number of Minnesotans under age 65 who are uninsured.

Not surprisingly, a mandate with subsidies would have a larger net fiscal impact than a mandate with affordability exemption. The estimated net fiscal impact of a mandate with exemptions (-$520 million) would be 24 percent less ($162 million) than that of a mandate with subsidies (-$683 million). The percentage difference between net fiscal impact of the combined reforms with exemptions (-$661 million) and the combined reforms with subsidies (-$853 million) is similar, but of course the magnitude of the difference ($192 million) is greater.

However, an alternative calculation—the net fiscal impact per person estimated to gain coverage—suggests that consideration of subsidies may in fact be the more cost-effective option. Among those who would gain coverage (net of any coverage loss), the per-person net fiscal impact of a mandate with subsidies (alone) is about 3 percent less than that of a mandate with an affordability exemption ($1,831 per person versus $1,886). In combination with other reforms, the difference is still greater: $2,341 per person for a mandate with subsidies versus $2,666 per person when affordability exemptions are allowed, or about 14 percent.

The incidence of the change in the components of net fiscal impact among Minnesota families at different levels of income is reported in Table VI.2. Both small group and individual guaranteed issue and community rating and a mandatory Section 125 offer could be viewed as a "middle class" benefits. While the net fiscal impact of guaranteed issue and community rating of small group and individual coverage is consistently very small, it mostly would benefit families with income above 400 percent FPL. In contrast, the net fiscal impact of a Section 125 mandate is much larger. An estimated 83 percent of the net fiscal impact of a Section 125 mandate would directly benefit families with income above 250 percent FPL, and 62 percent of the net fiscal benefit from these reforms would directly benefit families with income above 400 percent FPL. That being said, families at lower levels of income but above the poverty line also would benefit from a Section 125 mandate, especially in light of increases in the MWFC that lower-income families would receive by paying premiums pre-tax. However, their net fiscal benefit is much less than that for families with more income.

An individual mandate with an affordability exemption also would primarily yield net fiscal benefit for higher-income families, as premium payments reduce state income tax liabilities for these families. In contrast, individual mandates with subsidies would predominantly benefit lower-income families: 90 percent of the benefit would accrue to families with income below 250 percent FPL.

Similarly, when combined with other reforms, the net fiscal benefit of an individual mandate with subsidies would flow largely to low-income families, but higher-income families also would benefit from new availability of Section 125 plans under the combined reforms. An estimated 59 percent of the net fiscal benefit of the combined reforms with subsidies would accrue to families with income below 250 percent of poverty, and 41 percent of the net fiscal benefit would accrue to higher-income families.

Finally, it is worth noting that these estimates of fiscal impact are static: they do not consider the broader economic effects that would result from increased expenditures for health insurance and health care services, and additional federal funding for state programs. A more dynamic approach (such as the state's economic model likely uses) might find that addition of federal funding, in particular, would increase the state's economic base—generating greater revenues than our estimates account for. In turn, net fiscal impacts could be somewhat smaller than is estimated.

TABLE VI.2

INCIDENCE OF THE ESTIMATED CHANGE IN INDIVIDUAL INCOME TAX RECEIPTS AND EXPENDITURES FOR THE MINNESOTA WORKING FAMILY CREDIT AND AFFORDABILITY SUBSIDIES, FY2009
(Dollars in millions)

	Small Group and Individual Guaranteed Issue and Community Rating	Individual Mandate with Affordability Exemption	Individual Mandate with Subsidies	Mandatory Offer of Section 125 Plan	Combined Reforms with Affordability Exemption	Combined Reforms with Subsidies
	(1)	(2a)	(2b)	(3)	(1+2a+3)	(1+2b+3)
Change in Individual Income Tax Receipts (revenue)						
< 100% FPL	$0.0	$0.0	-$0.1	-$0.8	-$0.7	-$0.8
100-249% FPL	$0.0	-$0.7	-$2.3	-$10.7	-$11.0	-$13.7
250-399% FPL	$0.2	-$1.4	-$1.5	-$17.7	-$22.8	-$23.3
400% FPL +	-$0.2	-$2.4	-$2.4	-$52.8	-$56.6	-$56.6
Change in MWFC (net expenditure)						
< 100% FPL	$0.0	$0.0	$0.0	-$0.3	-$0.2	-$0.2
100-249% FPL	$0.0	$0.3	$1.0	$3.1	$3.3	$4.4
250-399% FPL	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
400% FPL +	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0
Affordability Subsidies (expenditure)						
< 100% FPL	N/A	N/A	$33.3	N/A	N/A	$34.9
100-249% FPL	N/A	N/A	$81.7	N/A	N/A	$81.9
250-399% FPL	N/A	N/A	$9.8	N/A	N/A	$15.9
400% FPL +	N/A	N/A	$0.0	N/A	N/A	$0.0
Net Change						
< 100% FPL	$0.0	$0.0	-$33.3	-$0.5	-$0.5	-$35.5
100-249% FPL	$0.0	-$1.0	-$85.1	-$13.7	-$14.3	-$100.1
250-399% FPL	$0.2	-$1.4	-$11.3	-$17.7	-$22.9	-$39.2
400% FPL +	-$0.2	-$2.4	-$2.4	-$52.8	-$56.6	-$56.6
Percent of Total Net Change:						
< 100% FPL	0.0%	-0.5%	25.2%	0.6%	0.5%	15.3%
100-249% FPL	-9.0%	21.4%	64.4%	16.2%	15.1%	43.3%
250-399% FPL	579.4%	29.2%	8.6%	20.9%	24.3%	17.0%
400% FPL +	-470.4%	49.9%	1.8%	62.3%	60.1%	24.5%

Source: Mathematica Policy Research.

Note: Net fiscal impact is calculated as the change in State tax revenues minus the change in State expenditures.

VII. IMPLEMENTATION ISSUES FOR AN EXCHANGE

Exchanges have been conceptualized and developed as platforms to improve access for small employers and individuals who do not have access to coverage that are portable, choice-based, tax-advantaged, and easy to access. Exchanges can be attractive alternatives for small employers, part-time employees that work for large employers, temporary and seasonal employees, and people purchasing in the non-group market.

This chapter presents discussion and preliminary recommendations for a number of operational and implementation issues associated with an Exchange in Minnesota. Two case studies, Connecticut and Massachusetts, will be used throughout this chapter to illustrate how Exchange-like structures can co-exist with other markets.

This chapter is structured as follows. First, major features of the Connecticut and Massachusetts models are reviewed. Second the potential advantages and disadvantages are presented associated with developing a Minnesota Exchange in a combined individual and small-group market, versus only the individual market. Third, administrative issues are discussed associated with integrating MinnesotaCare into the Exchange in order to facilitate the use of Section 125 plans to pay MinnesotaCare premiums. Fourth, three options for the administrative and governance structure of the Exchange are explored. These options include: 1) a private entity, 2) a quasi private-public entity, and 3) a public entity. Fifth, several of the options for the design and operation of the Exchange are discussed, including eligibility criteria and the types of health coverage that would be offered through the Exchange. Sixth and finally, the costs associated with various administrative functions of the Exchange are described.

Many of the implementation decisions presented and discussed in this chapter must be made in sequence, requiring policymakers to approach development of an Exchange in stages. In this chapter we present the options and issues that must be considered, but do not attempt to structure development stages.

A. OVERVIEW OF CONNECTICUT AND MASSACHUSETTS MODELS

1. Connecticut

The Connecticut Business and Industry Association Health Connections is a private-sector purchasing mechanism. Operated as a division of the Connecticut Business and Industry Association (CBIA) for more than 12 years, Health Connections was one of the first statewide, multi-vendor health insurance purchasing alliances in the country. It serves employers with three to 100 employees and provides choice among plans offered by four participating health insurance companies. Currently, more than 6,000 businesses with 88,000 covered lives participate. Health Connections offers a range of benefits to participating employers. These include a menu of health insurance policies that allows for employee choice. Enrollees need not switch coverage when they change jobs if the new employer also participates in Health Connections. For participating businesses, administration is consolidated and employer contributions are managed across plan options, with employees paying the difference between

the premium for the option they choose and the employer contribution (described further below). In addition, Health Connections offers small employers full-service human resources capability, which includes payroll services and assistance in complying with federal laws like COBRA. This particularly appeals to smaller firms without in-house human resources departments; Health Connection has been particularly successful in the 3-to-25-employee market. This turnkey approach allows small businesses to offer coverage with relatively low administrative burden.

The Health Connections model is intended to stimulate price competition as well as competition among alternative network designs and formularies. To mitigate the potential for adverse selection, Health Connections uses the same rating rules (age, gender, geographic area, family tiers) as those in the small group market and has established a floor of benefits which each of four participating carriers must meet. As a condition of group enrollment, at least 75 percent of eligible full-time employees must participate.

Employers that participate in Health Connections must select either of two suites of plan design options (one more comprehensive than the other) to make available to their employees. Each employer must establish a minimum premium contribution level, equal to at least 50 percent of the premium for the lowest cost plan in the suite. Typically, employers identify a "benchmark" plan of benefits within the suite; that benchmark plan becomes the basis for their premium contribution and monthly premium budget. Employees may choose to enroll in the "benchmark" plan or opt to 'buy up" or "buy down" to an alternative level of benefits within the suite offered. This concept allows employers to establish their premium budget while providing employees the opportunity to choose a plan that best meets their needs. In the general small group market, employee choice is precluded by insurer requirements that a minimum percentage of employees participate in any one plan offered by the employer.

Health Connection's success is attributed to having learned lessons from earlier models and focusing on implementation of best practices. It has maintained a good relationship with businesses, insurers, and brokers; it is small enough to be nimble; and it is willing to adapt to marketplace changes. Health Connection executives report that developing and maintaining a role for brokers was essential in order to gain market share, and that use of the same underwriting, rating, and eligibility rules inside Health Connections as outside has been critical to avoiding adverse selection.

2. Massachusetts

The Commonwealth Health Insurance Connector Authority (the Connector) was established in 2006 as an important part of system-wide reform in Massachusetts. Through a comprehensive law, Massachusetts restructured both how small-group and individual insurance is purchased, sold, and administered; and how public subsidies are delivered. By integrating these two major components, Massachusetts' goal is to cover most of its uninsured residents within several years.

The Connector is an independent, quasi-governmental entity designed to help eligible individuals and small groups purchase health insurance at affordable prices. The Connector is a self-governing, legal entity; it is separate from the state and governed by a 10-member board consisting of private and public representatives. After an initial infusion of $25 million in state appropriations, its operations are funded through retention of a percentage of premiums collected

on the subsidized and non-subsidized (private) products sold through the Connector. The Connector began offering subsidized products in October 2006 and private products in April 2007. The Connector certified for sale seven plans offered by six carriers, signaling to consumers that the approved plans were both comprehensive and affordable.

The Connector makes it easier for businesses to offer insurance to both full- and part-time employees and contractors on a pre-tax basis. To facilitate purchase of coverage with pre-tax dollars, employers (with 10 or more employees) must offer all employees a Section 125 plan (described later in this chapter), regardless of whether the employees are full- or part-time. In addition, the Connector enables individuals to purchase health insurance which meets their needs and which is portable. Portability—that is, the ability to keep one's coverage after leaving a job—is important to consumers, and it is also desirable for the system overall: carriers are encouraged to manage member health proactively because members can stay with carriers longer. In addition, easy consumer access to alternative coverage options offers an incentive for carriers to be more responsive to consumers in order to maintain their market share.

Depending on how small employers wish to purchase through the Connector, employees can be rated as individuals and choose among products; or they can be rated as group with a single product option. Importantly, rating factors are the same both inside the Connector and outside in the marketplace, and for the most part products sold in the Connector can also be sold outside.[18] The law allows only residents in certain circumstances to purchase insurance through the Connector, including:

- Non-working individuals
- Employees of non-offering companies of any size
- Employees of offering companies of any size who are not eligible for benefits (part-timers, contractors, new employees)
- Employees of small businesses (with 50 or fewer employees)
- Sole proprietors

The Connector facilitates pro-rata employer contributions for individuals working for more than one employer and also administers premium assistance for individuals between 150 percent and 300 percent of the federal poverty levels (FPL), and free coverage for those who earn less than 150 percent FPL, but who are not eligible for Medicaid. The Connector improves portability and ensures choice, two features missing from the current small group market in Massachusetts.

[18] Young Adult Products (those products offered to 19-26 year olds) may be sold only in the Connector.

B. BLENDING THE SMALL GROUP AND INDIVIDUAL MARKETS

With the exception of self-insured (also called self-funded) employers, an Exchange ideally would provide access to affordable choice-based coverage for all residents of a state—either through a small employer or on a direct-pay basis. CBIA does not provide access to very small firms or individuals, and thus is missing an important segment of the population that policymakers in Minnesota want to reach with an Exchange. However, CBIA is a private business with a close, natural link to businesses; it makes its own decisions regarding which markets to target. There is nothing to preclude CBIA from selling to individuals or groups smaller than 3, although it would need to consider the differences between Connecticut's rating rules in the small group and individual markets. Importantly, CBIA does sell to firms outside the small group market, to groups of fifty-one to 100. CBIA developed a separate mechanism for rating these larger firms, as the small group laws do not apply to them.

In Massachusetts, where the Connector is a quasi public-private entity established as part of a larger reform plan, both small groups and individuals may voluntarily purchase through the Connector. A separate but important decision to merge the two markets was also part of the reform plan. This decision was made for several reasons. First, policymakers observed that the non-group market was in a death spiral, losing covered lives each year. Average non-group premiums were nearly 40 percent higher than premiums for similar products in the small group market. Second, the small group market already included "groups of one"; policymakers felt it was inequitable for individuals without access to employer-sponsored health insurance to have different product choices and be rated differently from individuals who qualified as a group of one. Finally, preliminary and subsequent analyses convinced public policymakers that it would be feasible to merge the two markets, saving non-group subscribers at least 15 percent on average on their premiums while increasing premiums for small group only slightly, by one to 1.5 percent on average.

Nevertheless, one challenge was to persuade a few carriers whose small group rates could go up more than the average (given their employer mix) not to oppose the legislation. The decision to require individuals to maintain health insurance coverage (individual mandate) played a role in bringing these and other stakeholders together. Carriers recognized that bringing new, healthy lives to the market could potentially offset any small premium increases for small groups.

A number of states require guaranteed issue and adjusted community rating in the small group market, but in most states health underwriting persists. In Massachusetts, given that the two markets would be merged under the larger reform, it followed that the Connector would sell the same products to both small groups and individuals. Policymakers did consider requiring all individuals and/or small business to purchase insurance through the Connector, but there was tremendous resistance from brokers and carriers who wanted purchase through the Connector to be voluntary. While a mandatory program (for individuals, small employers, or both) would have offered maximum flexibility, portability, and convenience for consumers, the political hurdles were too many to overcome.

The decision to merge markets and allow the Connector to offer products in both markets was made somewhat easier by the fact that rating factors in both markets were almost identical. In both markets, adjusted community rating prohibited underwriting of any kind based on health status, and both markets used a fairly tight 2:1 overall compression band with age and geography

as the primary rating factors. The only differences in the rating rules between the markets were the fairly modest rating factors of industry-type and group size. Group size was adjusted when the markets were merged to account for the higher cost of administering plans for smaller groups.[19]

1. Advantages

There are at least two major advantages to providing access to both small group and individual coverage through an Exchange. First, an Exchange must enroll a significant number of covered lives to be a financially viable organization. Exchanges generate revenue from either an administrative fee that is built into the premium, a fee charged to employers for the HR services that the Exchange provides, or both. The fee is a percentage of the premium, usually 3 to 5 percent (in Massachusetts it is 4.5 percent). Therefore, the Exchange requires a certain number of lives to be self-supporting. This is more easily achieved if the Exchange provides services to both individuals and small employers, and an Exchange that can be broadly marketed to the entire population as a source of individual coverage is likely to be more attractive. Second, having the exchange available to both small group and individual purchasers helps workers to move between employment and self-employment more easily—a strong advantage in a dynamic economy.

In 2007, the Governor's health insurance proposal would have required individuals to purchase only through the Exchange. There is an appeal to such a simple approach, and it is likely that mandatory individual participation would not evoke the same resistance from brokers as mandatory small group participation. Requiring individuals to purchase through the exchange has several advantages, including: (1) beginning with a large number of covered lives in the Exchange; (2) known initial medical risk; and (3) the opportunity for the Exchange to "capture" carriers that have served those members. In addition, it would be easier for individuals to access insurance in one place: they could more easily compare benefit plans and prices across options available to them in the Exchange. This could encourage take-up of not only private health insurance, but also other state-sponsored health insurance programs for which people may be eligible if they were offered through an Exchange.

2. Challenges

One of the biggest challenges that states face in implementing an Exchange is resistance from brokers and possibly also carriers, especially if the Exchange is designed to provide an alternative system for selling coverage to small employers. In Massachusetts, there was significant resistance from brokers and carriers to permitting small employers to buy coverage through the Connector. Experience in both Connecticut and Massachusetts (and in other states where similar purchasing pools have failed) has shown that states need to work with brokers and carriers to successfully implement an Exchange. The reasons for this are practical: the

---

[19] The 2006 reforms also changed rating rules to allow insurers to rate individuals and small groups based on smoking status and for participation in wellness programs. The health care reform act imposed a moratorium on legislation of new health insurance benefit mandates through 2008.

Exchange depends on carriers participating; the state can require that carriers participate, but the relationship is likely to be antagonistic if they see no advantage in doing so. Additionally, brokers rely on commissions for their livelihood; they need reassurance that they will be reimbursed for bringing clients to the Exchange, even if somewhat less than if they brought them directly to a carrier.

In both Connecticut and Massachusetts, the Exchanges have financial arrangements with brokers. However, some residual broker resistance remains in Massachusetts, as evidenced by a section in the recently passed technical corrections bill to CH58 (the omnibus Health Care Reform Law):

> "There shall be a special commission to investigate and study the role of the Connector in providing access to health insurance products. The Commission shall examine the Connector's utilization of private sector entities, including insurance brokers and shall investigate ways to promote efficient enrollment of uninsured individuals into health insurance and prevent unnecessary duplications in the market." CH58 Section 28A Chapter 176Q, 15A.

The House version of the bill had included language to prevent the Connector from marketing plans to employers with existing coverage, a provision supported by health insurance brokers and agents. However, the Senate did not endorse that version.

In Minnesota, a second challenge relates to individual purchase exclusively through the Exchange. This could require the state to include for sale in the Exchange all carriers and products that are currently available in the non-group market, a result that would not be desirable if Minnesota wants to be more selective about the number and types of products that the Exchange sells and endorses as "good value." However, if individuals were required to purchase through an Exchange that limits product choices, they might perceive it as limiting choice. Both the Connector in Massachusetts and CBIA in Connecticut limit the number and types of products they offer, and in both states individuals and employers can purchase a non-Exchange product in the regular market.

A third challenge for Minnesota is that the rating rules are different in the non-group and small group markets. While it is easier to blend markets when the rating rules are the same for individuals and businesses, it is not essential. Nevertheless, there are several reasons to synchronize the rating rules in a blended market: First, it is consistent with one of the chief objectives of an Exchange: to facilitate transparency of price and quality and encourage portability. Employees in group plans are pooled, so that they see premiums based on the average demographics of the group. Should the employee leave that job and seek to purchase individual insurance directly, the premium could differ dramatically for essentially the same coverage. If the markets were blended with the same rating rules, the premium would be similar if not the same, whether the coverage is purchased as an individual policy or through an employer group. Second, rating factors that are the same for small businesses and individuals allow cross subsidies across the entire pool, minimizing potential burden and adverse incentives that can occur in smaller pools. Finally, employers that sponsor coverage have additional legal responsibilities that are addressed more easily if employees can obtain the same insurance as

individuals through the Connector for the same premium. (The legal requirements and responsibilities for an employer group plan are discussed in Chapter VIII.)

Finally, with individual purchase only through the Exchange, Minnesota might consider the possibility of integrating its high-risk pool, Alternatively, Minnesota Comprehensive Health Association (MCHA) products could be made available through the Exchange. Alternatively—and specifically in the context of an individual mandate—MCHA could be fully integrated into the Exchange. Current MCHA funding could be used to help offset the risk of high-cost individuals, if not also small group enrollees in the Exchange. For example, this funding could be used to finance a reinsurance system supporting individual and small group coverage alike.

3. Recommendations

If the desire is to sell to both individuals and small groups through the Exchange, as the Massachusetts Connector is designed to do, then Minnesota should begin by *allowing* individuals and small groups to purchase from the Exchange, but *not requiring* either to do so. The Exchange would offer affordable options and choice of plans to employers who want to contribute towards their employees' health insurance. In addition, if Minnesota requires businesses with 11 or more employees to offer Section 125 plans to their employees, it will be easier for employers to move from a noncontributory status (with no other involvement such that the plan would not legally constitute a group plan) to a contributory status (that is, a group plan) without affecting their employees' enrollment in a health plan.

If only individuals purchase through the Exchange, it is unclear how it would be very different from the current non-group market. The tax advantage could be conferred if the state required employers to offer a non-contributory Section 125 plan. There are only a few dominant insurers in the market, and the employer could send pre-tax premium payments to more than one insurer. While this would be administratively more complex for the employer than sending a single payment to an Exchange, with automated payroll systems, it is not out of the question. Further exploration with payroll administrators could help to understand this issue better.

C. MINNESOTACARE IN THE EXCHANGE

Policymakers in Minnesota would like to facilitate pre-tax payment of premiums for MinnesotaCare beneficiaries. To do this, the beneficiary would need to work for an employer who sponsors a Section 125 plan; he or she could not be self-employed. The employer would deduct dollars from eligible employees' paychecks and send them to the single state agency. There is no need for this to be run through the Exchange. This could be implemented today.

1. Advantages

For low-income working families, the advantages of pretax contributions are made more complex by the structure of the federal and state earned income tax credits (see Chapter VI). However, for most families that would both qualify for the tax credits and purchase MinnesotaCare coverage, the combined earned income tax structure (with both credits phased out at higher levels of income) probably would magnify the advantages of pre-tax contributions

to coverage. In any case, with appropriate tax guidance, there is no reason that MinnesotaCare beneficiaries (if employed) should not also benefit from the pre-tax payment of premiums.

The tax savings could accrue entirely to the beneficiary, making MinnesotaCare premiums more affordable. Alternatively, Minnesota policymakers could raise premiums, sharing the savings with beneficiaries. This would bring additional funding to the program that might be used to further subsidize some enrollees, expand eligibility, or provide more comprehensive benefits—depending on the State's policy objectives.

2. Challenges

The biggest operational challenge to pretax payment of MinnesotaCare premiums would be the administrative complexity for firms that employ beneficiaries. Individuals are eligible for MinnesotaCare only if they do not have access to employer-sponsored health insurance for which the employer pays at least half of the premium. Consequently, most MinnesotaCare enrollees, if working, either are not offered employer-based coverage or they are not eligible for the coverage when offered—typically because they are part-time or temporary employees.

Employers that do not sponsor coverage can nevertheless set up a Section 125 plan for their employees, whether full-time or part-time. When a MinnesotaCare beneficiary works in a firm that offers coverage, but belongs to an employment class (e.g., part-time workers) that is ineligible, the employer could set up a Section 125 plan for this class of employees. However, either could be perceived as additional administrative burden, and the state would most likely need to mandate that employers do so. An employer or employer group could challenge this requirement, especially if it related only to MinnesotaCare beneficiaries. The initiative would make more sense if it were coupled with a requirement that all employers offer Section 125 plans to all employees—not only MinnesotaCare beneficiaries—for the purpose of pre-tax payment of premiums.

Minnesota authorities would need to set up a means to accept premium payments from employers. An Exchange would not make these administrative tasks easier: either a state agency or an Exchange would need to build the same functionality. However, an Exchange could accept pre-tax payments from employers for all employees (MinnesotaCare and non-MinnesotaCare), easing the burden especially on employers that offer noncontributory Section 125 plans to all employees. If the Exchange already is working with complex situations (such as employees working for multiple employers), it may make more sense for the Exchange to administer this function coordinating with the single state agency for eligibility processing.

3. Recommendations

To include MinnesotaCare enrollees in the Exchange, it would be important for Minnesota policymakers to move forward with a plan to require employers of a certain size to offer Section 125 plans to their employees. Since relatively few Minnesota employers currently offer Section

125 plans, it might be advisable to phase-in such a requirement.[20, 21] Minnesota could set the target dates for implementation in statute and then work to help employers of various sizes implement the requirement.

Minnesota would need to legislate a requirement that employers also make available their Section 125 plans for payment of MinnesotaCare premiums by beneficiaries not enrolled in the employers' group health plan. Depending on the number of employed workers enrolled in MinnesotaCare, Minnesota policymakers could begin with employers who now have at least one employee enrolled in MinnesotaCare—although either the program or the employee would need to make employers aware of their participation in the program. This would involve outreach to employers as well as administrative assistance to enroll employees in Section 125 plans.

D. OPTIONS FOR THE ADMINISTRATIVE ENTITY

This section considers the administrative entity that would house the Exchange. The Exchange will need the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, confirming eligibility, billing premiums, monitoring employer contribution, reconciling payments, developing and maintaining a website, payment of commissions, broker training, ongoing marketing and outreach, and electronic interface. The Exchange may either make or buy these capacities, or it may partner with state agencies. These decisions will depend in large part on the administrative option that Minnesota chooses, available funding and the timetable for implementation.

There are potentially three administrative options for Minnesota to consider: (1) a private market entity; (2) a quasi public-private entity; or (3) a fully governmental entity (such as the organization that purchases for state employees). Each is discussed below.

1. Private Market Entity

This option would be similar to path taken in Connecticut—although in Connecticut, the state did not initiate the effort and neither enabling legislation nor financial assistance in start-up were required.

Advantages. Small businesses would likely trust an entity that already works with them and is not a state-run program. The business could offer administrative services beyond health insurance such as life insurance, short and long term disability, worker's compensation insurance, dental insurance, as well as administrative assistance in meeting requirements related

[20] In Minnesota, an estimated 64 percent of employers that offer self-insured coverage, and nearly 40 percent that offer insured coverage, also sponsor a Section 125 plan as a means by which employees can pay their share of premiums pre-tax (unpublished estimates provided by the Agency for Healthcare Research and Quality, tabulated from the combined 2003-2005 Minnesota sample of the Medical Expenditure Panel Survey—Insurance Component). Because the offer of coverage is more common in large firms than in small, large firms are much more likely to offer Section 125 plans currently.

[21] In Massachusetts, it was estimated that 80 percent of employers with more than 50 employees offered pre-tax payment of premiums, compared with 45 percent of employers with two to 50 employees.

to Section 125, COBRA, and IRS provisions related to health savings accounts (HSAs) or health reimbursement accounts (HRAs). In short, it could provide one-stop shopping for small business human resources functionality. CBIA does exactly this for small businesses in Connecticut. This model has been successful in meeting the limited objectives of providing health plan choice to small-firm employees, assisting small employers with the paperwork required to establish a Section 125 plan, and promoting competition in the small group market.

Challenges. In a private-sector model, the Exchange would operate as a private business that is responsible for all policies and decision-making—including decisions regarding eligibility, what products would be offered, and how much choice would be allowed. The state would have very little, if any, say in how these decisions were made. If the priorities of a private-sector organization do not align well with those of policymakers, it is more difficult to integrate roles that are viewed as "state responsibilities." Thus, it might be more difficult to bring MinnesotaCare into an Exchange that operated as a private-sector business. For the same reason, a private-sector model might not be ideal if Minnesota envisions a subsidy program at some later date, although it would not be prohibitive.

2. Quasi Public-Private Entity

This model would look similar to the Connector model in Massachusetts, although arguably the Massachusetts model became more public than private in the course of its development. The idea behind this approach was that it would be governed by a board comprised of several senior-level state officials and a number of outside experts appointed by the Attorney General and Governor—thereby maintaining balance in decision-making. This governing structure has been somewhat problematic during the first 18 months of operation. The Connector is required to make decisions that will sustain it as a business. At the same time, it was assigned to make policy decisions for state health care reform that sometimes were in conflict with its business needs.

How the Connector board determined standards for minimum creditable coverage and also qualified plans for sale through the Connector offers an example of how this conflict can ensue. The Connector was charged with determining health plan benefits that constitute minimum creditable coverage for compliance with the individual mandate. The Connector also has a role in selling insurance, and the board of the Connector did not want to sell insurance at the lowest level that constitutes minimum creditable coverage. Consequently, lower-cost plans are now available on the market, but are not offered through the Connector. From a business perspective, this is not sensible: some consumers will look for the lowest cost plan to comply with the individual mandate, and the Connector will lose that business. Recognizing that conflicts exist between making decisions that are good for the business and serving the policy goals of the state, there probably should be a separation of tasks allocated to the Connector.

Advantages. A quasi public-private structure could provide the balance between decision-making and responsibility that Minnesota would like to have. It might be perceived as sufficiently outside the state system to be more agile and business-friendly. It could maintain some independence but still attend to the State's priorities, since it would still be "part" of the state system. The board governance structure could allow the state to have some say in how policy decisions are made with respect to choice, eligibility, product availability, and

affordability. Some of the functionality that the Exchange would require probably exists in other state agencies (such as Medicaid), and a quasi public-private structure could facilitate use of that capacity. It would make sense to inventory the capacity available to determine whether some savings could be found by "buying" services from state agencies.

Challenges. A quasi public-private structure would require an infusion of funding for start-up. Moreover, the state could be responsible should the entity become unsustainable going forward. While the Exchange (depending on its functions) might not require as much funding as was provided to the Massachusetts Connector, it remains true that no single agency can be fully responsible for both meeting the business needs of the Exchange and pursuing the policy goals of the state. If Minnesota considers this option, off-line candid discussion with Connector staff is recommended to determine how well this administrative structure is working and what changes they would suggest to other states considering this type of governance structure.

3. Fully Governmental Entity

This is an appealing approach because of the knowledge and administrative capacity around managing health insurance purchases for state employees. Although this discussion could pertain to any governmental agency, the Minnesota Department of Employee Relations (DOER) might be the most likely public entity that could adapt its current responsibilities to include the additional responsibilities of an Exchange. However, with the exception of a relatively small number of enrollees, the DOER does not currently have the administrative capacity to collect premiums from individuals and small businesses. Thus, significant capacity building would need to occur. The Exchange would need to operate separately from the DOER risk pool, increasing complexity for DOER.

Advantages. The start-up costs of an Exchange would be lower if it was built upon an existing infrastructure, and some capacity to operate an Exchange already exists in the business of purchasing insurance and managing other benefits for state employees. In addition, the state could take credit for the initiative and easily build other reforms onto it.

Challenges. If DOER operated the Exchange, there could be pressure to blend the Exchange and state employee risk pools. The Exchange is not a purchasing pool *per se*, but unless all small employers purchased through the Exchange, bifurcating the market in this way could cause problems. Furthermore, the DOER has no experience working with the small business community that would either indicate a natural fit or support trust. Finally, some of the skills required to set up a "business" may not exist within state government, and adequately managing a contract to obtain such skills might not be possible.

4. Recommendations

Minnesota's history of state involvement with health care reform efforts is not dissimilar from Massachusetts. Massachusetts struggled with the decision of governance and ultimately decided on a quasi private-public structure. Minnesota, too, might find a quasi private-public structure for the Exchange to be the best fit.

Minnesota policymakers will need to determine how much policy-making responsibility should reside in the Exchange. Policy decisions regarding eligibility or product design could be laid out in legislation or assigned to a governmental agency such as the Department of Health to decide.

It will be important for Minnesota to consider what expertise and input the Exchange needs to make the decisions assigned to it, and balance the board between ex-officio members and appointees accordingly. The choice of an executive director is crucial: the staff of the Exchange will be responsible for developing the materials to which the board members respond, and thus they will help shape the discussion and policy direction of the Exchange.

E. OTHER IMPLEMENTATION AND OPERATIONAL ISSUES

The operation of an Exchange will entail a number of first-order decisions, including the number of plans that will be available through the Exchange, how to manage risk and risk selection among plans, eligibility to purchase through the Exchange, and the role of agents and brokers. Each is discussed below.

1. Number of Plans

Both Connecticut and Massachusetts restrict the number of plans participating in Health Connections and the Connector, respectively. The reasons for this include a desire to promote competition and reduce confusion in the marketplace.

It makes sense to limit available plans to those with meaningful differences in cost sharing, network design and/or formularies. Exactly how Minnesota should limit or require the number of plans will depend in part on the level of competition in the current marketplace and the number of carriers in the market.

What number and type of plans should be offered through the Exchange and the extent to which these plans should be available for purchase only through the Exchange are decisions that are difficult to make without having answered some of the larger questions about the Exchange that are still outstanding—such as whether both small groups and individuals would purchase through the Exchange, and whether the Exchange would be the exclusive source of coverage for them. Minnesota policymakers also will need to determine whether, and the extent to which, Exchange products will be standardized. Both Connecticut and Massachusetts have standardized plans to a certain extent in Health Connections and the Connector, respectively. When making this decision, policymakers will need to balance the objective of providing choice with the challenge of managing risk selection.

2. Choice and Risk Management

While there are no clear answers about how to manage risk-selection in an Exchange, history provides some guidance on this issue. In the early 1990's, health purchasing cooperatives such as the Health Insurance Plan of California (HIPC), pooled small employers to bargain for lower premiums (if not also to achieve some of the efficiencies of larger groups), but

they were unable to achieve lower premiums without underwriting.[22] In contrast, Connecticut and Massachusetts do not allow carriers to pool individuals and small groups inside the Exchange separately from those outside the Exchange: the rating rules for products sold in the Exchange are the same as for those outside, and products sold both in the Exchange and outside pool risk across both markets.

To mitigate risk selection, it is essential—first and foremost—to have the same rating rules and mandatory benefits for products both inside and outside the Exchange. Although it is appealing to establish new rules for products offered through the Exchange—for example, allowing products offered through the Exchange to exclude mandatory benefits—this will ultimately lead to fragmentation of the small group market and create selection issues.

An individual mandate, requiring all residents to obtain coverage, may help the Exchange avoid selection problems overall. However, it is unlikely to avert problems of selection that may arise between plans in the Exchange. If coverage through the Exchange is voluntary, it may help to have some standardization of plans to avoid risk selection within the Exchange. However, a mandatory, self-supporting reinsurance risk pool or system of risk adjustment could address many of the concerns that carriers will have in selling coverage through a voluntary Exchange. If Minnesota takes this course, it will be important to have the carriers contribute to the design of this mechanism, consistent with clear policy objectives. Massachusetts is assessing methods for risk-adjustment within the Connector plans but has not implemented such a process to date.

Finally, both Connecticut and Massachusetts have limited small-group employee choice to selection within a suite of plans. This helps to ensure that younger, healthier lives do not enroll predominantly in high-deductible plans, leaving sicker, higher-risk enrollees predominantly in more comprehensive plans. However, it does not provide for as much choice as some policymakers desire.

3. Eligibility

Minnesota policymakers will need to decide whether certain types of employers or individuals may be required to purchase through the Exchange or, conversely, whether some are ineligible to do so. In Connecticut, CBIA allows employers with 3 to 100 workers to purchase through Health Connections, but its niche market is in employers of 3 to 25. The Connector allows individuals without access to employer insurance and small businesses with 50 or fewer employees to join, but individuals must join only in order to receive subsidies or to purchase a Young Adult Plan. Recognizing that the Exchange must achieve a sustainable size, the eligibility criteria should correspond to the problems Minnesota is trying to solve and the populations it is attempting to reach. Decisions about risk selection and crowd-out should depend on the objectives of reform.

In Massachusetts and Connecticut, both the Connector and Health Connections require a minimum employer contribution of 50 percent for group participation. However, in

[22] COSE, the small business division of the Greater Cleveland Partnership, is an example of a private Exchange that underwrites applicants. It enrolls approximately 17,000 small groups and groups of one.

Massachusetts, a small employer can set up a Section 125 plan with no contribution or a contribution that is less than 50 percent of the benchmark premium to help employees buy individual policies through the Connector. In Connecticut, Health Connections also requires that 75 percent of eligible employees must enroll—the same minimum participation rule that carriers use in the market – to avoid adverse selection in the small employer market. Massachusetts has not yet decided on participation rate requirements; in light of the individual requirement to maintain health insurance (reducing the potential for adverse selection), it is proposed that there be no minimum participation rule in the Exchange.

4. Role for Brokers

Brokers may view an Exchange as competition for the services they provide to businesses. However, in many cases, it is hard to identify what businesses pay for these services. In most states, a broker fee is built into the small group premium rate that small employers pay (typically 3 to 5 percent of premium), whether or not a broker is used. An Exchange could encourage greater transparency for this transaction. While an Exchange probably would require a similar fee for administrative services, it would deliver greater value: small employers will be provided choice of plans for their employees, the ability to budget their contributions, assistance with Section 125 plan administration, and other services. In Connecticut and Massachusetts, Health Connections and the Connector respectively pay brokers a commission for bringing them business, but they keep most of the fee for administration of the account. Thus, the broker transaction and fee are fully transparent. Over time, brokers' fees could be separated from the rate, with the market determining the cost of their services.

F. OPERATING COSTS

Recent experience in Massachusetts provides useful insights about the potential start-up and ongoing budgetary requirements of the proposed Exchange. In this section, start-up and projected expenditures in Massachusetts are identified by main functional area.

1. Initial Capitalization

The Connector was initially capitalized with a $25 million investment from the General Fund, as authorized in legislation. It is expected that ongoing operating revenues will be generated from enrollment. As mentioned earlier, the Connector captures a percentage of all health insurance premiums, including premiums for subsidized products.

2. Operating Budget

While budget projections for the first year of operation (state fiscal year 2007 beginning July 1, 2006) assumed a net loss of $18.0 million, the Connector ultimately ran a smaller net loss—$14.7 million—in the first year. The Connector obtained a commercial line of credit to help with short-term cash flow.

Table VII.1 displays the Connector's administrative budget with both the original and projected year-end figures, based on the following Commonwealth Care enrollment assumptions:

- All eligible recipients under 100 percent FPL (approximately 50,000 persons) would be enrolled at the beginning of the fiscal year
- Most eligible recipients between 100 and 300 percent FPL (75,000 persons) would be enrolled by December 2007
- 35,000 Commonwealth Choice Members would enroll by year-end
- Projected Connector revenue of $1.6 million, net of intermediary fees.

TABLE VII.1

START-UP COSTS FOR COMMONWEALTH CONNECTOR AUTHORITY, FY2007

	Original Budget	Projected Year-End Budget	Variance
Operating Revenues:			
CommonwealthCare administrative fee	6,163,243	6,241,214	77,971
Total operating revenue	6,163,243	6,241,214	77,971
Operating Expenses:			
Salary and benefits	3,393,917	2,524,595	869,322
Appeals Department	1,003,103	-	1,003,103
General and administrative	70,920	108,668	(37,748)
Marketing and advertising	5,050,000	2,771,460	2,278,540
Maximus	4,364,968	5,269,946	(904,978)
MassHealth	5,910,592	5,940,269	(29,677)
CSC (web design)	700,000	700,000	-
Consulting and professional support	2,056,091	2,538,635	(482,544)
Facility and related	330,862	481,114	(150,252)
IT and communications	299,820	593,290	(293,470)
Decision support tool	1,000,000	-	1,000,000
Total operating expenses	24,180,273	20,927,976	3,252,297
Net Operating Loss	(18,017,030)	(14,686,762)	3,330,268

Source: Patrick Holland, Connector CFO.

Compared with the Massachusetts Connector, the Minnesota Exchange will likely experience significantly lower expenses in at least three areas: (1) eligibility processing (MassHealth); (2) enrollment, outreach and customer service (Maximus), and (3) administration of subsidies (CommonwealthCare). In addition, the marketing budget for the Connector's first year was larger than would be expected for launching a Connector model alone; depending on the expansiveness of Minnesota's final reform proposal, the Exchange could experience lower marketing costs.

Primarily, timing issues caused the variances for salaries and benefits, appeals, and marketing and advertising noted in Table VII.1. The higher variance in consulting and professional support reflected the legal resources that the Section 125 regulations and health plan

negotiations entailed. If Minnesota has access to these legal resources within its state agencies, these costs also could be reduced. In addition, if the Exchange operates as a private organization, it would not be the responsibility of the state to provide initial capitalization; in Connecticut, the CBIA received no start-up funding from the state.

Alternatively, operating strictly as a public entity could provide ongoing savings in the area of salaries, as states typically can hire staff at lower salaries than are characteristic in the private sector or quasi-governmental agencies (Table VII.2). Connector staff members earn substantially more (an estimated 50 to 100 percent, on average) than similarly positioned staff in state agencies. In addition, there may be some savings to be found if other agencies have excess capacity to assist the Exchange with functions such as appeals, IT, and general and administrative functions.

TABLE VII.2

ONGOING REVENUE AND EXPENSES FOR CONNECTOR

	Projected Year-End, FY07	Recommended, FY08	Change	Percent Change
Operating Revenues:				
CommonwealthCare	6,241,214	22,567,742	16,326,528	2.6%
CommonwealthChoice	–	3,211,832	3,211,832	N/A
Total operating revenue	6,241,214	25,779,574	19,538,360	3.1%
Operating Expenses:				
Salary and benefits	2,524,595	5,861,248	(3,336,653)	1.3%
Appeals department	–	685,500	(685,500)	N/A
General and administrative	108,668	182,840	(74,172)	0.7%
Marketing and advertising	2,771,460	4,857,770	(2,086,310)	0.8%
Maximus	5,269,946	5,865,957	(596,011)	0.1%
MassHealth	5,940,269	6,014,875	(74,606)	0.0%
CSC (web design)	700,000	670,150	29,850	(0.0%)
Intermediaries	–	1,587,360	(1,587,360)	N/A
Consulting and professional support	2,538,635	1,795,000	743,635	(0.3%)
Facility and related	481,114	815,000	(333,886)	0.7%
IT and communications	593,290	397,229	196,061	(0.3%)
Total operating expenses	20,927,977	28,732,929	(7,804,952)	0.4%
Net Operating Loss	(14,686,763)	(2,953,355)	11,733,408	(0.8%)

Source: Patrick Holland, Connector CFO.

VIII. LEGAL ISSUES FOR MINNESOTA

While states are the principal regulators of health insurance coverage, a number of federal laws and standards apply.[23] As Minnesota policymakers contemplate health care reform initiatives, these federal laws must be considered. Absent carefully structured reforms, state efforts may be challenged as being preempted, result in unintended federal tax consequences for employers and workers, or both.

For private market reforms (applicable to private coverage offered to individuals and/or private employers), the principal federal laws to consider include:

- The Employee Retirement Income Security Act of 1974 (ERISA);[24]
- The Health Insurance Portability and Accountability Act of 1996 (HIPAA),[25] amending ERISA, the Internal Revenue Code (Code), and the Public Health Service Act (PHSA);
- The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), amending ERISA and the Code (and continuation requirements in the PHSA applicable to governmental plans); and
- Three federal coverage standards that may apply—the Newborns and Mothers Health Protection Act of 1996, the Mental Health Parity Act of 1996, and the Women's Health and Cancer Rights Act of 1998.

Generally, these federal laws establish certain minimum standards for health coverage obtained as an employee benefit. Some standards apply even when state insurance laws regulate coverage. ERISA limits the scope of state-based health coverage reforms; if not properly addressed, ERISA and HIPAA especially may give rise to preemption challenges to state reforms.[26] In addition, due to the federal tax issues that job-based benefits raise (e.g. "Section 125 Plans") employers and workers may face financial penalties, and in some cases back taxes in addition to fines, when such plans are not properly established and structured.

---

[23] See: Mila Kofman and Karen Pollitz, Health Insurance Regulation by the States and the Federal Government: A Review of Current Approaches and Proposals for Change. Journal of Insurance Regulation, Vol. 24 No. 4, pages 77–108 (Summer 2006).

[24] In addition to ERISA and the Code, other federal laws apply to private employers and to health coverage they provide, including the Americans with Disabilities Act, the Pregnancy Discrimination Act, Family Medical Leave Act, USERRA, and others that should be considered but are not discussed in this analysis.

[25] In addition to coverage reforms, HIPAA included standards for privacy, administrative simplification, long-term care insurance, new fraud and abuse penalties, and other reforms. These are beyond the scope of this analysis.

[26] For additional information see: Mila Kofman, Health Care Reform: Recommendations to Improve Coordination of Federal and State Initiatives. Testimony before the U.S. House of Representatives Committee on Education and Labor, Subcommittee on Health, Employment, Labor and Pensions, May 22, 2007 (http://edlabor.house.gov/hearings/help052207.shtml, accessed March 1, 2008).

This chapter summarizes some key considerations related to ERISA, HIPAA, COBRA (both under ERISA and under the Code), and the Code (Section 125 Plans). It is not intended to serve as legal advice or tax advice. Key points of the chapter include the following:

- To avoid a preemption challenge under HIPAA, policymakers should ensure that state insurance laws are at least as protective of consumers as those under HIPAA for job-based and individual coverage.
- For employers, HIPAA's requirements are triggered when there is a group health plan. Generally, employer contributions result in a group health plan, but even in the absence of employer contributions there may be a group health plan if the employer has more than minimal involvement. The courts (in the course of a lawsuit, the U.S. Department of Labor (DOL) or the IRS) can review the facts and make a finding that there is a group health plan.
- Potential vulnerabilities to preemption include standards for: (1) non-discrimination in access and rates; (2) portability including preexisting condition exclusions; (3) special enrollment rights; and (4) other state standards applicable to individual health insurance policies that would be considered "group health plan" coverage under federal law. In Minnesota, HIPAA non-discrimination standards seem most likely to be triggered, due to differences in current state standards for individual coverage (which could be funded from a Section 125 plan) and HIPAA standards for group plans. Without standards that are at least as protective of consumers as HIPAA, the state would be exposed to a potential preemption challenge.
- Minnesota policymakers should seek ways to minimize the risk that the IRS would find employers in violation of the HIPAA or COBRA provisions in the Code. Because the Code defines a "group health plan" more broadly than ERISA, it is possible to have a group health plan under the Code but not under ERISA. For instance, when an employer offers a Section 125 Plan, an employer's obligations under COBRA (depending on employer size) may be triggered. Even absent a Section 125 Plan, HIPAA and COBRA obligations would be triggered when an employer's contribution to individual coverage or other involvement results in a group health plan. An employer that violates the Code could face significant financial penalties. One way to minimize the risk of unintentional violations would be to assume that HIPAA and COBRA obligations would exist, and to modify state law to reflect HIPAA and COBRA standards.
- When Section 125 Plans are incorporated into state-based health care reforms, efforts should be made to minimize the risk of non-compliance with the Code—perhaps especially with respect to resource-constrained small businesses. For example, state policymakers might consider providing model plan documents, as well as ways to help ensure that employers actually adhere to plan documents in administering the Section 125 Plan.

A. ERISA

Enacted in 1974, the Employee Retirement Income Security Act (ERISA) regulates job-based health and pension benefits. ERISA directly and indirectly affects states' ability to reform their health care marketplace. It limits options and imposes risks that are hard to assess when considering state-based broad and comprehensive health care financing reforms.[27]

ERISA explicitly exempts the regulation of insurance from its broad preemption, allowing states to regulate health insurance products and companies that sell coverage to ERISA plans. However, employers that self-insure (or "self fund") are not subject to state insurance laws. Self-insurance means that an employer is responsible for paying medical claims of workers and their dependents, although they may (and often do) use a third-party administrator to help them process claims and may also buy "stop loss" coverage to limit their risk. Otherwise, when an employer buys health insurance for its workers, it is "fully-insured" and the insurance company (not the employer) is obligated to pay medical bills.

ERISA broadly preempts state laws that "relate to" an "employee benefit plan." Not all state laws have been found to "relate to" an ERISA plan, but recent state reforms that require employers to contribute to workers' health benefits have been found preempted. Of particular note:

- A federal district court decision found that ERISA preempted a New York county law requiring employers to contribute to their employee's health care costs (Retailer Industry Leaders Association v. Suffolk County, 06 CV 00531; U.S. District Court Eastern District of NY, July 14, 2007).
- A federal court of appeals decision found ERISA preempted Maryland's fair share law (Retailer Industry Leaders Association v. Fielder, 475 F.3d 180 (4th Cir. 2007).

These cases demonstrate that even well crafted laws designed to avoid ERISA preemption can be challenged successfully.[28] They also show how ERISA limits certain state options for financing health care. Policymakers considering reforms that reflect an expectation of employers contributing to their worker's health coverage must carefully construct new laws to avoid or minimize the risk of an ERISA-based challenge.

---

[27] For a comprehensive analysis of ERISA and state authority to reform health care coverage and financing see, Patricia Butler, ERISA Preemption Manual for State Health Policymakers. State Coverage Initiatives, Alpha Center and National Academy for State Health Policy, January 2000 (http://www.statecoverage.net/pdf/erisa2000.pdf, accessed March 1, 2008).

[28] Because policymakers in Minnesota are not considering an employer contribution as part of the state's reforms, we do not discuss this in detail.

B. HIPAA

1. Background

HIPAA established standards for both employer-sponsored (or group) coverage and individual health insurance. [29] With respect to group coverage, HIPAA's requirements apply to all private employers with at least two employees as long as there is a "group health plan," even when an employer buys a state regulated insurance product.

Under HIPAA, group health plans may not discriminate based on factors related to health-status. This means group health plans cannot exclude employees or their dependents or charge higher rates based on such considerations as health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability. Insurers, however, may charge employers different rates, subject to state insurance law.

HIPAA also established standards for when a group health plan may apply a preexisting condition exclusion period to an employee (or dependent) with a medical condition. Under HIPAA, group health plans may exclude coverage of any medical condition that was present within 6 months of enrollment (or if a waiting period, the first day of the waiting period, typically first day on the job) for up to 12 months (18 months for late enrollees). In addition, group plans must reduce the exclusion period by prior creditable coverage as long as there was no significant break (63 days or more under federal law); and they may not apply a preexisting condition exclusion period to pregnancy or genetic information (absent a diagnosis).

Finally, HIPAA requires group health plans to offer employees and dependents special enrollment opportunities related to events such as childbirth, adoption, placement for adoption, marriage, and loss of other coverage.

HIPAA also established federal rights to access individual health insurance for people leaving job-based coverage. To qualify (that is, to be "HIPAA eligible"), a person must:

- Have at least 18 months of prior creditable coverage (aggregated), the last of which was through a group health plan (even if it was only one day) and without a significant break in that coverage;
- Elect and exhaust COBRA or state "mini-COBRA" if applicable;
- Not be eligible for public insurance like Medicare or Medicaid; and
- Not be eligible for another group health plan**.**

HIPAA-eligible people have the right to buy an individual health insurance policy. In other words, insurers may not deny coverage to anyone who is HIPAA eligible (a provision called

[29] For a more details about HIPAA, see Public Law No.104-191**.**

"guaranteed issue"), nor can they apply a preexisting condition exclusion period. HIPAA does not establish standards for how insurers set rates, however.

HIPAA allows states broad flexibility in implementing the guaranteed issue requirement. For example, guaranteed issue may be available through a high-risk pool. In Minnesota, the Minnesota Comprehensive Health Association (MCHA) is the HIPAA mechanism for individual market access. HIPAA also requires that all job-based and individual health insurance be guaranteed *renewable.* That is, insurers can non-renew or cancel coverage only for specified reasons like non-payment of premium, fraud or misrepresentation, or employers not meeting contribution or participation requirements as allowed under state insurance law.[30] These requirements and protections apply to all private employer groups (with at least two employees), even when an employer buys a state regulated insurance product.

2. Application of HIPAA

The application of HIPAA is complicated because it amended several federal statutes, some of which apply to different types of employers.[31] The PHSA also applies to insurers. Furthermore, in some cases an employer (or the group health plan) may have obligations under more than one federal statute (such as ERISA and the Code). In determining HIPAA's application, it is important to remember the following:

- For private employers, generally HIPAA obligations are triggered when there is a "group health plan."
- Definitions of "group health plan" are slightly different in ERISA and the Code—both of which apply to private plans and employers, respectively.
- The PHSA applies to non-federal governmental plans state government and insurers. Thus, group health plans sponsored by state or a local government employers for their employees are subject to HIPAA's requirements. However, HIPAA allows self-funded governmental plans to opt-out of most coverage requirements in HIPAA.

The courts (in the course of a lawsuit), the U.S. Department of Labor (DOL), and/or the IRS can review the facts and make a finding that there is non-compliance with HIPAA's requirements. This includes making a determination of whether there is a group health plan. In addition, insurers must comply with applicable requirements. Because the state's insurance regulators enforce the state's law implementing HIPAA, they also may make a determination of HIPAA compliance.

[30] For a complete list, see PHSA, Title XXVII, sections 2712 and 2792.

[31] For example, ERISA applies to group health plans sponsored by private employers while the PHSA applies to group health plans sponsored by governmental employers.

a. ***ERISA definition of a "group health plan"***

Under HIPAA amendments to ERISA (Part 7), a "group health plan" is an "*employee welfare benefit plan* providing medical care … to employees or their dependents directly or through insurance, reimbursement or otherwise."[32] ERISA defines "an employee welfare benefit plan" (in part) as "any plan, fund or program…established or maintained by an employer…to the extent that such plan…was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise…medical, surgical, or hospital care or benefits…."[33]

Determination of whether there is a group health plan depends on a "facts and circumstances" standard under ERISA. Generally, when an employer contributes any amount to coverage, there is a group health plan. This is the case even when employees purchase individual health insurance policies (the policyholder is the individual employee). *When an employer contributes to the premium of individual health insurance policies, the policies will be viewed as part of an employer's group health plan.*

Absent a financial contribution, the courts and DOL will look at the extent of the employer's involvement to determine whether there is a group health plan. If the employer only withholds from payroll and forwards those deductions to an insurer, and has not endorsed the coverage or been involved in other ways, generally there is no group health plan. Under ERISA, DOL has established a "safe harbor" for "voluntary employee-pay-all" plans (where the employee pays 100 percent of the premium for an individual health insurance policy). This safe harbor requires the employer's involvement to be minimal.[34] Additionally, the program must be voluntary, without employer contributions to premiums, and most importantly without employer "endorsement"—another factual determination requiring knowledge of what a particular employer may be doing. Permissible employer activities within this safe harbor include allowing an insurer to publicize the product to employees, and collecting premiums through payroll deductions and remitting them to the insurer. The employer may not receive compensation from the insurer except for administrative services rendered by the employer for payroll deductions.[35]

Whether an employer's involvement is "minimal" and whether an employer "endorses" a program depends on the facts and circumstances, which are determined by looking at the employer's actions. For instance, when an employer helps an employee fill out claim forms, an employer's involvement is more than minimal. Similarly, an employer advertising the program has been determined to be more than "minimal" involvement. The "facts and circumstances" standard—having to know specific facts and actions a particular employer takes—makes it difficult to predict with certainty when an employer has a group health plan, and therefore whether HIPAA and potential COBRA requirements (discussed below) are triggered.

---

[32] ERISA 733(a)(1) for HIPAA. Note that this definition is not exactly the same as for COBRA purposes under ERISA section 607(1)). Section 607(1): A "group health plan" is "an *employee welfare benefit plan* providing medical care (as defined in section 213(d) of the [Code] to participants or beneficiaries directly or through insurance, reimbursement or otherwise."

[33] ERISA Section 3(1).

[34] DOL 29 CFR 2510.3-1(j).

[35] *Ibid*.

b. *Code definition of a group health plan*

HIPAA amendments to the Code did not add a new definition, but instead relied on an existing definition. In part, the Code defines the term "group health plan" as "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees. …"[36]

The IRS regulations further clarify the term "group health plan" in part as "a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer… Health care is provided under a plan whether provided directly or through insurance, reimbursement or otherwise …or through a cafeteria plan (as defined in [Code section] 125 or other flexible benefit arrangement."[37]

Because the Code defines a "group health plan" more broadly than ERISA, the IRS may find that a group health plan exists under the Code even when under ERISA one does not exist. While this would not raise the same preemption risk as under ERISA, it would mean that employers could be fined significant penalties for violating the HIPAA provisions added to the Code.

3. Implications for State Policymakers

To avoid a preemption challenge under HIPAA, policymakers should ensure that state insurance laws are at least as protective of consumers as the standards that HIPAA established for job-based and individual coverage.[38] Non-discrimination protections (access and rates), specific definitions of a preexisting condition, allowable exclusions, special enrollment rights, and other standards must be the same or better than federal ones.

In a situation when employees buy individual health insurance policies and their employer contributes to the policy, a preemption challenge is likely. Employer contributions generally result in a group health plan, even when there are separate individual contracts issued to workers. If an employer pays a higher salary or wages to the worker and does not restrict its use to insurance, then the higher compensation alone would not result in a finding of a group health plan.

---

[36] Code section 5000(b)(1) for COBRA. For HIPAA purposes, the definition of "group health plan" is in Code section 9832(a) (referencing the definition in 5000(b)(1)).

[37] Treas. Reg. Section 54.4980B-2, Q/A-1(a).

[38] HIPAA preemption added to ERISA is (in part): "… this part shall not be construed to supersede any provision of State law which establishes…except to the extent that such standard or requirement prevents the application of a requirement of this part." (ERISA section 731(a)(1)) This preemption standard was added to ERISA in 1996 to apply to state-regulated products sold to ERISA covered plans; it reflects an important public policy of establishing a national standard with a minimum set of protections for workers and their families. It recognized that state policymakers may choose to have more consumer protective laws. The HIPAA preemption standard is also known as a "federal floor" and has been interpreted to mean that state laws that are as good as or better than HIPAA would apply to state regulated insurance products.

In Minnesota, HIPAA non-discrimination standards seem most likely to be triggered. For example, currently in Minnesota's individual market (like in many other states), insurers are not required to guarantee issue individual policies and are allowed to charge premiums based on health factors. HIPAA prohibits basing eligibility for group coverage and employee contributions to group premiums on health factors. *Absent modifications to Minnesota's individual market standards, new reforms may be challenged as preempted by HIPAA if an employer contributes to individual health insurance that is underwritten for either access or rates.*

Minnesota's individual market standards for preexisting conditions seem to be consistent with HIPAA's requirements for group health plans. However, to ensure consistency with standards applicable to group health plans (e.g., special enrollment rights) to try to avoid a preemption challenge, further modifications to individual health insurance products would be needed.[39] *Failure to have standards that are at least as protective of consumers as HIPAA would expose the state to a potential challenge of the state reform law as preempted under the HIPAA standards added to ERISA.*[40]

ERISA-covered group health plans must comply with other standards in ERISA including but not limited to fiduciary obligations, reporting requirements, and notice standards. State policymakers should seek ways to assist employers to comply with these standards when state requirements result in a group health plan subject to ERISA. In addition, state policymakers should seek ways to minimize the risk that employers may face financial penalties if found by the IRS to violate the HIPAA provisions added to the Code. As discussed above, because the Code defines a "group health plan" more broadly than ERISA, it is possible to have a group health plan under the Code but not under ERISA.

Finally, having non-compliant state laws has implications for the state's authority to enforce HIPAA's requirements. HIPAA established a back-up enforcement framework for states found not to substantially enforce HIPAA standards. The U.S. Department of Health and Human Services—more specifically, the Centers for Medicare and Medicaid Services (CMS)—is empowered to make a determination that a state is not substantially enforcing HIPAA and then assume direct enforcement responsibilities over state-regulated insurance companies' that sell policies subject to HIPAA. The risk of federal enforcement is in addition to the risk of having state reforms challenged as preempted by HIPAA's requirements under ERISA (as discussed above).

[39] For exact requirements under HIPAA, see Public Law section 104-191.

[40] It is recommended for state policymakers to review current state insurance laws to ensure consistency with HIPAA's requirements.

C. COBRA

1. Background

COBRA applies to employers with 20 or more employees. It gives workers and their dependents the right to continue job-based coverage for 18, 29, or 36 months depending on the qualifying event that triggers COBRA.

Congress added COBRA requirements to several federal statutes including the Code, which the U.S. Treasury Department (through the IRS) interprets and enforces; ERISA, which the U.S. Department of Labor (DOL) interprets and enforces; and the PHSA, which the U.S. Department of Health and Human Services (through CMS) interprets and enforces. Specifically:

- COBRA in the Code applies to almost all group health plans—except governmental plans, certain church plans, and group health plans sponsored by employers with fewer than 20 employees.
- COBRA in ERISA applies to most group health plans sponsored by private employers.
- COBRA in the PHSA applies to most governmental group health plans (e.g., state and local government employers providing benefits to their workers) and to church plans.

Although some COBRA requirements in the Code and ERISA are not identical, DOL has taken the position that the Treasury regulations nevertheless apply to ERISA covered group health plans, "except to the extent those rules are inconsistent with the statutory language of Title I of ERISA."[41] HHS's interpretation mirrors that of the IRS.

COBRA requirements apply to group health plans.[42] *The presence or absence of a group health plan is the core question triggering an employer's COBRA duty.* As discussed above, because the definitions of a "group health plan" are different in ERISA and in the Code, it is possible to have a group health plan under the Code but not under ERISA. Note that ERISA definitions of "group health plan" for COBRA requirements and HIPAA requirements also are different.

2. Application and implementation

Under the Code, PHSA, and ERISA the determination as to whether there is a "group health plan" is a factual one, based on the facts and circumstances related to a particular employer. This makes it difficult to say with certainty whether the courts or the federal government would find an existence of a group health plan, triggering COBRA duties for an employer. Furthermore, because of differences in the definitions between the Code and ERISA, in some

[41] Treas. Reg. section 54.490B-1, A-1(b).

[42] The term "group health plan" is defined in the Code section 5000(b)(1) and Treas. Reg. section 54.4980B-2.

circumstances an employer will have a group health plan and therefore COBRA obligations under the Code but not under ERISA.

Under the Code, a key factor to a finding of a "group health plan" is whether a plan is "maintained" by an employer. The IRS would consider a number of facts to determine whether this element is met:

- A premium contribution is one indication that an employer maintains a plan. This is also the case when an employer contributes to an "individual health insurance" policy, as long as the employer does so for two or more employees.[43]
- If an employer is not contributing to the premium, a plan may nonetheless be found to be maintained by an employer if there is other involvement by the employer including: (1) having a Section 125 Plan, (2) participation in ongoing administration of the plan, or (3) endorsing the plan.
- Generally there would be a group health plan if coverage under the plan would not be available at the same cost to the individual but for the individual's employment-related connection to the employer—even when an employer does not contribute to the premium. In the regulation, the IRS uses a discount vision card to illustrate that the card would not otherwise be available to workers absent the employer.[44]

Furthermore, an employer is likely to have COBRA duties under the Code when the employer contributes to a premium, even for an individual health insurance policy.

In the absence of a premium contribution, when an employer establishes a Section 125 Plan to pay for health coverage, there will be a group health plan under the Code. Under a Section 125 Plan, the "contribution" by the employer is the salary reduction (salary being considered employer's money). Therefore, individual health insurance policies funded with pre-tax dollars (through salary reductions) would be considered part of the employer's group health plan.

COBRA would apply to the individual health insurance policies funded through a Section 125 Plan.[45] Employers would have to send proper notice and comply with other COBRA requirements. Additionally, former workers could use their severance pay (but not pension distributions) to continue funding their health insurance with pre-tax dollars through the Section 125 Plan. As a practical matter, however, it is unlikely that most former employees would be able to fund their health insurance premiums using their former employer's Section 125 Plan.

Section 125 Plan when available for premium payments would also have to be available for current worker's COBRA payments. For example, if the new employer has a Section 125 Plan

---

[43] Treas. Reg. section 54.4980B-2, Q/A-1(a).

[44] *Ibid*.

[45] Although not the focus of this, the definition of "group health plan" in the Code for COBRA and HIPAA are the same. This means that HIPAA duties would also apply when there is a group health plan.

and the new employee is on COBRA from a prior employer, the Section 125 Plan may be used to pay for COBRA.

Finally, even when there is no employer contribution (no Section 125 Plan) to individual health insurance premium and only minimal employer involvement, *neither the IRS regulations implementing the COBRA provisions of the Code nor the regulations for the PHSA* provide a "safe harbor" such as DOL allows under ERISA. Because the definition of a "group health plan" under the Code is broader than under ERISA, the COBRA provision of the Code and PHSA may be triggered even when ERISA does not apply.

3. Implications for State Policymakers

Although the Code would not be used as a way to challenge state health care reforms, there are other implications for Minnesota policymakers to consider. An employer who violates the Code could face significant tax penalties. Policymakers should look for ways to minimize the risk of employers unintentionally violating the HIPAA and COBRA standards in the Code. Such violations may occur when an employer's contribution to individual coverage or other involvement results in a finding by the IRS or the courts that there is a group health plan, triggering HIPAA and COBRA obligations. One way to minimize this risk would be to assume that such obligations would exist, and to modify state law to reflect HIPAA and COBRA standards.

The above discussion of COBRA and HIPAA provisions under ERISA and the IRC is summarized in Table VIII.1.

TABLE VIII.1

SUMMARY: APPLICATION OF FEDERAL HIPAA AND COBRA UNDER ERISA AND IRC

Federal Statute	Group Health Plan Definition	Standard to Determine
COBRA under ERISA	Section 607(1): "an *employee welfare benefit plan* providing medical care (as defined in section 213(d) of the [Code] to participants or beneficiaries directly or through insurance, reimbursement or otherwise."	Facts and circumstances: • When an employer contributes to the premium of individual health insurance policies, the policies will be viewed as part of an employer's group health plan. • If no employer contribution, depends on employer's involvement *Safe harbor if no employer contributions but employer involvement must be minimal (determined by the facts and circumstances)*
HIPAA under ERISA	Section 733(a)(1): "*employee welfare benefit plan* providing medical care … to employees or their dependents directly or through insurance, reimbursement or otherwise." Section 3(1) "an employee welfare benefit plan": "any plan, fund or program…established or maintained by an employer…to the extent that such plan…was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise…medical, surgical, or hospital care or benefits…."	Same
COBRA AND HIPAA under IRC	Section 5000(b)(1) (COBRA) and section 9832(a) (HIPAA): "a plan (including a self-insured plan) of, or contributed to by, an employer (including a self-employed person) or employee organization to provide health care (directly or otherwise) to the employees, former employees…" The IRS regulations further clarify the term "group health plan" in part as "a plan maintained by an employer or employee organization to provide health care to individuals who have an employment-related connection to the employer… Health care is provided under a plan whether provided directly or through insurance, reimbursement or otherwise …or through a cafeteria plan (as defined in [Code section] 125 or other flexible benefit arrangement." *Because the Code defines a "group health plan" more broadly than ERISA, the IRS may find that a group health plan exists under the Code even when under ERISA one does not exist.*	Facts and circumstances: • Under the Code, whether a plan is "maintained" by an employer is a key factor. The IRS would consider a number of facts to determine whether this element is met: – Premium contribution – No premium contribution but other involvement by the employer including: (1) having a Section 125 Plan, (2) participation in ongoing administration of the plan, or (3) endorsing the plan.

D. INTERNAL REVENUE CODE AND SECTION 125 PLANS

A Section 125 Plan (or "cafeteria plan") is a way for workers without job-based health coverage to receive similar tax advantages as workers have with employer provided health coverage. Code Section 125 allows workers to lower their taxable income by the amount of premiums paid for health insurance and other qualified benefits. Employers also save: When payroll is lower by the amount of reductions for the employee share of premiums, the employer pays less in FICA taxes.

1. Who Can Sponsor a Section 125 Plan?

Any employer may sponsor a Section 125 Plan—including corporations (Subchapter S and Subchapter C), partnerships, limited liability corporations and partnerships, non-profit organizations, sole proprietors, and government employers. There are no minimum size requirements for the employer.

2. Who Can Participate?

Only employees may participate in a Section 125 Plan. Dependents of employees may receive benefits but are not considered "participants" with rights provided to participants (such as to make an election to reduce salary to pay for premiums for health insurance). Partners, self-employed people, and people who are more than 2-percent shareholders in an "S" corporation may *not* participate in a Section 125 Plan, but they may sponsor such plans.

An employer may decide which dependents qualify for benefits (for example, a spouse and children may receive benefits), but the employer must state so in a written Section 125 Plan document. Definition of "dependents" may be the same as the category of people considered "dependents" in the tax code, or it could be narrower. Pre-tax dollars may *not* be used to pay for dependents who would not qualify as such under the Code (e.g., domestic partners or children who are no longer considered dependents).

3. Basic Requirements

Whether an employer has established a qualified Section 125 Plan largely depends on many factors including the facts of a particular situation and the actual operation of a plan.[46] A qualified Section 125 Plan must offer employees a choice between taxable and nontaxable benefits (also called *qualified benefits*). For instance, a taxable benefit would include salary reduction (salary is usually taxed) and a non-taxable benefit would be an employee's share of the premium for health coverage (health coverage is not taxed). The choice between taxable and nontaxable benefits is an essential requirement for a Section 125 Plan.

In addition, the Section 125 Plan must (in part) be:

---

[46] In addition to those discussed, there are other requirements such as reporting. These and other requirements are beyond the scope of this discussion.

- A separate written plan that complies with the requirements of Section 125 requirements in the Code and the IRS regulations;
- Maintained by an employer for employees; and
- Operated in compliance with the requirements of Section 125 and regulations, and in accordance with the written plan terms.

The written plan must (in part) specifically describe all benefits, establish rules for eligibility to participate and the procedure for making elections, and indicate that elections are irrevocable (with some exceptions). In addition, it must state how employer contributions may be made under the plan and the maximum amount of elective contributions (e.g., maximum contribution to an FSA). Finally, it must state the plan year and specify that only employees may participate in the cafeteria plan.[47] All provisions of the written plan must apply uniformly to all participants. If the plan includes an FSA, the written plan must include a provision complying with the *uniform coverage rule* and *the use-or-lose rule.*

A Section 125 Plan must comply with non-discrimination rules in the Code. This means that highly compensated employees may not receive more favorable treatment than other employees in a Section 125 Plan. While violations of the non-discrimination rules would generally not result in the entire plan being disqualified, the highly compensated employees would be taxed on the amount of benefits received.[48]

An employer must adopt a Section 125 Plan using the same process and documentation as with other major business actions (e.g., a Board of Directors action). An employer must provide employees with documents including a summary of the cafeteria plan and an election form. An employer must also provide a summary plan description for all insurance benefits available through the Section 125 Plan, even if it is used exclusively for the purpose of paying health insurance premiums (called a "premium-only plan").

An employer must obtain a signed election form from employees enrolling. The form must include authorization for payroll to make pre-tax deductions for insurance and the employee's agreement to pay insurance premiums with pre-tax dollars. The form must instruct payroll to deduct premiums pre-tax; income withholding for FICA and income tax withholding will be based on each employee's reduced wages (gross pay minus pre-tax deductions).

4. Failure to Qualify as a Section 125 Plan

The IRS has indicated that there are many reasons why a plan may *fail* to satisfy section 125 requirements. These include (but are not limited to) the following:

---

[47] Dependents may receive benefits through the plan but may not "participate" in the plan; only an employee has the right to participate in the cafeteria plan.

[48] See Proposed Treasury Regulation section 1.125-1, Q/A-10.

- Offering nonqualified benefits (e.g., long-term care insurance). All benefits offered though a Section 125 Plan must be qualified benefits.
- Not offering an election between at least one permitted taxable benefit and at least one qualified benefit.
- Deferring compensation, which is not allowed in a Section 125 Plan.
- Failing to comply with the uniform coverage rule or use-or-lose rule.
- Allowing employees to revoke elections or make new elections during a plan year except as provided in section 1.125-4 of the regulations.
- Failing to comply with substantiation requirements (these require an employee to provide receipts/copies of bills, etc.).
- Paying or reimbursing expense incurred for qualified benefits before the effective date of the Section 125 Plan or before a period of coverage.
- Failing to comply with grace period rules.

In addition to these, federal regulators may see an issue when a state requires employers to provide a Section 125 Plan to pay for health coverage. Section 125 plan rules prohibit a group health plan from discriminating in favor of highly compensated employees based on eligibility for benefits. If employers must allow all employees to pay the employee contribution for health coverage through a Section 125 Plan, these benefits become subject to Section 125 nondiscrimination rules. If the health plan is available to only some employees, the amounts paid through the cafeteria plan with respect to highly compensated employees may be subject to tax. In other words, either limited access (e.g., underwritten individual health insurance policies that are not available to all employees) or other factors may result in a violation of the nondiscrimination rules prohibiting favorable treatment of highly paid workers.

When a plan fails to qualify, workers could face taxes on higher back wages and additional employment taxes. Employers could be taxed for additional employment (FICA) taxes and could also face penalties for failing to properly withhold and report taxes.

5. Implications for State Policymakers

When Section 125 Plans are incorporated in state-based health care reforms as a way to make health insurance premiums less expensive by funding premiums with pre-tax dollars (as in the case of Massachusetts health care reforms), efforts should be made to minimize the risk to employers, employees, and their families. For example, considering the complex technical requirements and the resource constraints for some businesses (especially small businesses), state policymakers should consider providing model plan documents for employers, to minimize the expense associated with hiring tax consultants. Such documents should be developed with assistance from professionals with extensive expertise with Section 125 Plans.

In addition, state policymakers contemplating a requirement that employers establish Section 125 Plans should consider ways to help ensure that employers actually adhere to plan

documents in administering the Section 125 Plan. In other words, although plan documents may be properly drafted and meet all the requirements in the Code and regulations, the way an employer actually operates or administers the plan may disqualify it. For example, if the employer provides benefits to a domestic partner of a participating employee contrary to plan documents, the plan would not qualify as a Section 125 Plan; here the plan would operate contrary to plan documents and provide pre-tax benefits to people who would not qualify as dependents under the Code.

State policymakers might consider offering free workshops to help educate employers interested or required to establish such plans. Suitable and easy to understand literature should also be available for employers who participate as well as those who may not have the time to attend a workshop.

State policymakers should also consider the prohibition on partners, self-employed people, and people who are more than 2-percent shareholders in an "S" corporation from participating in a Section 125 Plan. This may have a greater impact on small businesses that do not offer coverage to workers than on larger ones. Business owners who are unable to finance premiums with pre-tax dollars under a Section 125 Plan may continue to forego health insurance.

APPENDIX A

PROJECTION AND MICROSIMULATION METHODS

This page has been intentionally left blank for double-sided copying.

APPENDIX A. PROJECTION AND MICROSIMULATION METHODS

Using Minnesota-specific data, we estimated the effect of proposed policy changes on:

- The cost of the coverage choices that individuals and families in Minnesota face;
- Enrollment in private group or individual coverage or in public programs (Minnesota Care, GAMC and Medical Assistance); and
- The cost to individuals, employers, and the state.

The estimation process involved development of "base case" (i.e., current-case) estimates of coverage and cost, against which to compare microsimulation estimates. The microsimulation estimates are based on a model that reflects individual opportunities and decisions; it uses consistent assumptions and data to produce comparable estimates of alternative policy changes. The model constructed for this research also produces comparable estimates for two points in time, reflecting the population in Minnesota projected to state fiscal year (FY) 2009 and FY2011, respectively.

The microsimulation model has two major components: (1) the microsimulation databases and (2) the microsimulation logic. Each is described below.

A. THE MICROSIMULATION DATABASE

A microsimulation database was assembled for each of two output years, FY2009 and FY2011. The microsimulation databases were assembled in three steps:

- A person-level population data file was assembled, based on the 2004 Minnesota Health Access Survey (MNHA).
- Using state-specific trends in population demographics, insurance coverage, and public program enrollment, the population data file was "aged" from calendar year 2004 to FY2009 and FY2011, respectively.
- Public and private expenditures were scaled to projected levels of expenditures in Minnesota by source of payment.

1. The 2004 Population Data File

The primary data source for the microsimulation databases was the 2004 MNHA, which includes data on demographics, employment, health insurance, and out-of-pocket premiums for a representative sample of Minnesota households. The MNHA includes detailed information for one person in each household (the target), although coverage status (as well as demographic and basic employment information) is reported for every household member. When weighted, the household targets are representative of the 2004 Minnesota population.

The 2004 population data file for the microsimulation was based on 10,581 targets under age 65, who did not report Medicare coverage. (None of the policy changes that Minnesota is considering would affect Medicare beneficiaries.) For each target in the data file, MNHA information was retained on the primary source of health insurance, monthly premium contributions, socio-demographic characteristics, self-reported health status, employment characteristics, and family composition and income. Each married adult target's record was augmented with information about the spouse's source of health insurance coverage and employment (if working); each child target's record included information about the primary wage earner in the family.

Effective January 1, 2008, Minnesota law allows unmarried dependents under age 25 to be covered by their parent's policy.[1] To reflect this eligibility change in the population data file, we identified targets age 18 to 24 from MNHA who could become dependents on their parents' employer-sponsored coverage based on their current insurance status (uninsured), ineligibility for public program coverage, and evidence of an offer of coverage from a parent's employer.

In addition, because the MNHA is a household survey, it does not contain firm-level information that is critical for the microsimulation model. This includes employer contribution to health insurance premium, self-insured status, as well as current offer of section 125 plans. With support from the Agency for Healthcare Research and Quality (AHRQ), we obtained three-year average distribution of these three variables among employers by firm size, using Minnesota-specific data from the 2003-2005 Medical Expenditure Panel Survey – Insurance Component (MEPS-IC), which is summarized in Table A.1.

TABLE A.1

EMPLOYEE CONTRIBUTION, SELF-INSURED STATUS AND OFFER OF SECTION 125 PLANS AMONG EMPLOYERS IN MINNESOTA, BY FIRM SIZE, CURRENT CASE

Firm Size	Average Percent Employee Contribution for Single Policy	Average Percent of Employees with Self-Insured Plans	Average Percent of Employees with Section 125 Plans	
			Self-Insured	Non-Self-Insured
2-10 Employees	18.0	8.4	27.4	17.7
11-50 Employees	19.4	8.0	49.1	34.5
51-100 Employees	15.1	19.3	33.5	43.2
101-500 Employees	21.1	41.1	54.6	58.7
501-1000 Employees	18.6	50.6	65.3	85.1
1001 or More Employees	19.0	91.6	67.3	43.6
All Firms	19.0	59.8	64.5	39.8

Source: 2003-2005 MEPS-IC, AHRQ.

[1] Minnesota Department of Health. Guide to Purchasing Health Insurance. http://www.health.state.mn.us/clearinghouse/purchase.htm. Last accessed January 4, 2008.

Finally, to capture geographic differences within the state (while maintaining sufficient numbers of targets in each geographic location to support detailed estimates), we categorized geographic location into four regions of the state, as described in Table A.2.

TABLE A.2

DEFINITION OF GEOGRAPHIC REGIONS

Geographic Region	Economic Development Regions	Counties
North	Arrowhead; Headwaters; Northwest; North Central; West Central	Aitkin; Carlton; Cook; Itasca; Koochiching; Lake; St. Louis; Beltrami; Clearwater; Hubbard; Lake of the Woods; Mahnomen; Kittson; Marshall; Norman; Pennington; Polk; Red Lake; Roseau; Becker; Clay; Douglas; Grant; Otter Tail; Pope; Stevens; Traverse; Wilkin; Crow Wing; Morrison; Todd; Wadena
Central	Central; East Central; Mid-M; Upper MN Valley	Benton; Sherburne; Stearns; Wright; Chisago; Isanti; Kanabec; Mille Lacs; Pine; Kandiyohi; McLeod; Meeker; Renville; Big Stone; Chippewa; Lac qui Parle; Swift; Yellow Medicine; Cass
Twin Cities	Twin Cities	Anoka; Carver; Dakota; Hennepin; Ramsey; Scott; Washington
South	South East; South Central; South West	Blue Earth; Brown; Faribault; Le Sueur; Martin; Nicollet; Sibley; Waseca; Watonwan; Dodge; Fillmore; Freeborn; Goodhue; Houston; Mower; Olmsted; Rice; Steele; Wabasha; Winona; Cottonwood; Jackson; Lincoln; Lyon; Murray; Nobles; Pipestone; Redwood; Rock

Source: Mathematica Policy Research.

2. The Microsimulation Database

To "age" the 2004 MNHA to FY2009 and FY2011, respectively, the MNHA target weights were adjusted to match a series of "control totals" developed from the Minnesota samples of the American Community Survey (ACS) and the Current Population Survey (CPS), as well as population projections from the Minnesota State Demographic Center and public program projections from the Reports and Forecasts Division of Minnesota Department of Human Services.

Total population was projected based on the population totals estimated in 2005 and projected to 2010 and 2015 by the Minnesota State Demographic Center (MSDC).[2] These estimates and projections are based on the 2005 Census Bureau County Population Estimates, adjusted to state administrative data on school enrollments and births.[3] The County Population

[2] "Projected Minnesota population by age and gender by county, region, and metropolitan area," June 6, 2007, accessed at http://www.demography.state.mn.us/resource.html?Id=19169.

[3] This adjustment increases the number of children and parent-aged individuals, relative to the Census estimates.

Estimates include "institutionalized" individuals (such as military personnel living in barracks, college students living in dormitories, and individuals living in medical or penal institutions). Since the 2004 MNHA does not include such individuals, we adjusted the MSDC totals (by age group) downward by the percentage of the population in the 2006 American Community Survey (ACS) living in institutions such as the MNHA excluded.

These population estimates were then aggregated into three age groups (0-19, 20-44, and 45-64), by metropolitan and nonmetropolitan location in the state. Within each age-location category, the population was projected to FY2009 and FY2011, based on the estimated average annual growth rates from 2005 to 2010 and from 2010 to 2015.

Also within each age-location category, the population was distributed into racial categories in proportion to MSDC projections for 2005, 2010, and 2015.[4] The proportions were projected to FY2009 and FY2011, and were applied to the population totals to estimate the total non-institutionalized population by age group, race, and location in FY2009 and FY2011. The various data sources used for these calculations are documented in Table A.3.

TABLE A.3

KEY DATA SOURCES FOR MINNESOTA POPULATION PROJECTIONS

Data and Source	Key Information/Control Total	Key Assumption
2005 Census County Population Estimates, adjusted to state administrative data (MN State Demo Center, June 2007)	Estimated total population of Minnesota by age group and MSA/non-MSA location	Annual population growth from 2005 to 2010 and from 2010 to 2015 is equal to the average within each age group and location category.
American Community Survey, 2006 (Census Bureau)	Estimated proportion of the Minnesota population living in military, medical, penal or other institutions by age group	The growth rate of institutionalized population is equal to the growth rate of the non-institutionalized population.
2000 Census (MN State Demo Center, Jan 2005)	Estimated proportion of the Minnesota population by age group and race/ethnicity category (white, black, Hispanic, Asian, American Indian, other)	Annual population growth from 2005 to 2010 and from 2010 to 2015 is equal to the average within each age group and race/ethnicity category.

Source: Mathematica Policy Research.

Next, the data were aged to match projected changes in the income distribution of the population. Specifically, benchmarks for the number of Minnesotans under age 65 was estimated in five poverty categories (<100%, 100-199%, 200-299%, 300-399%, 400+%), by race and MSA/non-MSA location in the Minnesota sample of the 2005 and 2006 ACS.[5] Control totals in each poverty/race/location category were developed based on the rate of change in the number of persons in each category from 2005 to 2006.

[4] "Minnesota Projected Population by Age, Sex, Race and Hispanic Origin," January 2005.

[5] Changes to the ACS made development of a longer trend impossible.

Finally, population control totals were developed to reflect recent trends in health insurance coverage. The projected number of Minnesotans enrolled in state programs was based on the Minnesota Human Services Department's End-of-Session 2007 Forecast.

We developed benchmarks for the number of persons covered by employer-sponsored, non-group or military insurance or who are uninsured from the combined 2005-2007 Minnesota samples of the Current Population Survey (CPS). The Minnesota CPS population samples were used to estimate the change in the total number of persons insured by source of coverage (or uninsured).[6] The estimated changes were then applied to the baseline MNHA data. This method preserved the aggregate difference in the number of persons covered by source (or uninsured) in the 2004 MNHA and 2005 CPS (reporting 2004 coverage status), but forced the distribution of the uninsured by age and firm size to that reported in the 2007 CPS.

3. Cost Projection

The last step of building the microsimulation database was to adjust the cost data to ensure they reflect projected spending by Minnesotan insurers and public programs in FY2009 and FY2011.

The Minnesota Human Services Department provided annual data from 2002 to 2006 documenting total fee-for-service and managed care expenditures, as well as member months by age group for GAMC, Medicaid, and MinnesotaCare. Information about fee-for-service (FFS) spending was available by service type, but information about managed care (MCO) expenditures was not. To determine total spending for non-institutionalized enrollees, FFS expenditures for care in nursing facilities and ICF-MRs were subtracted from total FFS expenditures. Net FFS expenditures were then added to total MCO expenditures, the latter discounted to account for MCO plans' estimated administrative costs. The average annual rate of growth in pmpm expenditures from 2002 to 2006 was used to project pmpm expenditures in FY2009 and FY2011.

For expenditures covered by private insurance, we obtained data on plan expenditures and total enrolled member months in commercial plans in Minnesota. Individual and small group carriers must file a Health Plan Financial and Statistical Report (HPFSR) annually with the Minnesota Department of Health. Pmpm expenditures in the large-group market were determined by taking the difference between expenditures and member months in all group policies (as reported to the Department of Insurance) and expenditures and member months in small group policies (as reported in the HPFSR). The average annual rate of growth from 2003 to 2006 was used to project the FY2009 and FY2011 pmpm private insurance expenditures for individual, small group and large group plans, respectively.

[6] Distribution by firm size is also trended forward to FY2009 and FY2011 level, using 2005-2007 Minnesota sample of the CPS.

The data sources and projected growth rates for public and private insurance expenditures in Minnesota are reported in Table A.4.

TABLE A.4

DATA SOURCES AND ESTIMATED ANNUAL GROWTH RATES FOR BASELINE FY2009 AND FY2011 EXPENDITURE PROJECTIONS

	Estimated Average Annual Rate of Growth	Type and Source of Data
Public Program Expenditures		
Metropolitan Areas		
MA and GAMC	2.6%	Total fee-for-service (FFS) and managed care (MCO) expenditures, number of enrollees, and enrollment months (Minnesota Department of Human Services' Reports and Forecasts Division)
MN Care	3.7%	
Non-Metropolitan Areas		
MA / GAMC	1.0%	
MN Cares	4.3%	
Private Market Expenditures		
Individual Market	8.9%	Expenditures and member months from HPFSR (Minnesota Department of Health)
Small-Group Market	6.8%	
Large-Group Market	5.4%	Total expenditures and member months calculated as difference between reported totals for all group policies and HPFSR totals for small group policies

Source: Mathematica Policy Research.

MNHA respondents with employer-sponsored, COBRA, or individual coverage reported monthly out-of-pocket contributions or premiums paid for coverage. These amounts were inflated to FY2009 and FY2011 dollars using essentially the same methodology as was used to create projected pmpm private insurance expenditures. Average monthly premiums were estimated from premiums and member months reported in the HPFSR for individual and small group coverage. Average monthly premiums for large-group coverage were estimated as the difference between reported premiums and member months for all group policies and reported premiums and member months for small group policies reported in the HPFSR, again omitting outliers. The rate of growth in average pmpm premiums from 2003 to 2006 was calculated for each type of coverage. These sources of data and estimates are reported in Table A.5.

TABLE A.5

DATA SOURCES AND AVERAGE ANNUAL GROWTH RATES FOR BASELINE FY2009 AND FY2011 PRIVATE INSURANCE CONTRIBUTION AND PREMIUM PROJECTIONS

	Estimated Average Annual Rate of Growth	Type and Source of Data
Individual Premiums	3.6%	Premiums and member months by carrier from 2003 to 2006 (HPFSR)
Small-Group Premiums	5.5%	
Large-Group Premiums	4.0%	Premiums and member months by carrier, from 2003 to 2006, calculated as difference between all group policies and small group policies (Department of Insurance and HPFSR)

Source: Mathematica Policy Research.

B. MICROSIMULATION LOGIC

The logic of the microsimulation model simulates individuals' decisions to obtain coverage from various public and private sources available to them. Their choices will vary with differences in their personal and family characteristics, their current source of coverage, and most importantly, the magnitude of price change (if any) in the various options they face under each policy change. In order to simulate individuals' new coverage choice, we conducted a series of multivariate analyses in the current case, modeling individuals' decisions to obtain each of three different types of coverage: employer-sponsored insurance, individual (non-group) coverage, and public programs. While individuals' choice set and the insurance prices they face may change under each simulated reform, their relative preferences regarding each type of coverage is assumed to remain the same.

1. Employer-Sponsored Insurance

Most of the proposed policy changes target small-group market and workers in small firms with 50 or fewer employees, who can face very different choices and behave differently than their counterparts in large firms. Therefore, we developed separate estimates for obtaining small group and other group coverage, although methods and factors considered in each estimation are similar.

To model individuals' insurance coverage decisions, it is necessary to understand both employer and employee responses to price. MNHA reports employees' share of the insurance premium; for workers with missing information, we estimated a linear regression model to predict their contribution amounts. Because MNHA does not report the employer contribution to group premiums, we applied this information, taken from MEPS-IC (as described above), and estimated a linear model to predict the total group insurance premium for each worker.

Using a logistic regression model, we estimated the probability of both having an employer offer and being eligible for coverage in the current case for each adult working target, spouse, and parent or primary wage earner (PWEs) of a target under age 24 in the microsimulation

database. For those predicted to have an offer, we estimated the probability of their taking up the offer, which varied by the level of employee contribution, socio-demographics (age, gender, race, marital status, education and income), health status, hours worked, and geographic location.

Whether the insurance is a family policy also was considered in the estimations, so that targets could obtain group coverage through a spouse or (if under age 25) through a parent. If an individual could obtain group coverage in more than one way, we prioritized the choices so that own offer would be taken up before dependent coverage from a spouse, followed by dependent coverage from a parent.

2. Non-group Individual Coverage

Similar to the estimations for group coverage, we estimated multivariate regression models for individual market premiums and take-up. Each regression included targets currently enrolled in the individual market (including MCHA), as well as uninsured and COBRA enrollees. To allowed the decision of taking individual coverage to be a family-level decision, we evaluated coverage status of other family members: if the target was single, or had spouse or children with other types of coverage—such as coverage from an employer, or a military or public program—the decision to purchase individual coverage was assumed to be an individual decision. If target's spouse or children were also covered by individual insurance or if all family members were uninsured, the decision to purchase individual coverage was assumed to be a family-level decision.

A linear regression model of single and family individual premiums was estimated on various demographic, health status and employment characteristics likely to affect insurance rating. People currently enrolled in MCHA were assumed to face a 25 percent higher premium than the premium predicted over Minnesotans with individual coverage currently. People who are currently uninsured were assumed also likely to face a premium as much as 20 percent higher than their predicted amounts, to reflect differences in risk pooling even within a community rated market.

Using a logistic regression model, the probability of buying non-group individual insurance was estimated based on factors that are likely to affect demand for individual coverage, including the predicted premiums, demographics of the oldest person covered by the family policy, number of children to be covered, income, health status and geographic location.

3. Public Program Enrollment

Many Minnesotans eligible for public programs choose not to enroll. In order to capture this choice, we estimated each eligible person's probability of enrolling in a public program. Eligibility for Medicaid (including GAMC) or MinnesotaCare was assigned to each MNHA target, based on income and family size. MinnesotaCare premiums also were assigned using the most recent MinnesotaCare premium schedule.

For those eligible for both Medicaid and MinnesotaCare, we used a two-step model, first estimating the probability of enrolling in any public program, and then estimating the probability of choosing Medicaid versus MinnesotaCare among those predicted to enroll. Age, race,

education, income, presence of children, hours worked, health status, geographic location, and price (zero for Medicaid) were among the covariates included in this estimation. For targets eligible only for MinnesotaCare, we estimated a logistic regression model considering a similar set of factors.

After the behavioral parameters were estimated for each type of coverage, the current-case data were passed through the microsimulation logic—a series of multivariate decision-making processes—to produce simulated coverage estimates. The microsimulation model incorporated standard stochastic processes to introduce variation into the decisions that similar individuals and families would make. In effect, this simulation method compensates for unobserved characteristics without introducing bias. For each proposed reform, the output population data file was tabulated to produce estimates of simulated coverage and cost.

This page has been intentionally left blank for double-sided copying.

APPENDIX B

DETAILED ESTIMATES OF THE PROJECTED POPULATION WITHOUT POLICY CHANGE, FY2009 AND FY2011

This page has been intentionally left blank for double-sided copying.

TABLE B.1

ESTIMATED NUMBER OF INSURED AND UNINSURED MINNESOTANS UNDER AGE 65, BY PRINCIPAL SOURCE OF COVERAGE IN THE CURRENT CASE: CY2004, FY2009, AND FY2011

	CY2004		FY2009		FY2011		Percent Change	
	N	%	N	%	N	%	CY2004 - FY2009	CY2004 - FY2011
Total Population (000's)	**4,332.2**	**100.0%**	**4,583.5**	**100.0%**	**4,621.0**	**100.0%**	**5.8%**	**6.7%**
Employer Sponsored Insurance								
Private employer								
Self-employed	45.8	1.1%	38.1	0.8%	38.1	0.8%	-16.8%	-16.7%
Firms with 2-10 employees	216.2	5.0%	207.2	4.5%	202.4	4.4%	-4.1%	-6.4%
Firms with 11-50 employees	350.8	8.1%	296.0	6.5%	292.9	6.3%	-15.6%	-16.5%
Firms with 51-100 employees	267.2	6.2%	219.7	4.8%	213.5	4.6%	-17.8%	-20.1%
Firms with 101 or more employees	1,653.5	38.2%	1,725.4	37.6%	1,708.4	37.0%	4.3%	3.3%
Unknown firm size	101.4	2.3%	76.1	1.7%	74.8	1.6%	-24.9%	-26.2%
Government Employee Plans	480.6	11.1%	516.8	11.3%	509.2	11.0%	7.5%	5.9%
COBRA	57.5	1.3%	49.1	1.1%	49.5	1.1%	-14.6%	-13.9%
Individual Private Insurance								
MCHA	26.6	0.6%	25.1	0.5%	23.8	0.5%	-5.5%	-10.5%
Other private insurance	231.7	5.3%	225.7	4.9%	222.3	4.8%	-2.6%	-4.0%
Public Programs								
Medicaid or GAMC	282.9	6.5%	510.3	11.1%	536.2	11.6%	a	a
MinnesotaCare	170.9	3.9%	128.9	2.8%	126.7	2.7%	a	a
Military	73.6	1.7%	78.5	1.7%	79.7	1.7%	6.6%	8.3%
Uninsured								
Medicaid/MinnesotaCare eligible	220.8	5.1%	269.0	5.9%	314.7	6.8%	21.9%	42.6%
Not Medicaid/MinnesotaCare eligible	152.7	3.5%	217.4	4.7%	228.7	4.9%	42.4%	49.8%

Source: Mathematica Policy Research.

Notes: Government employee plans include federal, state, and local government employee plans. COBRA refers to continued group coverage purchased by qualified former employees and dependents, as authorized by the federal Consolidated Omnibus Reconciliation Act (COBRA) of 1986. Estimates of public program enrollment in CY2004 were derived from the Minnesota Health Access Survey (MNHA) as used by the Health Economics Program, and were not benchmarked to actual enrollment. FY2009 and FY2011 estimates are benchmarked to state projections, and are not comparable to the unadjusted MNHA estimates.

[a] Estimated change from CY2004 cannot be calculated (see notes).

TABLE B.2

ESTIMATED NUMBER OF INSURED AND UNINSURED MINNESOTANS UNDER AGE 65, BY SELECTED PERSONAL CHARACTERISTICS IN THE CURRENT CASE: CY2004, FY2009, AND FY2011

	CY2004		FY2009		FY2011		Percent Change	
	N (000's)	%	N (000's)	%	N (000's)	%	FY2004 - FY2009	FY2004-2011
Total Population[a]	**4,258.6**	**100.0%**	**4,505.0**	**100.0%**	**4,541.3**	**100.0%**	**5.8%**	**6.6%**
Adults Age 18-64								
0-275% FPL	979.7	23.0%	1,020.4	22.6%	1,079.9	23.8%	4.2%	10.2%
276% FPL or more	2,036.8	47.8%	2,246.2	49.9%	2,218.2	48.8%	10.3%	8.9%
Unknown FPL	14.7	0.3%	9.3	0.2%	7.6	0.2%	-36.5%	-48.5%
Children Age 0-17								
0-275% FPL	555.0	13.0%	572.3	12.7%	593.3	13.1%	3.1%	6.9%
276% FPL or more	671.0	15.8%	655.9	14.6%	641.6	14.1%	-2.3%	-4.4%
Unknown FPL	1.4	0.0%	0.9	0.0%	0.7	0.0%	-37.4%	-52.4%
Work Status								
Full-time worker	2,364.3	55.5%	2,692.6	59.8%	2,711.5	59.7%	13.9%	14.7%
Part-time worker	121.2	2.8%	132.2	2.9%	135.5	3.0%	9.1%	11.8%
Unemployed/non-worker	545.1	12.8%	449.9	10.0%	457.1	10.1%	-17.5%	-16.2%
Children	1,227.5	28.8%	1,229.1	27.3%	1,235.5	27.2%	0.1%	0.7%
Unknown	0.6	0.0%	1.2	0.0%	1.7	0.0%	103.0%	182.1%
Region								
North	677.5	15.9%	726.4	16.1%	734.9	16.2%	7.2%	8.5%
Central	568.3	13.3%	570.8	12.7%	572.6	12.6%	0.4%	0.8%
Twin Cities	2,340.9	55.0%	2,497.6	55.4%	2,523.1	55.6%	6.7%	7.8%
South	671.9	15.8%	710.2	15.8%	710.6	15.6%	5.7%	5.8%
Private Group Coverage	**3,173.1**	**74.5%**	**3,128.5**	**69.4%**	**3,088.8**	**68.0%**	**-1.4%**	**-2.7%**
Adults age 18-64								
0-275% FPL	492.1	11.6%	409.2	9.1%	411.2	9.1%	-16.9%	-16.4%
276% FPL or more	1,799.2	42.2%	1,942.5	43.1%	1,917.8	42.2%	8.0%	6.6%
Unknown FPL	13.4	0.3%	8.7	0.2%	7.0	0.2%	-35.4%	-47.5%
Children age 0-17								
0-275% FPL	260.4	6.1%	189.6	4.2%	185.1	4.1%	-27.2%	-28.9%
276% FPL or more	606.6	14.2%	577.7	12.8%	567.0	12.5%	-4.8%	-6.5%
Unknown FPL	1.4	0.0%	0.9	0.0%	0.7	0.0%	-37.4%	-52.4%
Work status								
Full-time worker	1,926.0	45.2%	2,086.9	46.3%	2,066.8	45.5%	8.4%	7.3%
Part-time worker	76.3	1.8%	77.4	1.7%	74.9	1.6%	1.4%	-1.8%
Unemployed/non-worker	301.8	7.1%	194.8	4.3%	192.6	4.2%	-35.5%	-36.2%
Children	868.4	20.4%	768.2	17.1%	752.8	16.6%	-11.5%	-13.3%
Unknown	0.6	0.0%	1.2	0.0%	1.7	0.0%	103.0%	182.1%

TABLE B.2 (*continued*)

	CY2004		FY2009		FY2011		Percent Change	
	N (000's)	%	N (000's)	%	N (000's)	%	FY2004 - FY2009	FY2004-2011
Region								
North	439.0	10.3%	394.9	8.8%	384.1	8.5%	-10.0%	-12.5%
Central	423.6	9.9%	387.8	8.6%	381.9	8.4%	-8.5%	-9.9%
Twin Cities	1,807.1	42.4%	1,866.0	41.4%	1,860.3	41.0%	3.3%	2.9%
South	503.3	11.8%	479.8	10.6%	462.5	10.2%	-4.7%	-8.1%
Private Individual Coverage (including MCHA)	**258.3**	**6.1%**	**250.9**	**5.6%**	**246.2**	**5.4%**	**-2.9%**	**-4.7%**
Adults age 18-64								
0-275% FPL	82.8	1.9%	80.5	1.8%	82.6	1.8%	-2.8%	-0.2%
276% FPL or more	109.2	2.6%	111.0	2.5%	104.8	2.3%	1.6%	-4.0%
Children age 0-17								
0-275% FPL	32.3	0.8%	26.5	0.6%	26.1	0.6%	-17.9%	-19.3%
276% FPL or more	34.1	0.8%	33.0	0.7%	32.6	0.7%	-3.3%	-4.3%
Work status								
Full-time worker	121.8	2.9%	140.9	3.1%	137.8	3.0%	15.7%	13.2%
Part-time worker	13.7	0.3%	15.2	0.3%	16.8	0.4%	11.0%	22.4%
Unemployed/non-worker	56.5	1.3%	35.3	0.8%	32.9	0.7%	-37.5%	-41.7%
Children	66.4	1.6%	59.5	1.3%	58.7	1.3%	-10.4%	-11.6%
Region								
North	49.6	1.2%	43.3	1.0%	43.2	1.0%	-12.7%	-12.9%
Central	46.0	1.1%	41.6	0.9%	41.1	0.9%	-9.6%	-10.6%
Twin Cities	115.0	2.7%	124.3	2.8%	122.0	2.7%	8.1%	6.1%
South	47.8	1.1%	41.7	0.9%	39.9	0.9%	-12.7%	-16.6%
Public Programs	**453.8**	**10.7%**	**639.2**	**14.2%**	**662.8**	**14.6%**	**b**	**b**
Adults age 18-64								
0-275% FPL	187.0	4.4%	270.5	6.0%	286.1	6.3%	b	b
276% FPL or more	41.7	1.0%	60.4	1.3%	55.6	1.2%	b	b
Children age 0-17								
0-275% FPL	202.2	4.7%	276.7	6.1%	293.3	6.5%	b	b
276% FPL or more	22.9	0.5%	31.6	0.7%	27.8	0.6%	b	b
Work status								
Full-time worker	117.4	2.8%	182.8	4.1%	189.2	4.2%	b	b
Part-time worker	15.0	0.4%	21.7	0.5%	23.0	0.5%	b	b
Unemployed/non-worker	96.4	2.3%	126.4	2.8%	129.6	2.9%	b	b
Children	225.1	5.3%	308.3	6.8%	321.1	7.1%	b	b
Region								
North	107.2	2.5%	170.1	3.8%	176.0	3.9%	b	b
Central	53.0	1.2%	77.1	1.7%	78.1	1.7%	b	b
Twin Cities	220.6	5.2%	283.0	6.3%	291.1	6.4%	b	b
South	73.0	1.7%	109.1	2.4%	117.7	2.6%	b	b

TABLE B.2 (*continued*)

	CY2004		FY2009		FY2011		Percent Change	
	N (000's)	%	N (000's)	%	N (000's)	%	FY2004 - FY2009	FY2004-2011
Uninsured	**373.4**	**8.8%**	**486.5**	**10.8%**	**543.5**	**12.0%**	**30.3%**	**45.5%**
Adults age 18-64								
0-275% FPL	217.8	5.1%	260.3	5.8%	300.0	6.6%	19.5%	37.8%
276% FPL or more	86.7	2.0%	132.3	2.9%	140.0	3.1%	52.6%	61.4%
Unknown FPL	1.3	0.0%	0.7	0.0%	0.5	0.0%	-47.5%	-59.3%
Children age 0-17								
0-275% FPL	60.2	1.4%	79.5	1.8%	88.8	2.0%	32.1%	47.6%
276% FPL or more	7.5	0.2%	13.7	0.3%	14.2	0.3%	81.9%	88.6%
Family type (spouse or parent is:)								
Full-time worker	199.2	4.7%	282.0	6.3%	317.6	7.0%	41.6%	59.5%
Part-time worker	16.2	0.4%	17.9	0.4%	20.8	0.5%	10.9%	28.8%
Unemployed/non-worker	90.4	2.1%	93.4	2.1%	102.0	2.2%	3.3%	12.8%
Children	67.7	1.6%	93.2	2.1%	103.0	2.3%	37.7%	52.1%
Region								
North	81.7	1.9%	118.1	2.6%	131.6	2.9%	44.5%	61.1%
Central	45.7	1.1%	64.4	1.4%	71.5	1.6%	40.8%	56.5%
Twin Cities	198.3	4.7%	224.4	5.0%	249.7	5.5%	13.2%	25.9%
South	47.8	1.1%	79.7	1.8%	90.6	2.0%	66.8%	89.8%

Source: Mathematica Policy Research.

Notes: Estimates of public program enrollment in CY2004 were derived from the Minnesota Health Access Survey (MNHA), as used by the Health Economics Program, and were not benchmarked to actual enrollment. FY2009 and FY2011 estimates are benchmarked to state projections and are not comparable to the unadjusted MNHA estimates.

[a] Estimates exclude persons with military coverage.

[b] Estimated change from CY2004 cannot be calculated (see notes).

APPENDIX C

DETAILED ESTIMATES OF THE PROJECTED COVERAGE IMPACTS OF MARKET REFORMS, FY2009

This page has been intentionally left blank for double-sided copying.

TABLE C.1

ESTIMATED NUMBER OF INSURED AND UNINSURED MINNESOTANS UNDER AGE 65, BY PRINCIPAL SOURCE OF COVERAGE: CURRENT CASE AND POLICY SIMULATIONS, FY2009

		(1)	(2a)	(2b)	(3)	(1+2a+3)	(1+2b+3)
	Current Case	Small Group and Individual Guaranteed Issue and Community Rating	Individual Mandate with Affordability Exemption	Individual Mandate with Subsidies	Mandatory Offer of Section 125 Plan	Combined Reforms with Affordability Exemption	Combined Reforms with Subsidies
Total Population (000's)	**4,584**	**4,584**	**4,584**	**4,584**	**4,584**	**4,584**	**4,584**
Employer Sponsored Insurance	3,128	3,093	3,279	3,348	3,173	3,227	3,291
Private employer							
Self-insured Plans	1,065	1,065	1,104	1,129	1,090	1,104	1,127
Insured Plans							
Self-employed	40	40	40	40	40	40	40
Firms with 2-10 employees	190	195	243	254	190	230	245
Firms with 11-50 employees	271	273	294	306	272	287	294
Firms with 51-100 employees	178	179	186	193	186	192	197
Firms with 101 or more employees	736	738	749	759	742	757	768
Unknown firm size	76	76	76	76	76	76	76
Government employee plan[a]	523	524	538	543	528	541	545
COBRA	49	3	49	49	49	0	0
Individual Private Insurance	251	304	282	300	267	294	334
MCHA	25	---	25	25	25	0	0
Other private insurance	226	---	257	275	241	294	334
Public Program	639	645	733	744	639	746	758
Medicaid or GAMC	510	512	601	607	510	610	617
MinnesotaCare	129	133	132	137	129	136	141
Military	78	78	78	78	78	78	78
Uninsured	486	463	211	114	426	239	122
Medicaid/MinnesotaCare eligible	246	243	111	52	231	129	61
Not Medicaid/MinnesotaCare eligible	241	220	100	62	196	109	62

Source: Mathematica Policy Research.

TABLE C.2

ESTIMATED NUMBER OF INSURED AND UNINSURED MINNESOTANS UNDER AGE 65, BY SELECTED PERSONAL CHARACTERISTICS: CURRENT CASE AND POLICY SIMULATIONS, FY2009

		(1)	(2a)	(2b)	(3)	(1+2a+3)	(1+2b+3)
	Current Case	Small Group and Individual Guaranteed Issue and Community Rating	Individual Mandate with Affordability Exemption	Individual Mandate with Subsidies	Mandatory Offer of Section 125 Plan	Combined Reforms with Affordability Exemption	Combined Reforms with Subsidies
Total Population (000's)[a]	**4,505.0**	**4,505.0**	**4,505.0**	**4,505.0**	**4,505.0**	**4,505.0**	**4,505.0**
Adults age 18-64							
0-275% FPL	1,020.4	1,020.4	1,020.4	1,020.4	1,020.4	1,020.4	1,020.4
276% FPL or more	2,255.5	2,255.5	2,255.5	2,255.5	2,255.5	2,255.5	2,255.5
Children age 0-17							
0-275% FPL	572.3	572.3	572.3	572.3	572.3	572.3	572.3
276% FPL or more	656.8	656.8	656.8	656.8	656.8	656.8	656.8
Work status							
Full-time worker	2,692.6	2,692.6	2,692.6	2,692.6	2,692.6	2,692.6	2,692.6
Part-time worker	132.2	132.2	132.2	132.2	132.2	132.2	132.2
Unemployed/non-worker	449.9	449.9	449.9	449.9	449.9	449.9	449.9
Children	1,229.1	1,229.1	1,229.1	1,229.1	1,229.1	1,229.1	1,229.1
Unknown	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Region							
North	726.4	726.4	726.4	726.4	726.4	726.4	726.4
Central	570.8	570.8	570.8	570.8	570.8	570.8	570.8
Twin Cities	2,497.6	2,497.6	2,497.6	2,497.6	2,497.6	2,497.6	2,497.6
South	710.2	710.2	710.2	710.2	710.2	710.2	710.2
Health Status							
Good, fair or poor	1,139.1	1,139.1	1,139.1	1,139.1	1,139.1	1,139.1	1,139.1
Excellent or very good	3,354.7	3,354.7	3,354.7	3,354.7	3,354.7	3,354.7	3,354.7
Unknown	11.3	11.3	11.3	11.3	11.3	11.3	11.3

TABLE C.2 (*continued*)

	Current Case	(1) Small Group and Individual Guaranteed Issue and Community Rating	(2a) Individual Mandate with Affordability Exemption	(2b) Individual Mandate with Subsidies	(3) Mandatory Offer of Section 125 Plan	(1+2a+3) Combined Reforms with Affordability Exemption	(1+2b+3) Combined Reforms with Subsidies
Private Group Coverage	**3,128.5**	**3,092.7**	**3,279.4**	**3,347.6**	**3,172.9**	**3,226.8**	**3,291.2**
Adults age 18-64							
0-275% FPL	409.2	401.8	460.6	518.1	426.0	435.4	490.5
276% FPL or more	1,951.1	1,930.6	2,019.4	2,021.3	1,970.5	1,999.7	2,000.8
Children age 0-17							
0-275% FPL	189.6	184.9	209.4	218.2	197.6	202.9	211.0
276% FPL or more	578.6	575.3	590.0	590.0	578.8	588.9	588.9
Work status							
Full-time worker	2,086.9	2,074.0	2,183.3	2,228.8	2,113.1	2,152.8	2,195.4
Part-time worker	77.4	74.1	80.4	84.6	78.6	79.4	83.6
Unemployed/non-worker	194.8	183.1	215.2	224.8	203.6	201.6	211.0
Children	768.2	760.3	799.4	808.1	776.4	791.7	799.9
Unknown	1.2	1.2	1.2	1.2	1.2	1.2	1.2
Region							
North	394.9	390.8	433.1	447.8	404.4	420.1	433.7
Central	387.8	384.8	405.9	420.3	394.6	404.5	416.7
Twin Cities	1,866.0	1,844.0	1,926.9	1,954.3	1,889.9	1,909.7	1,928.7
South	479.8	473.1	513.6	525.2	484.1	492.5	512.2
Health Status							
Good, fair or poor	656.7	643.0	705.5	731.2	676.4	690.1	710.2
Excellent or very good	2,468.8	2,446.8	2,570.9	2,613.2	2,493.5	2,533.7	2,577.9
Unknown	3.0	3.0	3.1	3.2	3.0	3.0	3.1
Private Individual Coverage[b]	**250.9**	**304.2**	**281.7**	**300.1**	**266.6**	**293.7**	**333.7**
Adults age 18-64							
0-275% FPL	80.5	95.8	83.6	98.8	86.2	79.8	111.4
276% FPL or more	111.0	146.8	134.0	136.4	120.6	149.7	156.8

TABLE C.2 (*continued*)

	Current Case	(1) Small Group and Individual Guaranteed Issue and Community Rating	(2a) Individual Mandate with Affordability Exemption	(2b) Individual Mandate with Subsidies	(3) Mandatory Offer of Section 125 Plan	(1+2a+3) Combined Reforms with Affordability Exemption	(1+2b+3) Combined Reforms with Subsidies
Children age 0-17							
0-275% FPL	26.5	26.7	29.8	30.7	26.8	28.9	30.3
276% FPL or more	33.0	34.9	34.3	34.3	33.0	35.3	35.3
Work Status							
Full-time worker	140.9	165.1	159.6	173.9	156.0	166.8	192.7
Part-time worker	15.2	16.4	16.5	16.5	15.6	14.6	15.6
Unemployed/non-worker	35.3	61.0	41.4	44.7	35.3	48.1	59.9
Children	59.5	61.6	64.1	64.9	59.8	64.2	65.5
Region							
North	43.3	50.8	46.2	52.6	45.2	49.0	58.3
Central	41.6	47.4	48.2	48.8	45.1	46.8	49.5
Twin Cities	124.3	155.8	144.1	151.2	132.4	154.5	175.8
South	41.7	50.3	43.2	47.6	43.8	43.3	50.2
Health Status							
Good, fair or poor	50.8	83.4	59.7	64.8	55.2	65.5	82.2
Excellent or very good	200.1	220.8	222.0	235.3	211.4	228.2	251.5
Public Program	**639.2**	**645.2**	**733.3**	**743.7**	**639.2**	**745.8**	**757.9**
Adults Age 18-64							
0-275% FPL	270.5	271.5	325.5	334.7	270.5	331.8	341.7
276% FPL or more	60.4	60.4	60.4	60.4	60.4	60.4	60.4
Children Age 0-17							
0-275% FPL	276.7	281.7	315.8	316.9	276.7	322.0	324.2
276% FPL or more	31.6	31.6	31.6	31.6	31.6	31.6	31.6
Work status							
Full-time worker	182.8	183.7	208.2	216.5	182.8	213.4	221.7
Part-time worker	21.7	21.8	27.3	27.3	21.7	26.4	26.4

TABLE C.2 (*continued*)

	Current Case	(1) Small Group and Individual Guaranteed Issue and Community Rating	(2a) Individual Mandate with Affordability Exemption	(2b) Individual Mandate with Subsidies	(3) Mandatory Offer of Section 125 Plan	(1+2a+3) Combined Reforms with Affordability Exemption	(1+2b+3) Combined Reforms with Subsidies
Unemployed/non-worker	126.4	126.4	150.4	151.3	126.4	152.4	154.0
Children	308.3	313.3	347.4	348.5	308.3	353.6	355.8
Region							
North	170.1	171.4	195.3	197.7	170.1	198.9	201.6
Central	77.1	79.8	83.5	86.8	77.1	83.7	88.5
Twin Cities	283.0	284.0	328.6	332.7	283.0	334.0	338.0
South	109.1	110.0	126.0	126.5	109.1	129.3	129.8
Health Status							
Good, fair or poor	251.4	252.4	287.0	289.2	251.4	291.7	294.1
Excellent or very good	386.0	391.0	438.9	447.0	386.0	446.8	456.3
Unknown	1.8	1.8	7.4	7.4	1.8	7.4	7.4
Uninsured	**486.5**	**463.0**	**210.6**	**113.7**	**426.3**	**238.7**	**122.3**
Adults age 18-64							
0-275% FPL	260.3	251.3	150.7	68.7	237.6	173.4	76.8
276% FPL or more	133.0	117.8	41.7	37.4	104.0	45.7	37.5
Children age 0-17							
0-275% FPL	79.5	79.0	17.3	6.6	71.2	18.5	6.9
276% FPL or more	13.7	14.9	0.9	0.9	13.4	1.0	1.0
Work status							
Full-time worker	282.0	269.8	141.6	73.4	240.7	159.6	82.8
Part-time worker	17.9	19.9	8.0	3.8	16.4	11.8	6.6
Unemployed/non-worker	93.4	79.3	42.8	29.0	84.6	47.7	24.9
Children	93.2	93.9	18.3	7.5	84.7	19.6	7.9
Region							
North	118.1	113.3	51.7	28.3	106.7	58.4	32.8
Central	64.4	58.9	33.3	15.0	54.0	35.8	16.2

TABLE C.2 (*continued*)

	Current Case	(1) Small Group and Individual Guaranteed Issue and Community Rating	(2a) Individual Mandate with Affordability Exemption	(2b) Individual Mandate with Subsidies	(3) Mandatory Offer of Section 125 Plan	(1+2a+3) Combined Reforms with Affordability Exemption	(1+2b+3) Combined Reforms with Subsidies
Twin Cities	224.4	213.9	98.1	59.5	192.3	99.4	55.3
South	79.7	76.8	27.5	10.9	73.3	45.1	18.0
Health Status							
Good, fair or poor	180.2	160.3	87.0	53.9	156.1	91.8	52.5
Excellent or very good	299.8	296.2	122.9	59.2	263.8	146.0	69.0
Unknown	6.5	6.4	0.8	0.7	6.4	0.8	0.7

Source: Mathematica Policy Research.

[a] Estimates exclude individuals with military coverage.

[b] Includes MCHA enrollees.

TABLE C.3

ESTIMATED CHANGE IN NUMBER OF INSURED AND UNINSURED MINNESOTANS BY PRIMARY SOURCE OF COVERAGE:
POLICY SIMULATIONS COMPARED WITH CURRENT CASE, FY2009
(Persons in thousands)

	Current Case											
	Self-insured Private Employer Plans	Insured Private Employer Plans	Government Employer Plans	COBRA	Military	MCHA	Other Private Individual Insurance	Medicaid or GAMC	MNCare	Uninsured	Uninsured and Medicaid/ MNCare Eligible	Uninsured and not Medicaid/ MNCare Eligible
Small Group and Individual Guaranteed Issue and Community Rating												
Self-insured private employer plans	1,064.7						0.7					
Insured private employee plans		1,489.5		0.6			4.9			5.4	2.6	2.9
Government employee plans			523.2				0.8					
COBRA				2.9								
Military					78.5							
MCHA												
Other private individual insurance		1.4		45.6		25.1	199.7			32.4	6.7	25.7
Medicaid or GAMC							1.6	510.3				
MinnesotaCare (MNCare)		0.5					3.8		128.9			
Uninsured												
Medicaid/MNCare eligible		0.1					5.9			236.6	236.6	
Not Medicaid/MNCare eligible							8.4			212.1		212.1
Individual Mandate with Affordability Exemption												
Self-insured private employer plans	1,064.7									39.6	10.1	29.4
Insured private employee plans		1,491.5								96.6	25.2	71.4
Government employee plans			523.2							14.8	2.6	12.1
COBRA				49.1								
Military					78.5							
MCHA						25.1						
Other private individual insurance							225.7			30.8	3.1	27.8

TABLE C.3 (*continued*)

	Current Case											
	Self-insured Private Employer Plans	Insured Private Employer Plans	Government Employer Plans	COBRA	Military	MCHA	Other Private Individual Insurance	Medicaid or GAMC	MNCare	Uninsured	Uninsured and Medicaid/ MNCare Eligible	Uninsured and not Medicaid/ MNCare Eligible
Medicaid or GAMC								510.3		90.7	90.7	
MinnesotaCare (MNCare)									128.9	3.4	3.4	
Uninsured												
Medicaid/MNCare eligible										110.7	110.7	
Not Medicaid/MNCare eligible										99.9		99.9
Individual Mandate with Subsidies												
Self-insured private employer plans	1,064.7									63,899	28,517	35,382
Insured private employee plans		1,491.5								135,892	44,448	91,444
Government employee plans			523.2							19,312	4,497	14,815
COBRA				49.1								
Military					78.5							
MCHA						25.1						
Other private individual insurance							225.7			49.3	12.0	37.3
Medicaid or GAMC								510.3		96.2	96.2	
MinnesotaCare (MNCare)									128.9	8.2	8.2	
Uninsured												
Medicaid/MNCare eligible										52.0	52.0	
Not Medicaid/MNCare eligible										61.7		61.7
Mandatory Offer of Section 125 Plan												
Self-insured private employer plans	1,064.7									25.3	10.3	15.0
Insured private employee plans		1,491.5								14.4	1.8	12.6
Government employee plans			523.2							4.8	0.7	4.1
COBRA				49.1								
Military					78.5							

TABLE C.3 (*continued*)

	Current Case											
	Self-insured Private Employer Plans	Insured Private Employer Plans	Government Employer Plans	COBRA	Military	MCHA	Other Private Individual Insurance	Medicaid or GAMC	MNCare	Uninsured	Uninsured and Medicaid/ MNCare Eligible	Uninsured and not Medicaid/ MNCare Eligible
MCHA						25.1						
Other private individual insurance							225.7			15.7	2.4	13.4
Medicaid or GAMC								510.3				
MinnesotaCare (MNCare)									128.9			
Uninsured												
Medicaid/MNCare eligible										230.7	230.7	
Not Medicaid/MNCare eligible										195.6		195.6
Combined Reforms with Affordability Exemption												
Self-insured private employer plans	1,064.7			6.8		1.2				31.7	4.8	26.9
Insured private employee plans		1,491.5		16.0		4.8				69.0	12.1	56.9
Government employee plans			523.2	2.8		0.3				14.9	2.6	12.2
COBRA												
Military					78.5							
MCHA												
Other private individual insurance				9.6		9.6	224.0			50.5	7.9	42.6
Medicaid or GAMC				5.8		1.1		510.3		92.7	92.7	
MinnesotaCare (MNCare)				0.6			0.5		128.9	5.9	5.9	
Uninsured												
Medicaid/MNCare eligible				3.7		4.8	1.1			119.7	119.7	
Not Medicaid/MNCare eligible				3.8		3.3				102.1		102.1
Combined Reforms with Subsidies												
Self-insured private employer plans	1,064.7			7.3		1.2				53.4	20.9	32.5
Insured private employee plans		1,491.5		17.5		6.4				103.8	32.4	71.4
Government employee plans			523.2	2.8		0.3				19.1	4.5	14.6
COBRA												

TABLE C.3 (*continued*)

	Current Case											
	Self-insured Private Employer Plans	Insured Private Employer Plans	Government Employer Plans	COBRA	Military	MCHA	Other Private Individual Insurance	Medicaid or GAMC	MNCare	Uninsured	Uninsured and Medicaid/ MNCare Eligible	Uninsured and not Medicaid/ MNCare Eligible
Military					78.5							
MCHA												
Other private individual insurance				14.2		15.5	224.0			79.9	19.5	60.4
Medicaid or GAMC				6.4		1,644		510.3		98.2	98.2	
MinnesotaCare (MNCare)				0.9			1.6		128.9	9.9	9.9	
Uninsured												
Medicaid/MNCare eligible							0.1			60.5	60.5	
Not Medicaid/MNCare eligible										61.7		61.7

Source: Mathematica Policy Research.

APPENDIX D

ESTIMATED MONTHLY PREMIUMS FOR SINGLE AND FAMILY COVERAGE: MINNESOTANS UNDER AGE 65 IN THE CURRENT CASE AND POLICY SIMULATIONS, FY2009

This page has been intentionally left blank for double-sided copying.

TABLE D.1

ESTIMATED MONTHLY PREMIUMS FOR SINGLE AND FAMILY COVERAGE: MINNESOTANS UNDER AGE 65 IN THE CURRENT CASE AND POLICY SIMULATIONS, FY2009

		(1)	(2a)	(2b)	(3)	(1+2a+3)	(1+2b+3)
	Current Case	Small Group and Individual Guaranteed Issue and Community Rating	Individual Mandate with Affordability Exemption	Individual Mandate with Subsidies	Mandatory Offer of Section 125 Plan	Combined Reforms with Affordability Exemption	Combined Reforms with Subsidies
Employer Coverage							
Number of workers (000's)	1,604.3	1,605.6	1,657.4	1,687.1	1,614.8	1,642.2	1,655.8
Number of dependents (000's)	1,359.1	1,368.2	1,456.9	1,495.4	1,393.0	1,468.6	1,519.3
Average employee contribution							
Single coverage	$122	$124	$118	$116	$110	$108	$107
Family coverage	$248	$249	$246	$245	$220	$219	$218
Percent of persons with employee contribution as a percent of income							
Less than 7%	89.6%	89.5%	90.1%	89.2%	91.6%	92.2%	90.8%
7 to 10%	5.2%	5.2%	5.0%	6.6%	3.8%	3.5%	5.0%
More than 10%	5.1%	5.3%	4.9%	4.6%	4.6%	4.3%	4.2%
Small Group							
Number of workers (000's)	294.5	295.9	334.3	352.9	295.1	308.5	311.1
Number of dependents (000's)	225.4	230.8	274.5	279.4	230.4	267.8	287.3
Average employee contribution							
Single coverage	$118	$129	$110	$106	$118	$107	$106
Family coverage	$181	$185	$177	$177	$180	$164	$164
Percent of persons with employee contribution as a percent of income							
Less than 7%	86.8%	86.0%	88.5%	87.4%	86.8%	89.7%	87.2%
7 to 10%	6.5%	6.1%	5.8%	7.1%	6.4%	4.6%	7.3%
More than 10%	6.7%	7.9%	5.7%	5.5%	6.8%	5.7%	5.5%

TABLE D.1 (*continued*)

	Current Case	(1) Small Group and Individual Guaranteed Issue and Community Rating	(2a) Individual Mandate with Affordability Exemption	(2b) Individual Mandate with Subsidies	(3) Mandatory Offer of Section 125 Plan	(1+2a+3) Combined Reforms with Affordability Exemption	(1+2b+3) Combined Reforms with Subsidies
Large Group		-					
Number of workers (000's)	1,309.8	1,309.8	1,323.0	1,334.2	1,319.7	1,333.7	1,344.8
Number of dependents (000's)	1,133.6	1,137.4	1,182.4	1,216.0	1,162.6	1,200.8	1,232.1
Average employee contribution							
Single coverage	$123	$122	$122	$120	$108	$108	$107
Family coverage	$262	$262	$262	$260	$228	$231	$230
Percent of persons with employee contribution as a percent of income							
Less than 7%	90.2%	90.2%	90.5%	88.9%	92.6%	92.7%	91.6%
7 to 10%	5.0%	5.0%	4.9%	6.4%	3.3%	3.3%	4.4%
More than 10%	4.8%	4.8%	4.7%	4.8%	4.2%	4.0%	3.9%
Individual Coverage							
Number of persons (000's)							
Single coverage	94.4	115.0	107.6	114.4	101.8	115.6	133.0
Family coverage	156.5	189.2	174.1	185.8	164.8	178.2	200.7
Average premium							
Single coverage	$215	$246	$221	$217	$202	$215	$206
Family coverage	$340	$353	$338	$330	$322	$322	$309
Percent of persons with employee contribution as a percent of income							
Less than 7%	63.0%	57.5%	64.8%	62.0%	65.2%	69.3%	63.9%
7 to 10%	12.7%	14.3%	13.1%	17.1%	12.2%	11.6%	19.3%
More than 10%	24.2%	28.2%	22.2%	20.8%	22.6%	19.1%	16.8%

Source: Mathematica Policy Research.

Note: Employer coverage excludes COBRA, self-employed workers, and workers and dependents in firms of unknown size.

APPENDIX E

ESTIMATED ANNUAL STATE AND FEDERAL EXPENDITURES FOR PUBLIC PROGRAMS IN THE CURRENT CASE AND POLICY SIMULATIONS, FY2009

This page has been intentionally left blank for double-sided copying.

TABLE E.1

ESTIMATED ANNUAL STATE AND FEDERAL CONTRIBUTIONS BY PROGRAM, CURRENT CASE AND POLICY SIMULATIONS, FY2009

		(1)	(2a)	(2b)	(3)	(1+2a+3)	(1+2b+3)
	Current Case	Small Group and Individual Guaranteed Issue and Community Rating	Individual Mandate with Affordability Exemption	Individual Mandate with Subsidies	Mandatory Offer of Section 125 Plan	Combined Reforms with Affordability Exemption	Combined Reforms with Subsidies
Number Enrolled and Total Annual State Expenditure							
Medical Assistance and GAMC							
Number enrolled (thousands)	510.3	511.9	601.0	606.5	510.3	609.9	616.6
State expenditure (billions)	$2.450	$2.450	$2.960	$2.990	$2.450	$3.000	$3.050
Federal expenditure (billions)	$1.990	$2.000	$2.410	$2.440	$1.990	$2.450	$2.480
MinnesotaCare							
Number enrolled (thousands)	128.9	133.2	132.3	137.1	128.9	136.0	141.3
State expenditure (billions)	$0.249	$0.253	$0.260	$0.268	$0.249	$0.269	$0.277
Federal expenditure (billions)	$0.124	$0.128	$0.126	$0.133	$0.124	$0.128	$0.135
Individual premium (billions)	$0.032	$0.033	$0.033	$0.034	$0.032	$0.034	$0.035
Affordability subsidies							
Number receiving subsidies (thousands)	N/A	N/A	N/A	89.9	N/A	N/A	108.8
State expenditure (billions)	N/A	N/A	N/A	$0.125	N/A	N/A	$0.133
Average Annual State Expenditure, per Enrollee							
Medical Assistance and GAMC	$4,791	$4,784	$4,918	$4,933	$4,791	$4,922	$4,939
MinnesotaCare	$1,934	$1,902	$1,967	$1,954	$1,946	$1,977	$1,962
Affordability subsidies	N/A	N/A	N/A	$1,389	N/A	N/A	$1,220

Source: Mathematica Policy Research.

This page has been intentionally left blank for double-sided copying.

APPENDIX F

CALCULATION OF STATE REVENUE EFFECTS

This page has been intentionally left blank for double-sided copying.

APPENDIX F: CALCULATION OF STATE REVENUE EFFECTS

Net fiscal impact is calculated as the sum of the change in state revenue received (ΔRev) plus the change in state expenditures (ΔExp). How the revenue effects are estimated is explained below.

The proposed health policy alternatives can affect state revenues in two ways: as a result of a change in taxes that individuals pay, and as a result of a change in the taxes that carriers pay. The total change in state revenue is the sum of the two components, represented as:

$$\Delta\text{Rev} = \Delta\text{Rev}_1 + \Delta\text{Rev}_2 \,.$$

We explain how each component is estimated below.

A. CHANGE IN INDIVIDUAL INCOME TAX REVENUES

The first source of a change in state revenue (ΔRev_1) is due to factors that change the amount of taxes paid by individuals. We separate this effect into two components:

- A change in tax receipts due to a change in individuals' taxable premium payments (ΔRev_{1a})
- A change in tax receipts received from low-income families due to changes in their eligibility for and/or amount of the MWFC (ΔRev_{1b})

Each is discussed below.

a. Taxable premiums

The change in tax receipts due to a change in individuals' taxable premium payments is calculated as:

$$\Delta\text{Rev}_{1a} = \sum_{i=1}^{I} (\Delta p_i * t_i) \quad (1)$$

where *i* indexes Minnesota families, p is the change in the family's premium contribution paid with pre-tax dollars, and *t* is the family's state marginal income tax rate. We assume the family's marginal tax rate does not change.

If a family that was not initially paying for health insurance with pre-tax dollars begins to do so, then p will be negative and equal to the total amount the family begins to pay for health insurance. If the family previously was paying for health insurance with pre-tax dollars, then p reflects the change in the cost of the family's portion of the premium.

Note that ΔRev_{1a} could be either negative or positive. An increase in the number of families using pre-tax dollars to pay health insurance premiums would decrease aggregate AGI and therefore reduce tax revenues. However, for families that previously paid for health insurance with pre-tax dollars, the impact on AGI depends on whether their premium payments increase or decrease. If premium payments decrease, aggregate AGI (and therefore tax revenues) will increase; conversely, lower premiums would increase aggregate AGI and total tax revenues.

b. The MWFC

The second source of a change in individual income tax payments, ΔRev_{1b}, could occur either because families newly qualiFYfor the MWFC or because previously qualified families experience a change in the amount of the credit they receive. In some cases—such as when families begin to use Section 125 plans to pay health insurance premiums, lowering their AGI—both could occur.

We estimate the change in state tax receipts due to changes in MWFC as:

$$\Delta \text{Rev}_{1b} = \sum_{m=1}^{M} \left(MWFC_{m0} - MWFC_{m1} \right) \qquad (2)$$

where *m* indexes families, the subscripts 0 and 1 refer to before and after the policy change respectively, and *MWFC* is the value of the family's credit. For families who newly qualiFYfor the MWFC, their tax payments will decrease by the value of the MWFC ($-MWFC_{m1}$). For families who already receive the credit, their tax payments will change by the amount of any change in their credit.[7]

All else being equal, when families newly qualiFYfor the MWFC, state individual tax revenues decline. However, tax revenues received from individuals who already receive the credit could increase or decrease, depending on their level of AGI—although for families who would newly make use of a Section 125 plan, the amount of their credit probably would increase and, therefore, net state tax revenues would decrease.[8]

---

[7] Because ΔRev_{1a} captures the change in individual tax payments due to a potential change in families' taxable income, ΔRev_{1b} reflects only the change in families' tax payments due to changes in the amount of credit received through MWFC.

[8]At the lowest levels of income, both the EITC and the MWFC increase dollar benefits as earned income increases. Therefore, at very low levels of income, the credits would decline as adjusted gross income is reduced via use of Section 125 accounts. However, individuals at this level of income would not reasonably use Section 125 accounts, since the after-tax price of insurance would *increase* as their reported gross income (net of Section 125 contributions) declined.

The overall change in tax receipts from individuals is calculated as:

$$\Delta\text{Rev}_1 = \Delta\text{Rev}_{1a} + \Delta\text{Rev}_{1b} \qquad (3)$$

B. CHANGE IN PREMIUM TAX REVENUES

The second source of a change in state revenue (ΔRev_2) results from a change in the insurance companies' tax payments due to a change in their premium base. There are two potential sources for a change in the premium base: (a) a change in the level of premiums; and (b) a change in insured lives.

The change in premium tax revenue is represented by:

$$\Delta\,\text{Re}\,v_2 = \sum_{sl=1}^{SL}(\Delta P_{sl} * .02) + \sum_{h=1}^{H}(\Delta P_h * .01) + \sum_{nh=1}^{NH}(\Delta P_{nh} * .02)$$

where *sl* indexes workers and dependents in self-insured plans with stop-loss coverage; *h* indexes those enrolled in HMOs, nonprofit health service plan corporations and community integrated service networks; *nh* indexes all other insured individuals not in the other plan types (*h* or *sl)* and subject to the premium tax[9]; and P represents stop-loss premiums per covered life, or otherwise carriers' gross premiums less return premiums.[10]

Not having information to identiFYwhether individuals in the microsimulations are (or become) enrolled in a specific insured plan type (*h* or *nh),* we simpliFYestimation of the change in premium tax revenue as follows:

$$\Delta\,\text{Re}\,v_2 = \sum_{sl=1}^{SL}(\Delta P_{sl} * .02) + \sum_{hp=1}^{HP}(\Delta P_{hp} * .014) \qquad (4)$$

where *hp* represents all carriers that pay the premium tax, and the premium tax rate is adjusted by the weighted average by the average of the number of health insurance providers of each type (*h* and *nh).* To estimate P for self-insured with stop-loss coverage, we assume stop-loss premium

---

[9] Minnesota Statute 2971.15 lists all exemptions from the insurance tax, including plans covering government employees; revenues and reimbursements for Medicare-related coverage; self-insured groups without stop-loss coverage; premiums for Minnesota Comprehensive Health Association; and premiums paid to fraternal benefit societies.

[10]This calculation in based on information in Sec. 297I.05, Minnesota Statutes 2006 (http://ros.leg.mn/bin/getpub.php?pubtype=STAT_CHAP_SEC&year=current§ion=297I.05&image.x=0&image.y=0&image=Get+Section, accessed December 1, 2007). Minnesota also levies a 2 percent tax on claims paid by joint self-insurance plans. However, these plans are believed to be rare, if they exist at all; therefore, we assume that there is no change in claims paid by joint self-insurance plans. Return premiums refer to the amount that individuals are reimbursed when they disenroll having already paid for additional months of coverage.

revenue is 2.30 percent of all self-insured expenditures.[11] For those in insured plans (*hp*), we estimate P as total earned premiums.

The change in state revenue due to the change in stop loss and/or health premium tax revenues could be positive or negative. An increase in insured lives would increase the premium base and premium tax revenues. But the decrease in health insurance premiums that would drive increased enrollment could reduce the premium base (even with increased enrollment) and, therefore, decrease premium tax revenues. The net effect would depend on which impact dominates.

[11] The Minnesota Department of Health estimates that stop-loss premium revenues are equal to 123.6 percent of all stop-loss medical payments, and that stop-loss medical payments are equal to 1.86 percent of all self-insured medical payments.