MILLIMAN REPORT

State of Minnesota Department of Human Services

Public Option Study

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Exhibits

I. EXECUTIVE SUMMARY

Milliman, Inc. (Milliman) has been contracted by the Minnesota Department of Human Services (DHS) to perform an analysis of public option (PO) models to assist the State of Minnesota (the State) in evaluating the financial impact of such a program on the State and the feasibility of implementing a potential amendment to the State's 1332 waiver. This report provides DHS and other key stakeholders with analysis to evaluate the budgetary impacts to the State and whether to submit a 1332 waiver amendment for a PO and, if so, the design of the PO. The legislation that grants authority for this analysis was introduced through Minnesota Senate File 2995[1] as passed during the 2023-2024 State Legislative Session[2] (SF 2995) and is described in more detail in Section II of this report.

Based on SF 2995, our analysis assumes a public option health plan will be effective beginning in 2027. Furthermore, we assume enhanced federal premium subsidies available through the American Rescue Plan Act (ARPA) and extended by the Inflation Reduction Act (IRA) will expire after 2025, consistent with current law. We refer to these subsides as "enhanced premium subsides" throughout the remainder of this report. In addition, the analyses in this report assume the Medicaid redeterminations related to the expiration of the COVID-19 public health emergency (PHE) will be completed prior to the implementation of the PO. Finally, based on input from the State, our analysis assumes the existing 1332 waiver reinsurance program is approved through 2027, but ceases to operate after 2025. Other key modeling assumptions and considerations are described throughout this report. Our data and methodology, including a glossary of key terms, is included in Section VI.

Consistent with the requirements of SF 2995 and at the request of the State, we provide the analyses under two frameworks:

- ***Model 1***: The PO is offered through the same program structure as the MinnesotaCare program, which currently operates as a Basic Health Program (BHP) under Section 1331 of the ACA for eligible enrollees with incomes between 133% and 200% of the federal poverty level (FPL). Under this framework, enrollees in the PO with incomes above 200% FPL would be eligible to enroll in the same benefit plan currently offered under the BHP. PO enrollees will not be enrolled on the state-based marketplace (SBM), also known as MNsure, but may continue to use the MNsure platform to evaluate their health insurance options. To partially fund the cost of this program, a 1332 Waiver amendment would be submitted to CMS to generate pass-through funding (PTF) by capturing federal savings on subsidized individuals currently enrolled in a QHP through MNsure who enroll in the PO.
- ***Model 2***: The PO is offered through MNsure as a qualified health plan (QHP) at platinum, gold, and silver metal levels. Enrollees in platinum PO plans, referred to as MinnesotaCare Platinum plans throughout this report, will be eligible for a state-funded premium wrap and supplemental benefits. To partially fund this program, an amendment to the State's current 1332 waiver would be submitted to capture subsidy savings as PTF generated from the PO silver plan lowering the benchmark on MNsure.

Eligibility for the PO under either model framework will be limited to those with incomes greater than 200% FPL who are not otherwise eligible for a Minnesota Health Care Program and who do not have an affordable offer of employer-sponsored insurance.[3] The PO is not expected to impact MinnesotaCare enrollment under either framework.

This report is not the required actuarial and economic analysis and certification for a 1332 waiver. Rather, this report provides sufficient analyses to support the State's determination of whether a PO program under either of these two models could meet the requirements of a Section 1332 waiver, thereby capturing any available federal funds as pass-through savings under such a waiver. These funds could then be used to fund or partially fund the public option program.

The modeled waiver scenarios are based on input and guidance from the State. Table 1 summarizes the models and the scenarios modeled in this report:

[1] Minnesota Senate File (SF) 2995; https://www.revisor.mn.gov/bills/text.php?number=SF2995&version=latest&session=ls93&session_year=2023&session_number=0

[2] Laws of Minnesota 2023, Chapter 70, Article 16, Sections 20-21

[3] To qualify as affordable, the employee's required contribution for the plan must not exceed 9.5% of the applicable taxpayer's household income. [26 USC 36(c)(2)(C(i)(II)]. This value is indexed for the excess of the rate of premium growth over the rate of income growth. [26 USC 36B(c)(2)(IV)]

Table 1 State of Minnesota Department of Human Services Public Option Study Scenarios		
Framework	**Scenario**	**Description**
	Baseline	Baseline – No PO / No waiver amendment
Model 1: MinnesotaCare Public Option Administered by DHS	Scenario 1A	BHP Reimbursement / No Subsidy Limit[4]
	Scenario 1B	BHP Reimbursement / 400% FPL Subsidy Limit
	Scenario 1C	Medicare Reimbursement / No Subsidy Limit
	Scenario 1D	Medicare Reimbursement / 400% FPL Subsidy Limit
Model 2: Public Option offered as a QHP on MNsure	Scenario 2A	BHP Reimbursement / No Subsidy Limit
	Scenario 2B	BHP Reimbursement / 400% FPL Subsidy Limit
	Scenario 2C	Medicare Reimbursement / No Subsidy Limit
	Scenario 2D	Medicare Reimbursement / 400% FPL Subsidy Limit

The initial scenario assumes the State does not have a PO and therefore does not have a waiver amendment. We refer to this scenario as the "Baseline" scenario. The waiver scenarios are compared to the Baseline scenario to measure the projected PTF available to the State after the introduction of the PO, as well as the funding expected to be provided through enrollee premiums.

The aggregate cost of health care is funded by three sources, as follows:

- Enrollees are responsible for a portion of the gross premium (depending on eligibility for federal and state premium subsidies) and cost-sharing at the point of service (e.g., copays and deductibles). Please note, the enrollee out-of-pocket responsibility related to cost-sharing is not explicitly quantified in this analysis; however, we discuss the relative impact on cost-sharing obligations.

- The federal government is responsible for the portion of the gross premium that qualifies for federal subsidies for enrollees on the SBM and PTF from the 1332 waiver. Federal subsidies are dependent on enrollee income, enrollee plan selection, and the premium for the second lowest cost silver plan on the SBM. PTF is explained throughout this report.

- The State is responsible for the amount of aggregate gross premium not funded by enrollee premiums and federal funding. The State's cost would need to be funded by a state-based source (e.g., general fund revenue, insurer assessment).

With the exception of enrollee cost-sharing at the point-of-service, the scenarios in this report estimate the portion of PO program costs funded by each of these sources. These scenarios and the calculation of PTF are also required to demonstrate compliance with federal 1332 waiver deficit neutrality requirements.[5]

The first scenario under each framework assumes current MinnesotaCare provider reimbursement levels and an enrollee premium scale for enrollees above 200% FPL that is the same as the ARPA enhanced premium subsidies (i.e., increases with income to a maximum of 8.5% of income with no subsidy limit). The second scenario under each framework assumes the same provider reimbursement levels and enrollee premium scale as in the first scenario up to 400% FPL, but enrollees with incomes greater than 400% FPL do not receive premium subsidies.

We modeled two additional scenarios under each framework to show the impact if provider reimbursement (inpatient facility, outpatient facility, and professional, but excluding prescription drug costs) increases to Medicare levels. Scenarios 1C, 1D, 2C, and 2D are the same as Scenarios 1A, 1B, 2A, and 2B, respectively, except they reflect Medicare provider reimbursement levels.

The primary difference between the scenarios with the same letter under Model 1 and Model 2 (e.g., Scenario 1A and Scenario 2A) is the PO framework (i.e., MinnesotaCare versus QHP).

[2] With a subsidy limit, subsidies are not available (i.e., subsidies are $0) above a certain income level. Under the ACA and prior to enhanced federal subsidies currently available as a result of ARPA, the subsidy limit occurred at 400% FPL, at which point enrollees with incomes that exceeded 400% FPL by one dollar incurred a large increase in enrollee premiums.

[5] Waiver requirements require projections for the 5-year waiver window and the 10-year deficit neutrality window. For brevity, this analysis provides single year estimates of PTF, but future years of either 5 or 10-year projections are consistent with the 1-year projection.

We do not expect the PO to have an impact on current MinnesotaCare program components. In other words, MinnesotaCare program components (e.g., eligibility, cost-sharing) are not affected by the presence or absence of the PO. However, federal funding for the MinnesotaCare program is based on the second lowest cost silver (SLCS) plan premium on MNsure, which may be impacted by the PO. We explain the relationship between MinnesotaCare federal funding and the SLCS in Section II.C. The PO's impact on the SLCS, and likewise the BHP federal funding, is driven by different factors between Models 1 and 2. We discuss these drivers and the related modeling assumptions reflected in each waiver scenario throughout this report.

A. SUMMARY OF RESULTS

Tables 2A and 2B show the projected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required state funding in CY 2027 for each scenario under Models 1 and 2 on a per member per month (PMPM) basis and in total. The cost of PO coverage under both frameworks is based on the gross premium for all coverage, including non-EHB benefits which are covered as state-funded supplemental benefits under Model 2. Under Model 1, the cost of PO coverage is borne by the State, and enrollee premiums and PTF reduce the State's cost. Under Model 2, the cost of PO coverage is borne by the QHP issuers, and enrollee premiums are paid directly to the QHP issuers. The State's cost under Model 2 is driven by the state premium wrap and supplemental benefits, but reduced by PTF. The State will pay the state premium wrap and supplemental benefit costs directly to the QHP issuers.

We apply a 10% margin to projected required state funding to account for unknown contingencies including, but not limited to changes in federal or state law, significant healthcare innovations, new prescription drugs, variances in PO take-up patterns and consumer selection.

Note, PMPM values shown throughout this report represent averages. Actual PMPM values for individual enrollees will vary significantly by rating area, enrollee age, income, and metal level prior to the PO. We illustrate this variance by age and income in Section III.E.

Model 1: MinnesotaCare Public Option administered by DHS

Based on the assumptions and program parameters outlined in this report, we estimate the following results under Model 1 relative to a baseline scenario that assumes no PO, as shown in Table 2A:

- Under the Model 1 framework, the estimated cost of PO coverage based on the modeled scenarios is between $652 and $805 PMPM and between $943 million and $1.26 billion in total annual cost.
- The estimated cost to the State of a PO program under the Model 1 framework is between $65 and $213 PMPM and between $103 million and $331 million in total annual cost. The estimated annual cost to the State after the 10% margin for unknown contingencies is between $113 million and $364 million in total.
- We estimate between 107,000 and 144,000 people will enroll in the PO, coming from the projected 2027 MNsure population, individuals with off-exchange individual coverage, and people with uninsured status. See Table 8 for detailed information on projected 2027 enrollment by source of coverage.
- The primary driver of the lower cost for the State in Scenario 1B versus Scenario 1A is the enrollee premium scale that eliminates state premium subsidies above 400% FPL. This lowers projected PO uptake and increases the average federal funding per enrollee. See Table 10 for additional details on this effect.
- The primary driver of the higher cost for the State in Scenario 1C versus Scenario 1A is the higher provider reimbursement levels, from approximately 83% of Medicare in Scenario 1A to 100% of Medicare in Scenario 1C. The higher provider reimbursement increases the cost of PO coverage. Federal funding and PO enrollee premiums also increase, but by a smaller percentage than the cost of PO program cost coverage, so the State's costs increase by more. See Table 11 for additional details on this effect.
- The total cost for the State under Scenario 1D is similar to the total cost under Scenario 1A because of the net effect of higher provider reimbursement, lower average PO enrollee premiums PMPM, and lower enrollment. The higher provider reimbursement increases the cost of PO coverage PMPM, while the lower enrollment and a younger age mix reduces the cost of PO coverage. The lower average enrollee premiums PMPM and lower enrollment are both driven by State subsidies ending at 400% FPL, which reduces program take-up from higher income and older individuals. See Table 12 for additional details on this effect.

- Using data and methodologies that would be used to certify a 1332 waiver, we estimate federal PTF under Model 1 will cover approximately $328 million of annual program costs. This estimate is largely consistent across all Model 1 scenarios, despite the differences in projected PO enrollees, because we assume the scenario differences primarily impact unsubsidized enrollees, and unsubsidized enrollees do not generate PTF. As a result, we estimate the PTF PMPM will be between $190 and $255.

- Approximately $421 million to $656 million of annual PO program costs under Model 1 is estimated to be funded through enrollee premiums. On a PMPM basis, the average enrollee premium is estimated to cover between $327 and $382 of the cost of PO coverage.

Table 2A
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option Cost and Funding in 2027 for Model 1

		Scenario 1A	Scenario 1B	Scenario 1C	Scenario 1D
Enrollment					
(a)	Projected 2027 population* – Baseline	471,000	471,000	471,000	471,000
(b)	% selecting PO	31%	28%	28%	23%
(c)	Projected PO enrollees = (a) * (b)	144,000	131,000	131,000	107,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$682	$652	$805	$734
(e)	PO enrollee premium PMPM	$380	$377	$382	$327
(f)	Federal subsidies for PO enrollees PMPM	n/a	n/a	n/a	n/a
(g)	Federal PTF from PO enrollees PMPM	$190	$210	$210	$255
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$112	$65	$213	$152
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$1,177,000	$1,021,000	$1,255,000	$943,000
(j)	PO enrollee premium	$656,000	$590,000	$596,000	$421,000
(k)	Federal subsidies for PO enrollees	n/a	n/a	n/a	n/a
(l)	Federal PTF from PO enrollees	$328,000	$328,000	$328,000	$328,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$193,000	$103,000	$331,000	$194,000
(n)	Required state funding with margin = (m) * 1.1	$212,000	$113,000	$364,000	$213,000

** Includes people with individual market coverage through MNsure and the off-exchange individual market, and uninsured people.*

Model 2: Public Option offered as a QHP on MNsure

Based on the assumptions and program parameters outlined in this report, we estimate the following results under Model 2 relative to a baseline scenario that assumes no PO, as shown in Table 2B:

- Under the Model 2 framework, the estimated total cost of PO coverage based on the modeled scenarios is between $665 and $737 PMPM and between $1.15 billion and $1.27 billion in total annual cost.

- The estimated cost to the State of a PO program under the Model 2 framework is between $45 and $99 PMPM and between $78 million and $170 million in total annual cost. The estimated annual cost to the State after the 10% margin for unknown contingencies is between $86 million and $187 million in total.

- The cost of PO coverage is similar between Model 1 and Model 2, but average enrollee premiums PMPM are generally higher under Model 2 because of the assumed mix of PO enrollees by rating area, enrollee age, income, and metal level.

- In general, we project that the PO enrollment and costs under Model 2 are less sensitive to the subsidy limit than under Model 1.

- Using data and methodologies that would be used to certify a 1332 waiver, we estimate federal PTF under Model 2 will cover between $157 million and $188 million of annual program costs.

Table 2B
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option Cost and Funding for Model 2

		Scenario 2A	Scenario 2B	Scenario 2C	Scenario 2D
Enrollment					
(a)	Projected 2027 population* - Baseline	471,000	471,000	471,000	471,000
(b)	% selecting PO	32%	31%	30%	29%
(c)	Projected PO enrollees = (a) * (b)	151,000	145,000	143,000	135,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$681	$665	$737	$712
(e)	PO enrollee premium PMPM	$425	$417	$435	$417
(f)	Federal subsidies for PO enrollees PMPM	$92	$96	$112	$120
(g)	Federal PTF from MNsure enrollees PMPM	$104	$108	$91	$97
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$60	$45	$99	$77
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	**$1,234,000**	**$1,159,000**	**$1,272,000**	**$1,152,000**
(j)	PO enrollee premium	$771,000	$726,000	$751,000	$675,000
(k)	Federal subsidies for PO enrollees	$167,000	$167,000	$194,000	$194,000
(l)	Federal PTF from MNsure enrollees	$188,000	$188,000	$157,000	$157,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$108,000	$78,000	$170,000	$126,000
(n)	Required state funding with margin = (m) * 1.1	**$119,000**	**$86,000**	**$187,000**	**$139,000**

** Includes people with individual market coverage through MNsure and the off-exchange individual market, and uninsured people.*

Under Model 2, the components of the required state funding can also be allocated between the cost of the state premium wrap and the cost of supplemental benefits, minus the federal PTF. Table 2C shows this allocation of the required state funding under each scenario.

Table 2C State of Minnesota Department of Human Services Public Option Study Projected 2027 Public Option State Cost Components for Model 2					
		Scenario 2A	Scenario 2B	Scenario 2C	Scenario 2D
PMPM State Cost Components					
(a)	Cost of state premium wrap	$132	$122	$158	$143
(b)	Cost of supplemental benefits	$32	$32	$32	$32
(c)	Federal PTF from MNsure enrollees	$104	$108	$91	$97
(d)	Required state funding = (a) + (b) - (c)	$60	$45	$99	$77
Annual State Cost Components (in thousands)					
(e)	Cost of state premium wrap	$238,000	$212,000	$273,000	$232,000
(f)	Cost of supplemental benefits	$57,000	$55,000	$54,000	$51,000
(g)	Federal PTF from MNsure enrollees	$188,000	$188,000	$157,000	$157,000
(h)	Required state funding = (e) + (f) - (g)	$108,000	$78,000	$170,000	$126,000

Model limitations

The estimated cost of PO coverage, federal subsidies and PTF, and PO enrollee premium amounts are sensitive to the assumptions used in the modeling of each of these amounts. The financial results under the PO could vary significantly from what is shown in Tables 2A, 2B, and 2C and elsewhere in this report if the actual experience does not conform to the assumptions used to develop these estimates. We include sensitivity analyses on Scenarios 1A and 2A in Section IV around select assumptions to provide additional context.

Results are also sensitive to the number and distribution of people who migrate to the PO from either the individual market (MNsure and off-exchange) or from the uninsured population. The required state funding shown in Tables 2A and 2B could change depending on several factors, including age and FPL mix of people who enroll in a PO (in the case of both model frameworks) or who migrate to MNsure from either off-exchange coverage or the uninsured population (in the case of Model 2).

Additionally, federal subsidies for enrollees who remain enrolled in a QHP through MNsure (in Model 1) and BHP federal funding for MinnesotaCare enrollees (under both models) are sensitive to certain modeling assumptions, such as the change in the second lowest cost silver plan premium and the morbidity of the individual market single risk pool after accounting for expected migration into or out of MNsure under a PO program. We discuss our assumptions and the potential implications of these assumptions in more detail throughout this report.

The remainder of this report explains the detailed assumptions we applied in our calculation of these estimates. Additionally, we provide information for the State's consideration as to how changes to the assumptions and program design parameters may impact the PO program costs and funding levels from different sources.

Potential impact on other revenue sources

The PO will impact other state and non-state revenue streams. We identify these below; however, there may be additional revenue sources that are also impacted which are not listed.

BHP federal funding

As noted above and described in more detail in Section II.C, the BHP federal funding formula relies on the subsidies that would otherwise be paid to enrollees had they been enrolled in Marketplace coverage. Marketplace subsidies are indexed off the second lowest cost silver (SLCS) plan in a county.

Under Model 1, the primary driver of a change in the SLCS is the potential change in morbidity among MNsure enrollees due to people who leave MNsure to enroll in the PO. While it is likely that MNsure morbidity will change due to migration from MNsure to the PO, the direction and magnitude are difficult to predict with any practical certainty. Therefore, the results shown for Scenarios 1A through 1D assume no morbidity difference in populations enrolled on MNsure before

and after the establishment of a public option. We provide sensitivity analyses for Scenario 1A in Section IV.B to illustrate how Scenario 1A would change if MNsure morbidity increases or decreases. The general direction and magnitude of these sensitivity analyses can be extrapolated to Scenarios 1B through 1D.

Under Model 2, the primary driver of the change in the SLCS is the decrease in provider reimbursement. New MNsure enrollees who migrate from off-exchange or uninsured status as a result of the PO may have some impact on MNsure morbidity; however, we expect this impact to be relatively immaterial since the individual market is already reasonably large and stable.[6] Individual market enrollment increases due to the PO, which we estimate to be approximately 27% under Model 2, are likely to stabilize the risk profile further. We estimate the SLCS will decrease from the Baseline scenario by 35% in Scenarios 2A and 2B and by 30% in Scenarios 2C and 2D due solely to reduced provider reimbursement. We describe these SLCS changes in more detail in Section VI. Based on these assumed changes in the SLCS, we estimate BHP federal funding could decrease by approximately $184 million in Scenarios 2A and 2B and $158 million in Scenarios 2C and 2D, unless CMS applies a Section 1332 Waiver Factor[7] to the BHP funding calculation.

If CMS does not apply a Section 1332 Waiver Factor to the BHP funding formula, the amount of BHP federal funding at risk may exceed the 1332 waiver federal PTF. In this case, the State may consider offering the PO without a 1332 waiver and without a silver metal level offering to avoid the potential loss of BHP federal funding.

State insurance premium tax

The State receives a premium tax for all health insurance premiums for coverage issued in Minnesota. The premium tax is one percent of annual gross premiums for township mutual insurance companies and two percent of annual gross premiums for all other health insurers. The impact of the PO on state insurance premium tax revenue is outside the scope of our analysis.

MNsure exchange fee

MNsure collects a 3.5% assessment on all exchange premium revenue. Under Model 1, we expect aggregate exchange premium revenue will decrease as enrollees migrate to the PO offered as a MinnesotaCare program. Under Model 2, the impact on the MNsure exchange fee is more sensitive to PO take-up experience since we expect aggregate exchange premium revenue will increase due to new exchange enrollment, but exchange premiums for MNsure enrollees who switch to a PO plan may increase because higher premiums under the MinnesotaCare Platinum plan will replace current premiums in bronze, silver, and gold plans. The MNsure exchange fee is collected by MNsure to fund MNsure operations and does not impact state funding requirements. Therefore, the impact of the PO on the MNsure exchange fee is outside the scope of our analysis.

B. DATA RELIANCE AND IMPORTANT CAVEATS

Differences between the projected amounts in this report and actual program experience will depend on the extent to which future experience conforms to the assumptions made in the calculations. It is certain that actual experience will not conform exactly to the assumptions used in the calculations due to differences in program design, health care cost and utilization trends, economic changes, provider reimbursement levels, regulatory or legislative changes, consumer behavior, exchange issuer pricing assumptions, population changes, and many other factors. The most material assumption in this modeling is the extent to which migration to the PO occurs, once offered. This depends in part on predictions of consumer behavior, which is subject to significant uncertainty and variability.

There is heightened uncertainty concerning future insurance market enrollment due to the recent expiration of the COVID-19 public health emergency (PHE) and its associated policies, specifically the redetermination of current Medicaid enrollees and in certain cases, the termination of Medicaid coverage.

This report represents our best estimate of future experience, given the assumptions described in this report and information that is currently available.

[6] Although we assume no impact on MNsure morbidity due to the PO under both Models 1 and 2, the reasons are different. Under Model 1, we make a neutral assumption because no reliable prediction can be made, whereas the impact is predictable but immaterially small under Model 2.

[7] 42 CFR Part 600 Basic Health Program; Federal Funding Methodology for Program Year 2023 and Changes to the Basic Health Program Payment Notice Process: https://www.govinfo.gov/content/pkg/FR-2022-12-20/pdf/2022-27211.pdf; Section III.D.7; Retrieved January 3, 2024.

Milliman developed certain models to estimate the values included in this report. The intent of the models was to estimate the financial impact of a public option program based on Minnesota's Basic Health Program, known as MinnesotaCare, and provide analysis to support the requirements of Minnesota SF 2995. We reviewed the models, including their inputs, calculations, and outputs, for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data, assumptions, and other information as inputs. We relied upon certain data and information provided by the Minnesota Department of Human Services (DHS), Minnesota Department of Commerce (COMM), MNsure, and publicly available data published by the State of Minnesota and federal agencies to develop the analyses shown in this report. We did not audit this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency, and we did not find material defects in the data. If there are material defects in the data, it is possible they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable, or for relationships that are materially inconsistent. Such a review was beyond the scope of our engagement.

We prepared this report for the specific purpose of evaluating the enrollment changes and financial impacts due to the introduction of a public option program. This report should not be used for any other purpose. This report has been prepared for the internal business use of, and is only to be relied upon by, the management of DHS and COMM. We understand this report may be shared with other interested parties as a part of the State of Minnesota's 1332 waiver design and modeling discussions. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. This report should only be reviewed in its entirety. The results of this analysis may not be appropriate for every stakeholder.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

The authors of this report are health actuaries. Milliman's advice is not intended to be a substitute for qualified tax, legal, or accounting counsel.

The authors of this report are actuaries for Milliman, members of the American Academy of Actuaries, and meet the Qualification Standards of the Academy to render the actuarial opinion contained herein. To the best of their knowledge and belief, this report is complete and accurate and has been prepared in accordance with generally recognized and accepted actuarial principles.

II. BACKGROUND

A. STATE AUTHORITY

Minnesota Senate File 2995 (SF 2995)[8] requires the Department of Human Services (DHS) to contract with an independent third-party actuarial firm to perform an analysis of public option models so the Commissioner of Commerce, in consultation with the Commissioners of Human Services and Health and the Board of Directors of MNsure, can report to the chairs and ranking members of the legislative committees with primary jurisdiction over health care finance and policy and health insurance, as required by Section 21 of Chapter 70, Article 16 of the Minnesota state statutes.

B. FEDERAL 1332 WAIVER REQUIREMENTS

The federal requirements applicable to Section 1332 State Innovation Waivers are summarized below.

Section 1332 waiver guardrails

CMS requires 1332 waivers to satisfy four guardrails. Minnesota's Public Option (PO) waiver will need to meet each of these guardrails, which are explained in more detail below.

1. Affordability of premiums and cost-sharing.

   Section 31 CFR 33.108(f)(3)(iv)(B) requires that premiums and cost-sharing under the waiver must be at least as affordable overall as premiums and cost-sharing absent the waiver.

   The State of Minnesota (the State) could implement a PO 1332 waiver amendment that satisfies this guardrail through several program designs, including but not limited to:

   - Offering the **same** levels of enrollee premiums and cost-sharing currently available for the SLCS on MNsure.
   - Offering the **same** levels of enrollee premiums and **lower** cost-sharing than currently available for the SLCS on MNsure.
   - Offering **lower** enrollee premiums and the **same** levels of cost-sharing than currently available for the SLCS on MNsure.
   - Offering **lower** levels of enrollee premiums and cost-sharing than are currently available for the SLCS on MNsure.

   The State does not intend to force enrollees to select a PO offering; however, **the waiver would satisfy this guardrail if enrollee premiums and cost-sharing *available* under the waiver will be at least as affordable as enrollee premiums and cost-sharing absent the waiver for all enrollees**. In short, the affordability guardrail is fulfilled if all enrollees will have *access* to a PO offering whose enrollee premiums and cost-sharing are at least as affordable overall as premiums and cost-sharing absent the waiver. The scenarios modeled in this report for both Models 1 and 2 would satisfy the affordability guardrail because enrollee premiums based on the PO premium scale are always less than or equal to premiums available on MNsure after federal subsidies, and premiums for PO offerings under Model 2 will be lower than premiums available without the waiver (for those who are not eligible for state premium subsidies). Cost-sharing on the PO is more affordable than without the waiver due to the higher actuarial value[9] (AV) of the PO offerings.

2. Comparable number of state residents covered.

   Section 31 CFR 33.108(f)(3)(iv)(C) requires that coverage must be provided to a comparable number of state residents under the waiver as would be covered without the waiver. It is our understanding that a Minnesota PO will not contain any provisions that would be expected to decrease the number of state residents covered.

[8] Minnesota Senate File (SF) 2995; https://www.revisor.mn.gov/bills/text.php?number=SF2995&version=latest&session=ls93&session_year=2023&session_number=0

[9] Actuarial value (AV) is the percentage of non-premium health care expenses expected to be covered by the plan. A 94% AV means the enrollee can expect to be responsible for 6% of non-premium costs, on average. A higher AV implies lower out-of-pocket costs for enrollees.

To the contrary, the PO may increase the number of state residents covered because it offers lower enrollee premiums and better coverage than would be available without a PO.

3. Comparable coverage.

   Section 31 CFR 33.108(f)(3)(iv)(A) requires that coverage provided under the waiver must be at least as comprehensive overall as coverage available without the waiver. It is our understanding that the State does not intend to make any changes to the requirements for qualified health plans (QHPs), network adequacy, metallic level requirements (including de minimis amounts), essential health benefits, or other coverage requirements on MNsure. All waiver scenarios modeled in this report assume the PO will offer the same coverage as the BHP, which offers enhanced coverage versus QHPs. Therefore, we expect all scenarios modeled in this report will comply with this guardrail.

4. No increase to federal deficit.

   Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires the total of various costs to be considered when determining the impact on the federal deficit. The scenarios presented in this report are not expected to increase the federal deficit when compared to the Baseline scenario without the waiver. All models and scenarios result in a material reduction to federal spending on premium subsidies and no increase in federal outlays or reductions in federal revenues elsewhere.

Other federal requirements

The foregoing requirements are the most important from an actuarial perspective. Based on this analysis, which includes a calculation of pass-through funding (PTF) identical to that which would be done in a 1332 waiver certification, we believe a public option under any of the scenarios shown herein will meet these requirements and will qualify to receive PTF.

A 1332 waiver must meet other federal requirements related to modeling parameters, program operations, and reporting. Additional federal requirements that the State will need to consider, but that do not impact the actuarial analysis, are listed in the CCIIO Checklist for Section 1332 State Relief and Empowerment Waivers..[10]

C. CURRENT MINNESOTA COVERAGE AND MINNESOTACARE FUNDING LANDSCAPE

As context and a baseline for further modeling, we estimate the number of Minnesotans in 2022 with coverage in the various available public and private health insurance markets. Note, these enrollment totals are provided as general estimates, particularly given shifts in the market related to the COVID-19 pandemic, Medicaid continuous enrollment and disenrollment, and the enhanced premium subsidies. Eligibility for coverage in each of these markets is primarily a function of employment status, employer health insurance offerings and affordability, household income relative to the federal poverty level (FPL), age, disability status, family circumstances, and other potential factors.

In 2022, approximately 95.3% of Minnesotans had health insurance coverage through one of the public or private markets, leaving approximately 4.7% of Minnesotans uninsured. Since March 2020, all coverage markets have been affected by the public health emergency (PHE), which has several implications for the PO and the waiver modeling herein. In addition to the overall impact of the PHE on health care utilization and costs in all markets, PHE-related policy changes may also affect how the PO will interact with other markets. For each of the existing markets, we discuss the relative importance of the market in terms of its relationship with the individual market, the impact of the end of the PHE, the impact of enhanced premium subsidies, and the interaction of those effects.

Medicare

Medicare is the primary source of coverage for older Americans and those with qualifying disabilities. Based on the program design of the PO, we do not assume any enrollment will transition between Medicare and the PO. Although some individual market enrollees will become eligible for Medicare based on age between 2022 and 2027, we assume the overall enrollment distribution among insurance markets in Minnesota, excluding the uninsured population and individual market, will remain consistent over time under the non-waiver Baseline scenario and the waiver scenarios..[11]

[10] CMS (July 2019). Checklist for Section 1332 State Relief and Empowerment Waivers (also called Section 1332 waivers or State Innovation Waivers) Applications. Retrieved December 14, 2023, from https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Checklist-for-Section-1332-State-Relief-and_Empowerment-Waivers.pdf.

[11] Medicare enrollment does not impact the determination of whether Minnesota's 1332 waiver meets the required guardrails discussed in this report.

Employer-sponsored coverage

We do not assume any enrollment will transition between employer-sponsored coverage and the individual market, other than what would normally happen. Normal movement between these markets often occurs due to the offering rate of employer-sponsored coverage and the affordability of that offer. We assume these dynamics will remain consistent with past patterns and similar under waiver and non-waiver scenarios. There is some possibility that the popularity of the Individual Coverage health reimbursement arrangement (ICHRA) could grow, migrating members from group coverage, in either the small group or large group markets, to the individual market but we make no explicit assumption related to this.

Medical Assistance

The Minnesota Medicaid program (known as the Medical Assistance program, together with MinnesotaCare also called "Minnesota Health Care Programs") provides health care coverage for beneficiaries who qualify on the basis of income, disability, or other factors, such as being in foster care or receiving adoption assistance. In general, beneficiaries who qualify for Medical Assistance (MA) are not eligible to acquire private coverage or receive premium tax credits on private health insurance plans sold through MNsure. However, enrollment application increases on MNsure have sometimes led to increased MA enrollment because some uninsured individuals who apply for coverage on the exchange are redirected to the Medical Assistance program.

As a result of the Families First Coronavirus Response Act (FFCRA), state Medicaid programs were subject to maintenance of eligibility (MOE) requirements to qualify for a temporary additional 6.2% federal medical assistance percentage (FMAP)..[12] States were not permitted to disenroll anyone from Medicaid until the PHE expired unless the enrollee was deceased, moved out of state, or asked the state to be disenrolled. Enrollment in Medicaid populations where eligibility is tied to income has grown significantly since the beginning of the PHE, particularly among adults. Coinciding with the expiration of the PHE in early 2023, states began redetermining Medicaid eligibility and disenrolling those who no longer qualify.

We expect some people disenrolled from the Medical Assistance program to be eligible for individual insurance and premium tax credits through MNsure, some may already have employer-sponsored coverage, and some will become uninsured. Disenrollments due to the expiration of the PHE are expected to be completed prior to the PO effective date. This waiver analysis assumes a portion of 2023 MA enrollees will enroll in MNsure between 2023 and the PO effective date. We do not expect the exact timing of the disenrollments to have a material impact on the results of the waiver analysis. This transition from Medicaid to other markets is reflected in all Baseline and waiver scenarios.

MinnesotaCare Basic Health Program

Minnesotans who are not eligible for MA but have incomes at or below 200% FPL are eligible to enroll in the Minnesota Basic Health Program (BHP), operated as MinnesotaCare. Enrollees in the BHP receive substantially all Medical Assistance state plan benefits, which offer more coverage than the essential health benefits (EHBs) required to be provided through MNsure, Minnesota's SBM. BHP enrollees pay a portion of the premium, ranging from $0 to $80, based on income level. The MinnesotaCare BHP receives federal funding equivalent to 95% of the estimated federal premium subsidies that enrollees would have received had they been enrolled in MNsure, which is different than the federal matching percentage approach applied in other Public Programs.

Federal funding for the BHP is currently calculated as 95% of federal subsidies the enrollee would have received on the exchange based on a budgeted SLCS selected by CMS (which may or may not be the actual SLCS for the year), with the following adjustments:

- A premium adjustment factor to account for the impact of the BHP on silver loading in MNsure
- A reinsurance 1332 waiver adjustment factor to account for the impact of reinsurance on the SLCS
- An income reconciliation factor that mimics the income reconciliation for federal subsidies on the exchange

Our model assumes some enrollment will migrate to the BHP due to Medicaid redeterminations. We do not assume any migration to or from the BHP as a result of the PO.

[12] Dolan, R. et al. (December 17, 2020). Medicaid Maintenance of Eligibility (MOE) Requirements: Issues to Watch. Kaiser Family Foundation. Retrieved November 8, 2022, from https://www.kff.org/medicaid/issue-brief/medicaid-maintenance-of-eligibility-moe-requirements-issues-to-watch/

Individual coverage

Since the inception of the ACA, health care coverage on MNsure has been available on a guaranteed issue basis to Minnesotans who are not eligible for other coverage (employer, Medicare, MA, MinnesotaCare) and have qualifying immigration status. This includes people with household incomes greater than 200% FPL and some specific populations with incomes less than 200% of the FPL, such as legal immigrants,[13] who are not eligible for MA.

The State adopted a 1332 waiver reinsurance program which began in 2018. The reinsurance program reduces the risks to individual market issuers associated with high-cost claimants. The 1332 reinsurance waiver is approved through 2027; however, the state funding for the reinsurance program will expire after 2025.

Prior to the PHE, qualifying enrollees with household incomes up to 400% FPL were eligible for federal premium subsidies to offset part or all of their premiums. The American Rescue Plan Act of 2021 (ARPA) legislation passed in response to the PHE extended federal premium subsidies on marketplace plans to enrollees with incomes greater than 400% FPL and increased premium subsidies for those below 400% FPL. These enhanced premium subsidies were renewed through 2025 with the Inflation Reduction Act.

The expiration of the PHE and enhanced premium subsidies will both have significant impacts on the individual market in Minnesota. Material changes in enrollment and morbidity are expected to occur that will affect PTF estimates modeled in this report. As with MA, we assume these changes will occur between now and the beginning of the PO in 2027.

In 2021, the Biden administration announced administrative changes that affected certain individuals previously unable to enroll in exchange coverage due to the so called “family glitch.” Proposed rules for these changes were released in October 2022 and implemented by the State effective January 1, 2023. These changes made it more affordable for these individuals and their families to enroll, in many cases. This may result in a potential increase in enrollment in Minnesota’s individual market, coming primarily from people with uninsured status.[14] However, based on discussions with MNsure, the observed increase in MNsure enrollment to date for enrollees above 200% FPL has been small, as expected. This change would appear in both the Baseline and waiver scenarios, with an immaterial impact overall on PTF. Therefore, we do not make any specific assumptions on the impact of this change in our modeling, assessing it to be relatively small, with the estimated effect being similar with or without the waiver.

Uninsured

The number of uninsured people in Minnesota will fluctuate for various reasons over time, but for purposes of this analysis material fluctuations can be expected due to the end of the PHE, the end of enhanced premium subsidies, and the end of the State 1332 waiver reinsurance program. Specifically, we assume a portion of those disenrolled from Medicaid due to the ending of the PHE will become uninsured. Likewise, we assume some people on the individual market will disenroll and migrate to an uninsured status due to the expiration of enhanced premium subsidies.

The number of uninsured people in Minnesota does not have a direct impact on the PTF under the Model 1 framework since they would not receive any federal premium subsidies under either the Baseline or waiver scenarios. However, the number of uninsured people who enroll in the PO under the Model 1 framework will increase required state funding. Under the Model 2 framework, the uninsured people who enroll in the PO and who are eligible for subsidies would increase aggregate federal premium subsidies. Based on 1332 waiver requirements, the PTF generated by the waiver reflects the *net change* in federal funding due to lower federal subsidies for continuing MNsure enrollees and new federal premium subsidies attributable to newly covered enrollees from an uninsured status. Therefore, the PTF under Model 2 is dependent on the number of uninsured people in Minnesota, and particularly those who are eligible for federal subsidies who also enroll in MNsure in response to the PO. In addition, the required state funding under the Model 2 framework will increase due to the additional costs of any premium subsidies for uninsured people who enroll in the PO.

D. PROJECTED MINNESOTA COVERAGE AND MINNESOTACARE FUNDING LANDSCAPE

The PO is assumed to begin in 2027; however, as described above, we anticipate changes in the Minnesota coverage landscape between 2022 and 2027 due to the expiration of the PHE, the expiration of enhanced premium subsidies, and the expiration of funding for the reinsurance program for the individual market. To advance the enrollment and population estimates from 2022 to 2027 for purposes of establishing a baseline scenario for modeling PTF, the impacts

[13] Beginning in 2025, legal immigrants with qualifying income levels will be eligible to participate in Medicaid and MinnesotaCare.
[14] CMS has estimated an increase of 1 million individual market enrollees nationwide due to this change. https://www.federalregister.gov/documents/2022/10/13/2022-22184/affordability-of-employer-coverage-for-family-members-of-employees#p-215

from the PHE, ARPA, and general population growth are shown in Table 3. These values are rounded to emphasize that they are estimates of enrollment several years into the future with material known changes to the coverage landscape, as well as potential unknown changes. There is a high degree of uncertainty related to these projections, but they represent reasonable expectations given current information and for the purposes of this modeling. Note, the sums of some rows and columns may not match the totals due to rounding.

Table 3
State of Minnesota Department of Human Services
Public Option Study
Summary of 2022-2027 Enrollment Changes by Insurance Type (in thousands)

	MNsure	Off-Exchange	Employer / Group	Minnesota Care	Medicaid*	Uninsured	Medicare / Other	Total
2022 Population	107	56	2,805	106	1,365	269	1,010	5,718
2024 Medicaid Redeterminations**	17	0	60	9	(106)	20	0	0
2026 ARPA Subsidies Expire	(10)	0	2	0	0	8	0	0
2026 End of Reinsurance Funding	(5)	(5)	1	0	0	10	0	0
Population Growth 2022-2027	1	1	29	1	13	3	10	57
2027 Estimated Population (Before PO)	110	51	2,897	116	1,271	310	1,020	5,776

**Medicaid includes Dual-eligibles*
***Medicaid enrollment grew into 2023 before redeterminations, so total redeterminations reflected in projections are greater than the net change from 2022 enrollment shown above*

We note the following regarding Table 3:

- As recommended by the State, we estimate total Medicaid disenrollment (approximately 171,000) based on the difference between June 2023 and June 2024 enrollment in the DHS enrollment forecast. The Medicaid redeterminations shown in Table 3 represent the net change from 2022, accounting for the additional growth in enrollment due to the PHE into 2023. We assume beneficiaries disenrolled from Medicaid who transition to the individual market will all be eligible for federal premium subsidies.
- We assume beneficiaries disenrolled from Medicaid will enroll in employer-sponsored and individual coverage or become uninsured approximately in proportion to current market sizes (i.e., proportional allocation).
- We assume population growth at 0.2% annually..[15]
- We assume the expiration of enhanced premium subsidies at the end of 2025 will result in some current individual market enrollees transitioning to an uninsured status because required enrollee premiums will increase.
- We estimate the total number of enrollees transitioning out of individual coverage due to the expiration of enhanced premium subsidies (10,000) by reviewing the change in historical enrollment from 2019 to the open enrollment of 2022 in the State.
- We estimate the total number of enrollees transitioning out of MNsure (5,000) and off-exchange individual market coverage (5,000) populations due to the end of funding for the state reinsurance program by reviewing historical enrollment in the State. The higher gross premiums due to the expiration of reinsurance will primarily affect the unsubsidized population enrolled through MNsure and off-exchange, and they will affect the lightly subsidized population enrolled through MNsure to a lesser extent. MNsure enrollees who have larger subsidies are shielded from gross premium increases. The estimated number of enrollees transitioning out of individual coverage is incremental to the impact of the expiration of enhanced premium subsidies.

[15] https://www.census.gov/quickfacts/fact/table/MN

III. DESCRIPTION OF MODELS AND SCENARIOS

Consistent with Sections 20 through 22 of Chapter 70, Article 16 of SF 2995, we prepared our analysis under two frameworks to allow the State to consider different delivery models for the PO. We describe the two PO model frameworks considered in this analysis below and discuss the key policy differences, as well as the federal pass-through mechanics of each. Each model will require a 1332 waiver amendment for the State to recapture PTCs or recoup savings in PTCs in the form of PTF, but each model will produce PTF through different mechanisms.

A. DESCRIPTION OF MODELS

Model 1: MinnesotaCare Public Option administered by DHS

As required by Sections 20.4 and 20.5 of SF 2995, the first framework (Model 1) assumes the PO is offered through the same program structure as the MinnesotaCare program, which currently consists of a Basic Health Program established under section 1331 of the ACA for eligible Minnesotans with incomes at or below 200% FPL. Under this model, the existing 200% FPL income limit in the MinnesotaCare program would be expanded. This model would be partially funded from a 1332 waiver where the State would request PTF for subsidized enrollees who leave MNsure and enroll in public option coverage.

Under this model, enrollees in the PO would receive the same benefit plan that is currently offered under the BHP. The BHP benefit plan is based on a 94% actuarial value plan, which means it offers lower enrollee cost-sharing than most plans available through MNsure. In addition, PO enrollees would receive some additional benefits that might not otherwise be covered in a typical employer group or SBM plan. These benefits are referred to as supplemental benefits throughout this analysis and include hearing, vision, non-emergency transportation, and dental.

The administration of Model 1 would involve managed care organizations (MCOs) and DHS, similar to the BHP. Based on input from the State, the procurement and administration of the MinnesotaCare program, inclusive of the PO, may be decoupled from the Medicaid managed care program (i.e., the Medical Assistance program) under this framework. **Note, analysis of the impact of these administrative and operational considerations are outside the scope of this report.**

Model 2: Public Option offered as a Qualified Health Plan (QHP) on MNsure

The second framework (Model 2) assumes the PO is offered through the MNsure platform by either existing or new qualified health plan (QHP) issuers. This model is similar to models in other states such as Washington, Nevada, and Colorado. We discuss the mechanics of 1332 waiver PTF for this model further below.

Under this model, the PO will be offered at the platinum, gold, and silver metal levels; however, the state premium wrap will only be available for platinum PO plans, known as MinnesotaCare Platinum plans. The State could choose to allow enrollees to apply the state premium wrap to other metal levels to "buy down" coverage. This option could reduce enrollee premiums, with some enrollees possibly having no premium. However, enrollees who "buy down" would risk having higher out-of-pocket cost-sharing. **For purposes of our analysis, we assume PO enrollees cannot use the state premium wrap to buy down their coverage. We also conservatively assume all PO enrollees enroll in a MinnesotaCare Platinum plan to take full advantage of the state-funded benefits.**[16]

The ACA allows for de minimis variation of plus or minus two percentage points of the AV defined under the ACA for each metal level. The AV for a platinum plan is 90%, which results in an AV de minimis range of 88% to 92% for platinum plans. However, our analysis assumes the State will request and receive CMS approval to offer MinnesotaCare Platinum plans with a 94% AV to align with the AV of MinnesotaCare plans.

In addition, benefits included in the PO that exceed the EHBs required for QHPs would also be administered by health plans and funded by the State. The supplemental benefits noted above under the BHP would have to be administered by QHPs and paid for by the State, as they are not considered essential health benefits (EHB) and cannot be covered by federal premium tax credits. Our modeling assumes these supplemental benefits will only be available to enrollees in MinnesotaCare Platinum plans; however, the State may choose to provide the supplemental benefits to enrollees in PO plans at other metal levels at an additional cost.

[16] In summary, it is a policy decision as to whether the PO is available at all metal levels. Gold and silver offerings are required by exchange issuers, and we assume the PO issuers will be considered exchange issuers in the regulatory sense. An additional policy decision is to allow enrollees to "buy-down" coverage by applying their subsidy to coverage at a lower metal level (e.g., silver, gold, etc.), in order to obtain a lower enrollee premium. If this is allowed and occurs, the State's net cost modeled herein would be lower, all else equal.

The administration of Model 2 would involve QHP issuers, MNsure, and other relevant state agencies.

B. KEY POLICY DIFFERENCES BETWEEN THE MINNESOTACARE AND MNSURE FRAMEWORKS

Key policy differences between the MinnesotaCare and MNsure frameworks are described below. Some of these differences will exist regardless of policy decisions (e.g., differences in the gross premium pricing structure between MinnesotaCare and QHPs). However, the frameworks included in this analysis assume the benefit package offered in Models 1 is the same as the benefit package offered under Model 2 as MinnesotaCare Platinum.

Gross premium pricing

Under Model 1, we assume gross premiums will be priced using a methodology similar to the current MinnesotaCare BHP premiums, with a single premium developed by the State's actuary, except we assume the application of an age rating factor similar to MNsure (i.e., the federal 3:1 age rating curve). The age rating factor results in some costs for older PO enrollees being subsidized by younger PO enrollees, and it creates a difference between the cost of PO coverage and the PO enrollee premium for some enrollees. We assume the gross premium under Model 1 does not vary by rating area.

Under Model 2, we assume gross premiums will be priced using a methodology similar to the current QHP premiums, with issuers developing a unique premium for each offering. Gross premiums vary by rating area. We assume the application of the QHP age rating factor will apply to the PO.

Application of enrollee premium scale

In both models, we use an enrollee premium scale that is similar to the existing BHP enrollee premium requirements for enrollees at or below 200% FPL and similar to federal exchange enrollee responsibility amounts with the enhanced subsidies for enrollees over 200% FPL. However, the premium scale is applied to different gross premium amounts under each model.

Under Model 1, the enrollee premium scale is applied to a gross premium that represents a 94% AV and includes the cost of supplemental benefits. Under Model 2, the enrollee premium scale is applied to a gross premium that represents a 94% AV but does not include the cost of supplemental benefits, consistent with the requirement to exclude EHBs from the calculation of federal subsidies; we assume the QHP issuers' costs for the supplemental benefits will be reimbursed in full by the State.

Therefore, enrollee premiums for lightly subsidized and unsubsidized enrollees in the PO may be lower under Model 2 than under Model 1, all else being equal.

Provider reimbursement

The current MinnesotaCare program being offered as a BHP leverages provider contracting in the Medicaid managed care program. Under Medicaid managed care, health plans negotiate reimbursement rates with providers that are often based on the Medicaid fee schedule. Managed care provider reimbursement levels are generally higher than the Medicaid fee schedule but lower than Medicare provider reimbursement in aggregate, i.e., across all services. Our analysis assumes provider reimbursement for the BHP is approximately 83% of Medicare provider reimbursement.

In the individual market, health plans and providers typically negotiate provider reimbursement rates that are higher than Medicare reimbursement rates. Our analysis assumes baseline provider reimbursement on the SBM without the waiver is approximately 200% of Medicare provider reimbursement.

Based on guidance from the State, the first two scenarios under both Models 1 and 2 reflect BHP provider reimbursement levels. The second set of scenarios under Models 1 and 2 reflect provider reimbursement levels at 100% of Medicare, which is lower than the average provider reimbursement underlying QHPs currently offered on MNsure. This approach allows for comparisons of the impact on PO costs driven by the differences between delivery systems, and it allows the State to evaluate the impact of incremental changes in provider reimbursement on PO costs under each delivery system.

Administrative expenses

Within the scope of our analysis, we include assumptions related to the health plan administrative expenses included in gross premiums that would be used to cover issuer expenses. Many overhead costs for the MinnesotaCare BHP leverage resources that are also used for the Medicaid managed care program, including but not limited to claims processing and provider contracting. Therefore, administrative expenses reflected in the BHP capitation rates under MinnesotaCare are generally lower than administrative expenses reflected in premiums for QHPs. Our analysis inherently captures these cost differences by assuming administrative expenses in the PO are consistent with administrative expenses for the respective framework.

Other administrative expenses related to program implementation and operation (e.g., State agency costs and information technology changes) are not within the scope of our analysis. However, we note that these costs will likely differ in total between Models 1 and 2, with potentially significant impacts by entity.

Pharmacy costs

The MinnesotaCare program uses the same preferred drug list (PDL) as MA to provide continuity to enrollees who transition between MA and MinnesotaCare. Under the Medical Assistance program, managed care plans often pay gross drug costs (prior to rebate), and the State collects rebates paid through the Medicaid Drug Rebate Program.[17] (MDRP). Manufacturers must participate in the MDRP in order for their products to be covered by the Medical Assistance program. Additionally, the Medical Assistance program is required to cover all drugs from manufacturers who participate in the MDRP. Because of MDRP rebates, the net cost to the State for some brand drugs net of rebates is less than the cost of a generic alternative. Therefore, the state PDL favors brand drugs over generic drugs in many instances. Consistent with MinnesotaCare, we assume PO pharmacy costs under Model 1 will be based on the State Medical Assistance PDL.[18]

Manufacturer rebates negotiated by health plans are typically less favorable than MDRP rebates, so QHPs on MNsure generally achieve lower net costs by favoring generic drugs over brand drugs on their PDLs. Consistent with QHPs, we assume PO pharmacy costs under Model 2 will be based on pharmacy claims experience reflected in QHP premiums before the waiver.

Pharmacy costs are assumed to be higher in MinnesotaCare than they would be for the same population in QHPs because of these differences in PDLs. Our analysis inherently captures these cost differences by assuming pharmacy costs in the PO are consistent with pharmacy costs in the respective delivery system.

Covered benefits

QHPs offered through MNsure are required to cover the essential health benefits (EHBs) defined by the ACA. The BHP, however, covers a scope of benefits similar to EHBs plus additional supplemental benefits. The primary benefits covered by the BHP that are not covered by QHPs are dental, vision, hearing, and non-emergency medical transportation (NEMT). NEMT benefits are only provided for children. Based on guidance from the State, our analysis assumes the PO covers the same benefits as the BHP, regardless of the PO framework. Our analysis implicitly captures the cost of supplemental benefits in Model 1 by using actual BHP claims costs to estimate the cost of PO coverage. In Model 2, we make an explicit adjustment to capture the cost of these supplemental benefits.

Cost-sharing

The actuarial value (AV) of a plan is a proxy for the degree of enrollee cost-sharing, where a higher AV means the plan or payer pays more and enrollee cost-sharing is lower. The BHP has a 94% AV, while QHPs offered through MNsure are required to provide plans with AVs that align with metal levels defined by the ACA.[19] The AVs for QHPs range from 60% for a bronze plan to 90% for a platinum plan. The AV for a silver plan is 70%. Based on guidance from the State, our analysis assumes the PO has the same AV as the BHP in both Models 1 and 2. Our analysis implicitly reflects the higher AV in Model 1 by using actual BHP claims costs to estimate the cost of PO coverage. In Model 2, we capture the higher AV with an explicit adjustment to the silver PO plan premium reflecting the difference in AV and expected induced utilization (IU) based on CMS published risk adjustment IU factors.

[17] Medicaid.gov Medicaid Drug Rebate Program (MDRP): https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html. Retrieved January 4, 2024.

[18] Non-Medicaid programs, including MinnesotaCare and a PO, are not eligible for MDRP rebates.

[19] https://www.cms.gov/cciio/resources/files/downloads/av-calculator-methodology.pdf. Retrieved December 14, 2023.

The current MNsure SLCS plan reflects a slightly higher actuarial value (AV) of 73% for members between 200-250% FPL compared to a standard silver plan with 70% AV. However, we understand from the State that the increase (i.e., silver load) applied to premiums to account for this higher AV is very small (i.e., less than 0.5%). Therefore, we do not make any adjustments for the silver load.

Pass-through savings under a 1332 waiver

Generally, pass-through savings under a 1332 waiver are realized through reductions in outlays of federal premium tax credits for individual coverage on MNsure. These reductions in federal spending on premium tax credits are offset by any increases in other federal spending as a result of the waiver (e.g., new subsidy-eligible enrollees on MNsure from uninsured status) or in reductions in federal revenues (e.g., loss of PCORI revenue).[20] The final PTF available to the State will be equal to the net reduction in federal spending on premium tax credits as a result of the 1332 waiver. Under either model, PO implementation would be accompanied by an amendment to the existing State 1332 waiver for the reinsurance program. The availability of PTF will be contingent on approval of the waiver amendment.

PTF under Model 1

If the PO is administered by DHS (or through any other vehicle other than MNsure), pass-through savings will be generated by the reduction in federal premium subsidies currently paid on behalf of QHP enrollees through MNsure who disenroll from individual coverage on the exchange and migrate to the PO. In effect, the waiver will request that the subsidy currently being paid on behalf of the enrollee will "move" with the individual when they enroll in the PO. Pass-through savings will not be generated by PO enrollees who migrate from unsubsidized individual coverage or from uninsured status because they do not receive federal premium subsidies prior to the PO.

It is important to note that, because a large number of enrollees may exit from the individual risk pool under Model 1, the stability of the remaining individual market may be compromised. This could result in an increase or decrease to premium rates of QHPs on MNsure that could impact the federal funding for Minnesota's BHP. It is possible, depending on CMS interpretation, that any change in funding to the BHP caused by the introduction of the PO might be offset by changes in the BHP funding formula. We cannot reasonably predict the direction or magnitude of changes to MNsure rates under Model 1. To avoid any implied prediction or precision of this impact, the scenarios modeled in this report assume the SLCS under the Model 1 framework does not change as a result of the PO; however, we provide sensitivity analyses on Scenario 1A to illustrate the potential impact on MinnesotaCare federal funding and PTF if the SLCS increases or decreases due to the implementation of a PO offered through the MinnesotaCare framework.

PTF under Model 2

If the PO is offered through MNsure as a QHP, pass-through savings will be generated if the PO creates a reduction to the SLCS premium by county, as this would result in lower federal premium subsidies. As noted earlier, we assume the PO will be offered at the silver metal level. We further assume there will be at least two PO QHPs in each rating area, one that becomes the lowest cost silver plan and one that becomes the SLCS. As in the Model 1 framework, this reduction in the SLCS may decrease federal funding for the BHP, depending on CMS interpretation of appropriateness of various factors used in the BHP funding formula.

C. DESCRIPTION OF SCENARIOS

The scenarios are summarized in Table 1, as shown in the Executive Summary and reproduced here for convenience. All PO scenarios assume no impact to the existing Basic Health Plan (BHP) due to the introduction of the PO. In addition, all PO scenarios assume enhanced premium subsidies and funding for the 1332 reinsurance waiver program expire at the end of 2025.

[20] https://www.irs.gov/newsroom/patient-centered-outcomes-research-institute-fee

Table 1 State of Minnesota Department of Human Services Public Option Study Scenarios		
Framework	**Scenario**	**Description**
	Baseline	Baseline – No PO / No waiver amendment
Model 1: MinnesotaCare Public Option Administered by DHS	Scenario 1A	BHP Reimbursement / No Subsidy Limit[21]
	Scenario 1B	BHP Reimbursement / 400% FPL Subsidy Limit
	Scenario 1C	Medicare Reimbursement / No Subsidy Limit
	Scenario 1D	Medicare Reimbursement / 400% FPL Subsidy Limit
Model 2: Public Option offered as a QHP on MNsure	Scenario 2A	BHP Reimbursement / No Subsidy Limit
	Scenario 2B	BHP Reimbursement / 400% FPL Subsidy Limit
	Scenario 2C	Medicare Reimbursement / No Subsidy Limit
	Scenario 2D	Medicare Reimbursement / 400% FPL Subsidy Limit

For simplicity, we model a single maximum enrollee premium PMPM by FPL band. Table 4 shows the maximum enrollee premium amount we modeled for the second lowest cost silver plan as a percentage of income and a PMPM in the Baseline (federal premium scale[22]) and PO scenarios (8.5% premium scale).

For example, the maximum enrollee premium amount we modeled for an enrollee who earns between 200% to 250% FPL is $273.44 in the Baseline scenario and $128.35 in the PO scenarios (based on the 8.5% state PO premium scales). The annual incomes used to model these enrollee premiums within each FPL band are based on an estimate of the distribution of incomes from enrollees through MNsure in 2022.

Table 4 State of Minnesota Department of Human Services Public Option Study Maximum Modeled Enrollee Premium								
	Federal Premium Scale After Expiration of Enhanced Premium Subsidies		**8.5% State PO Premium Scale with No Subsidy Limit**		**8.5% State PO Premium Scale with 400% FPL Subsidy Limit**		**10.0% State PO Premium Scale with No Subsidy Limit**	
Scenarios:	**Baseline**		**1A, 1C, 2A, 2C**		**1B, 1D 2B, 2D**		**Sensitivity Tests for 1A and 2A**	
	(1)	**(2)**	**(3)**	**(4)**	**(5)**	**(6)**	**(7)**	**(8)**
FPL Bucket	**% of Income**	**Maximum Enrollee Premium PMPM**	**% of Income**	**Maximum Enrollee Premium PMPM**	**% of Income**	**Maximum Enrollee Premium PMPM**	**% of Income**	**Maximum Enrollee Premium PMPM**
Under 100%	N/A	N/A	0.75%	$10.00	0.75%	$10.00	0.75%	$10.00
100 to 133%	2.07%	$36.65	0.90%	$15.88	0.90%	$15.88	0.90%	$15.88
133 to 150%	4.02%	$79.75	1.21%	$23.94	1.21%	$23.94	1.21%	$23.94
150 to 200%	6.42%	$170.61	2.95%	$78.28	2.95%	$78.28	2.95%	$78.28
200 to 250%	8.26%	$273.44	3.88%	$128.35	3.88%	$128.35	5.38%	$178.02
250 to 300%	9.71%	$386.71	5.88%	$234.10	5.88%	$234.10	7.38%	$293.84
300 to 400%	9.83%	$475.11	7.51%	$362.95	7.51%	$362.95	9.01%	$435.45
400 to 500%	N/A	No Max	8.50%	$554.66	N/A	No Max	10.00%	$652.55
500 to 600%	N/A	No Max	8.50%	$646.30	N/A	No Max	10.00%	$760.36
Over 600%	N/A	No Max	8.50%	$792.75	N/A	No Max	10.00%	$932.65

[21] With a subsidy limit, subsidies are not available (i.e., subsidies are $0) above a certain income level. Under the ACA and prior to enhanced federal subsidies currently available as a result of ARPA, the subsidy limit occurred at 400% FPL, at which point some enrollees with incomes that exceeded 400% FPL by one dollar incurred a large increase in enrollee premiums.

[22] Prior to ARPA, the federal maximum premium percentages were indexed based on premium and income growth. The exact percentage limits if ARPA expires are unknown. Current projections indicate the indexed limits may be lower in 2027 than immediately prior to ARPA. For conservatism, we model the same percentages immediately prior to ARPA.

Table 5 lists the key factors for which we make modeling assumptions that impact each scenario. A brief description of our assumptions for each factor is provided in Tables 6A through 6D. Detailed methodology and sourcing can be found in Section VI of this report.

Table 5
State of Minnesota Department of Human Services
Public Option Study
Scenario Assumptions

		Model 1				Model 2			
	Baseline	Scenario 1A	Scenario 1B	Scenario 1C	Scenario 1D	Scenario 2A	Scenario 2B	Scenario 2C	Scenario 2D
Enrollment									
General population growth	X	X	X	X	X	X	X	X	X
Expiration of the PHE	X	X	X	X	X	X	X	X	X
Expiration of enhanced premium subsidies	X	X	X	X	X	X	X	X	X
Expiration of the 1332 reinsurance waiver program	X	X	X	X	X	X	X	X	X
PO migration		X	X	X	X	X	X	X	X
Premiums									
Premium trend	X	X	X	X	X	X	X	X	X
PO provider reimbursement		X	X	X	X	X	X	X	X
Actuarial value adjustment						X	X	X	X
Morbidity – PO impact on MNsure		X	X	X	X				
Morbidity – expiration of the PHE	X	X	X	X	X	X	X	X	X
Morbidity – expiration of enhanced premium subsidies	X	X	X	X	X	X	X	X	X
Expiration of the 1332 reinsurance waiver program	X	X	X	X	X	X	X	X	X
Pharmacy cost basis (BHP versus QHP)		X	X	X	X	X	X	X	X
Administrative cost basis (BHP versus QHP)		X	X	X	X	X	X	X	X
Level of covered benefits		X	X	X	X	X	X	X	X
Subsidies									
Indexed FPL	X	X	X	X	X	X	X	X	X
PO Enrollee premium scale		X	X	X	X	X	X	X	X
Expiration of enhanced premium subsidies	X	X	X	X	X	X	X	X	X
Other funding sources									
BHP federal funding	X	X	X	X	X	X	X	X	X
State premium wrap						X	X	X	X

Tables 6A through 6D describe the assumptions in each of the categories listed above.

Table 6A
State of Minnesota Department of Human Services
Public Option Study
Scenario Assumption Descriptions – Enrollment

Assumption	Brief Description
General population growth	We assume all markets grow by 0.2% annually due to general population growth. This growth is assumed to apply uniformly across the individual market (e.g., across income levels, age groups, metallic levels, etc.).
Expiration of the PHE	We assume approximately 171,000 Medicaid enrollees are disenrolled between 2023 and 2025 following eligibility redeterminations due to the expiration of the PHE. We assume some of the disenrolled Medicaid enrollees have other coverage and some are uninsured.
Expiration of enhanced premium subsidies	We assume individual market enrollment decreases by approximately 10,000 enrollees between 2025 and 2026 due to the expiration of enhanced premium subsidies. The number of uninsured individuals increases due to the expiration of enhanced premium subsidies.
Expiration of the 1332 reinsurance waiver program	We assume individual market enrollment decreases by approximately an additional 10,000 enrollees between 2025 and 2026 due to the expiration of the 1332 reinsurance waiver program, with about 5,000 each leaving from MNsure and off-exchange. This assumption is incremental to the impact of the expiration of enhanced premium subsidies. The number of uninsured individuals increases due to the expiration of the 1332 reinsurance waiver program.
PO migration	We assume migration to the PO will come from current enrollment on the exchange (MNsure), off-exchange, and people with uninsured status and will vary by market and scenario based on the impact of the following considerations: ▪ Enrollee premiums ▪ Actuarial value of the PO ▪ Covered benefits

Table 6B State of Minnesota Department of Human Services Public Option Study Scenario Assumption Descriptions – Premiums	
Assumption	**Brief Description**
Premium trend	Gross premiums for the individual market and MinnesotaCare are projected with a 4% annual increase.
PO provider reimbursement	We assume provider reimbursement for PO plans is the same as provider reimbursement for BHP plans or 100% of Medicare, depending on the scenario. For Model 1, we assume a 0% increase for BHP reimbursement (since Model 1 premiums are based on BHP experience) and a 14% increase to benefit expenses for 100% of Medicare reimbursement. For Model 2, we assume a 35% decrease to gross premiums for BHP reimbursement (since Model 2 premiums are based on commercial MNsure experience) and 30% decrease for 100% of Medicare reimbursement. The derivation of these factors is described in Section VI.
Actuarial value	We assume the MinnesotaCare Platinum plan will be priced using theoretical relativities for AV and IU compared to the PO silver SLCS.
Morbidity	PO impact on individual market: Individual market morbidity is not assumed to change as a result of the PO. However, based on the PO migration assumptions under the Model 1 framework, it is possible the morbidity of enrollees remaining in the individual market will change. We have no reliable basis to evaluate the direction or magnitude of the morbidity impact. Therefore, we assume no change, but we evaluate the sensitivity of key metrics to a 10% increase or decrease in morbidity.
	Expiration of the PHE: Individual market morbidity is not assumed to change due to the expiration of the PHE.
	Expiration of enhanced premium subsidies: Individual market morbidity is not assumed to change due to the exit of enrollees who lose enhanced premium subsidies.
Expiration of the 1332 waiver reinsurance program	Based on estimates from the State, we assume gross premiums in the individual market increase by 25% from 2025 to 2026 due to the expiration of the 1332 waiver reinsurance program.
Pharmacy cost basis (BHP versus QHP)	We assume PO premiums will reflect the pharmacy cost policy consistent with the delivery framework. Pharmacy costs for a PO under Model 1 are based on the state formulary and drug costs reflected in MinnesotaCare. Pharmacy costs for a PO under Model 2 are based on health plan formularies and drug costs reflected in QHPs offered through MNsure.
Administrative cost basis (BHP versus QHP)	We assume PO premiums will reflect the administrative expense policy consistent with the delivery framework. Administrative costs for a PO under Model 1 are based on MinnesotaCare administrative expense loads. Administrative costs for a PO under Model 2 are based on administrative costs reflected in QHPs offered through MNsure.
Level of covered benefits	We assume the PO will cover the same benefits covered under MinnesotaCare, except we assume the supplemental benefits are only offered on MinnesotaCare Platinum plans under Model 2. We assume the PO under Model 1 and the MinnesotaCare Platinum plans under Model 2 will also have the same AV as the BHP.

Table 6C State of Minnesota Department of Human Services Public Option Study Scenario Assumption Descriptions – Subsidies	
Assumption	**Brief Description**
Indexed FPL	The 100% federal poverty level (FPL), used to calculate a PTC-eligible person's subsidy, is increased in 2023 by 7.3% and by 2.5% annually thereafter.
PO Enrollee premium scale	We assume PO enrollee premiums vary by scenario, as shown in Table 4. This premium scale will apply to all PO plans under Model 1 and to MinnesotaCare Platinum plans on-exchange under Model 2.
Expiration of enhanced premium subsidies	We assume eligibility for federal subsidies and federal subsidies by income level revert to pre-ARPA levels after 2025, i.e., when the enhanced premium subsidies expire.

Table 6D State of Minnesota Department of Human Services Public Option Study Scenario Assumption Descriptions – Other Funding Sources	
Assumption	**Brief Description**
BHP federal funding	We assume CMS will offset any impact of the PO on the BHP federal funding amount through either a population health factor adjustment under Model 1 or a 1332 waiver adjustment under Model 2. Therefore, we assume the PO will have no impact on BHP federal funding.
State premium wrap	We assume Minnesota will fund a state premium wrap under Model 2 to cover the difference between the PO enrollee premium scale and the federal premium scale for enrollees in a MinnesotaCare Platinum plan. The state premium wrap is not available to enrollees on other plans (e.g., silver or gold PO plans).

Each of the assumptions described in Tables 6A through 6D is developed independently based on our best estimates; however, actual experience relative to each assumption will most likely differ to varying degrees. Furthermore, the amount of time between this analysis and the beginning of the PO introduces additional potential for variability to the projected impact of the PO on enrollment and costs because it extends the duration of the projection and increases the possibility of unforeseen events occurring. The potential variances include, but are not limited to, enrollment volume and distribution, plan selection, regulatory changes, utilization and cost trend, and member agency.

Additional details about the data sources, methodology, and assumptions used to model each of these scenarios are provided in Section VI of this report below.

Impact on Minnesota Health Care Programs

We assume the PO will have no impact on the Minnesota Health Care Programs, which include Medical Assistance (i.e., Medicaid), MinnesotaCare, the Medicare Savings Programs, and the Minnesota Family Planning Program. Minnesota evaluates eligibility for Insurance Affordability Programs (which include the Minnesota Health Care Programs and the individual market) in the following order:[23]

- Medical Assistance for Families with Children and Adults
- MinnesotaCare
- Qualified health plan (QHP) with advanced premium tax credit (APTC) (i.e., MNsure with subsidy eligibility)
- Qualified health plan (QHP) without subsidy (i.e., MNsure without subsidy)

Based on input from DHS, we expect the PO to have a similar enrollment hierarchy as APTC and QHP without subsidy, with the difference being eligibility for a state subsidy. Therefore, applicants who are eligible for Medical Assistance or MinnesotaCare will not be eligible to enroll in the PO. Furthermore, the PO does not make any changes to benefits or premiums in the Minnesota Health Care Programs.

If the PO is offered through the MinnesotaCare framework, we assume capitation rates for the BHP and the PO will be developed separately. Federal funding for MinnesotaCare is dependent on the SLCS. If the implementation of the PO results in changes to the SLCS, we expect CMS may apply an adjustment to offset that impact. We describe the potential CMS adjustments and quantify the potential exposure in this report.

D. OTHER MODELS CONSIDERED

BHP and PO offered through MNsure

We considered an additional framework, Model 3, in which both the BHP and the PO are offered on the exchange, i.e., through QHPs on MNsure. Under this framework, the existing BHP and the MinnesotaCare program would transition to a QHP product offered on MNsure with supplemental benefits and CSRs, as necessary, such that the PO coverage would be equivalent to the coverage offered under the BHP.

Advantages of the Model 3 framework include:

- Operational and public-facing benefits from having both programs under MinnesotaCare on a single platform, such as a unified enrollment approach for all incomes

[23] https://hcopub.dhs.state.mn.us/epm/1_2_1.htm. Retrieved December 14, 2023.

- An increase in federal funds from 95% of federal subsidies payable towards the BHP to 100% of the federal subsidy allowance on the exchange
- A single delivery system for all income levels, both below 200% FPL and above, through QHPs on MNsure, which would reduce the administrative burden on the State related to MinnesotaCare
- A program that would be fully administered by MNsure

Disadvantages of the Model 3 framework include:

- Administrative burden on the State and MNsure to develop and implement state premium wraps and CSR wraps to keep BHP enrollees financially whole relative to their current out-of-pocket costs and premium responsibility
- Ineligibility of undocumented Minnesotans to enroll in plans through MNsure

Under Model 3, federal funding for BHP enrollees would be generated directly through the federal subsidies provided on the exchange, without the 5% reduction applied under the BHP.

The State determined that this framework is not consistent with overall program goals, which include protecting the current MinnesotaCare program.

PO offered through both MinnesotaCare and MNsure

We considered a framework in which the BHP remains in MinnesotaCare, but the PO is offered through both MinnesotaCare and MNsure. Under this framework, the State would offer a PO similar to Model 1 and a PO similar to Model 2 at the same time. The State determined that this framework would be inefficient, confusing, and inconsistent with overall program goals.

E. DISCUSSION OF PUBLIC OPTION TAKE-UP RATE ASSUMPTIONS

An important driver of overall PO program costs in all scenarios is the extent to which individuals and families switch their coverage from individual market coverage or take up new coverage under the PO from uninsured status. The out-of-pocket costs a potential enrollee will incur are a key determinant in coverage decisions. Lower out-of-pocket premiums and cost-sharing will generally correlate with higher take-up rate assumptions.

Enrollee premium scale

Under either Model 1 or Model 2, enrollees will have a responsibility for a portion of the premium, proportional (scaled) to their income. The premium responsibility for enrollees on any PO plan in the Scenarios modeled in this analysis[24] will always be less than or equal to what is required after the application of federal subsides alone. As seen by comparing columns 4, 6, and 8 to column 2 in Table 4 below (repeated here from Section III.C for convenience), the state enrollee premium scale, will almost always reduce the enrollee premium. Note, the 10% state enrollee premium scale may be higher than the federal premium scale for some individuals.[25] In this case, we assume the state premium subsidy wrap is zero, and the enrollee premium is the same as it would be based on federal subsidies alone.

[24] See discussion in Section III.A on the State's policy option related to required metal level offerings for the PO.

[25] As shown in Table A-3 in Section VI, an enrollee with income slightly below 400% FPL may have a maximum enrollee premium of 9.9% of income based on the state enrollee premium scale but a maximum enrollee premium of 9.83% of income based on the federal premium scale.

Table 4
State of Minnesota Department of Human Services
Public Option Study
Maximum Modeled Enrollee Premium

Scenarios:	Federal Premium Scale After Expiration of Enhanced Premium Subsidies Baseline		8.5% State PO Premium Scale with No Subsidy Limit 1A, 1C, 2A, 2C		8.5% State PO Premium Scale with 400% FPL Subsidy Limit 1B, 1D 2B, 2D		10.0% State PO Premium Scale with No Subsidy Limit Sensitivity Tests for 1A and 2A	
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
FPL Bucket	% of Income	Maximum Enrollee Premium PMPM	% of Income	Maximum Enrollee Premium PMPM	% of Income	Maximum Enrollee Premium PMPM	% of Income	Maximum Enrollee Premium PMPM
Under 100%	N/A	N/A	0.75%	$10.00	0.75%	$10.00	0.75%	$10.00
100 to 133%	2.07%	$36.65	0.90%	$15.88	0.90%	$15.88	0.90%	$15.88
133 to 150%	4.02%	$79.75	1.21%	$23.94	1.21%	$23.94	1.21%	$23.94
150 to 200%	6.42%	$170.61	2.95%	$78.28	2.95%	$78.28	2.95%	$78.28
200 to 250%	8.26%	$273.44	3.88%	$128.35	3.88%	$128.35	5.38%	$178.02
250 to 300%	9.71%	$386.71	5.88%	$234.10	5.88%	$234.10	7.38%	$293.84
300 to 400%	9.83%	$475.11	7.51%	$362.95	7.51%	$362.95	9.01%	$435.45
400 to 500%	N/A	No Max	8.50%	$554.66	N/A	No Max	10.00%	$652.55
500 to 600%	N/A	No Max	8.50%	$646.30	N/A	No Max	10.00%	$760.36
Over 600%	N/A	No Max	8.50%	$792.75	N/A	No Max	10.00%	$932.65

Under Model 1, the state PO enrollee premium scale is applied directly to the gross premium for all PO enrollees.

Under Model 2, the federal premium scale and the state PO enrollee premium scale are both applied to the gross premium net of supplemental benefits, which are excluded because they are not EHBs. The State would pay an additional subsidy to wrap around the federal premium subsidy, resulting in lower enrollee premiums. The PO take-up rate under Model 2 depends on the State's policy decision related to the application of the state premium subsidy wrap, as described below:

- The State can allow the state premium wrap subsidy to be applied to all subsidized enrollees eligible for the PO (regardless of whether they enroll in a PO). This would likely result in a lower PO adoption rate.
- This State can allow the state premium wrap subsidy to be applied only to the purchase of any PO plan (i.e., any metal level). This would result in a higher PO adoption rate, but significant enrollment in lower metal plans.
- This State can allow the state premium wrap subsidy to be applied only to the purchase of a MinnesotaCare Platinum plan. This would result in a high PO adoption rate. The PO adoption will likely be lower than if the state premium wrap subsidy is available at any metal level, but adoption of the MinnesotaCare Platinum plan will be higher.

The scenarios shown in this report assume the state premium subsidy wrap resulting from the enrollee premium scale is available only to qualified enrollees in a MinnesotaCare Platinum plan. As noted previously, we continue to assume that the PO plans at the silver and gold level are also available, but the state subsidy is not available for those metal levels.

We did not attempt to model all possible variations of consumer behavior in response to the PO, but we believe the 10% margin applied to the required state funding, as shown in the Executive Summary, is sufficient to address possible variations caused by these situations.

Take-up modeling

Actual PO take-up will depend on many different factors, including some consumer behaviors that are difficult to predict. For purposes of our analysis, we assume PO take-up is a function of two key financial factors:[26] the difference in enrollee premium between the PO and the enrollee's current plan, and the difference in the value of benefits (estimated based on difference in AV) between the PO and the enrollee's current plan. Table 4 shows the PO enrollee premium amounts reflected in the take-up assumption. We dampen the value of the change in benefits by 30% to simulate general consumer biases that favor of definitive savings in out-of-pocket expenses over the potential value of lower cost-sharing.

There is considerable judgement applied to the overall resulting take-up assumptions under all scenarios. However, the use of a defined function based on measurable financial factors ensures consistency between various individuals, the scenarios, and models.

Table 7 illustrates a hypothetical consumer's costs and benefits between the PO and a current non-PO plan under both frameworks, using Scenarios 1A and 2A (BHP Reimbursement / No Subsidy Limit) to illustrate the dynamics. This hypothetical consumer is 33 years old, resides in rating area 8 (in the Minneapolis metropolitan area), and has income at 201% FPL. This consumer is enrolled in a bronze plan on MNsure prior to the PO. We assume the consumer will choose one of two options in 2027: remain enrolled in the current bronze plan or enroll in the PO.

Table 7
State of Minnesota Department of Human Services
Public Option Study
Sample Calculation for Age 33 Enrollee in Rating Area 8 at 201% FPL

		(a) Gross Premium	(b) Federal Subsidy	(c) State Subsidy Wrap	(d) Enrollee Premium	(e) Actuarial Value
Scenario 1A						
(1)	2027 Bronze Plan (non-PO)	$374.89	$185.03	N/A	$189.86	60%
(2)	2027 PO Plan as MinnesotaCare	$459.12	N/A	$351.30	$107.83	94%
(3)	Premium Savings by Moving to PO				$82.03	
(4)	Improvement in Benefits				$192.26	
(5)	Total Value Improvement				$274.29	
Scenario 2A						
(6)	2027 Bronze Plan (non-PO)	$374.89	$41.67	N/A	$333.21	60%
(7)	2027 MNsure Platinum Plan	$399.15	$41.67	$249.65	$107.83	94%
(8)	Premium Savings by Moving to PO				$225.38	
(9)	Improvement in Benefits				$192.26	
(10)	Total Value Improvement				$417.64	

Scenario 1A

- The monthly gross premium for the consumer's current bronze plan is $374.89 (row 1, column a). However, the consumer qualifies for a federal subsidy of $185.03 (1b), resulting in an enrollee premium of $189.86 (1d) if the consumer stays enrolled in the same bronze plan.
- If the consumer enrolls in the PO, the monthly gross premium is $459.12 (2a), which is higher[27] than the gross premium for the consumer's current bronze plan; however, the State pays a premium subsidy of $351.30 (2c) to reduce the enrollee premium to $107.83 (2d).
- If the consumer enrolls in the PO, the monthly out-of-pocket enrollee premium is $82.03 less (3d) than if the consumer stayed enrolled in the bronze plan.

[26] For uninsured people who have neither a current enrollee premium nor a current benefit plan, we use a simplified elasticity function to simulate the choice of remaining uninsured and paying zero premium or obtaining coverage on the PO Platinum plan for a subsidized cost. We use premium as a percentage of income as a proxy for take-up; the higher the enrollee premium is as a percentage of income, the lower the take-up.

[27] Note it is not known at this writing if enrollees in the PO under Model 1 will see the gross cost or if they will only be aware of their enrollee premium.

- We estimate the improvement in benefits will be $192.26 (4d) based on projected allowed claims (net of non-benefit expenses), adjusted for the change in actuarial value.

- The total increase in value if the consumer enrolls in the PO (5d) is the sum of the enrollee premium savings (3d) and the improvement in benefits (4d).

Scenario 2A

- The monthly gross premium for the consumer's current bronze plan is the same $374.89 (6a) as under Scenario 1A. However, the consumer qualifies for a smaller federal subsidy of $41.67 (6b) under Scenario 2A, resulting in an enrollee premium of $333.21 (6d) if the consumer stays enrolled in the same bronze plan. Federal subsidies are lower under Scenario 2A than under Scenario 1A due the assumed 35% decrease in the SLCS.

- If the consumer enrolls in the PO, assumed to be a MinnesotaCare Platinum plan, the consumer's monthly gross premium is $399.15 (7a). The consumer continues to receive the $41.67 federal subsidy (7b), and the State pays a premium subsidy wrap of $249.65 (7c). The resulting enrollee premium is $107.83 (7d).

- The PO enrollee premium is the same in Scenario 2A as in Scenario 1A because it is limited by the State's PO enrollee premium scale.

- If the consumer enrolls in the PO, the monthly out-of-pocket enrollee premium is $225.38 less (8d) than if the consumer stayed enrolled in the bronze plan.

- We estimate the improvement in benefits will be $192.26 (4d) based on projected allowed claims (net of non-benefit expenses), adjusted for the change in actuarial value.

- The total increase in value if the consumer enrolls in the PO (10d) is the sum of the enrollee premium savings (8d) and the improvement in benefits (9d).

In Exhibits 1 and 2, we provide examples for two additional sample individuals with different ages and incomes. These examples illustrate that different individuals will face different tradeoffs between enrollee premium and cost-sharing when deciding whether to enroll in the PO, in addition to other factors. We generally expect individuals with both lower enrollee premiums and lower cost-sharing to enroll in the PO at very high rates, while those facing higher premiums on the PO will enroll the PO at lower rates, depending on how they value the enrollee premium versus lower cost-sharing.

Small employer migration

While the PO is not assumed to be formally available for purchase by small employers in Minnesota, these employers currently have the option to use an Individual Coverage HRA (ICHRA) to allow employees to purchase coverage on the individual market using employer contributions. Under this analysis, this option would be available under both the Baseline and waiver scenarios.

Under a waiver scenario, gross premium decreases relative to the Baseline could be material. If so, some incremental number of employers could consider offering an ICHRA benefit to some or all their employees. However, under an ICHRA, an employee waives the federal subsidies they might otherwise have received. Thus, under a waiver scenario, we expect that the largest part of any incremental membership growth coming from the small group to the individual market in response to an ICHRA offering will be unsubsidized. Consequently, there would be no increase in federal subsidies for these individuals.

There is a limited circumstance under which ICHRAs (or the offer of an ICHRA) might increase federal subsidies in the waiver scenario. If an employee received an ICHRA benefit that is deemed unaffordable, that individual can refuse the ICHRA benefit and claim any subsidy for which they might be eligible. However, an offering of an unaffordable ICHRA does not make sense relative to simply not offering coverage in any form, traditional or ICHRA. Therefore, this circumstance is very unlikely, and its only effect might be to increase an employee's awareness of their subsidy eligibility.

For these reasons, when evaluating the waiver against the deficit neutrality guardrail, we make no assumption of any enrollment increases under a waiver scenario relative to ICHRA offerings in the small group market. This assumption might somewhat understate federal subsidies in the waiver scenario, thereby increasing the estimate of PTF. This would be offset, however, by possible individual market morbidity improvements in the waiver scenario from any incremental membership migration. All told, we consider the net effect of this dynamic to be a very small impact on the calculation of PTF and of little consequence to our overall evaluation of compliance with the deficit neutrality guardrail.

IV. PROJECTED IMPACT OF THE PUBLIC OPTION IN 2027

A. BASELINE SCENARIO ASSUMPTIONS

The PO scenarios and projected PTF under the PO scenarios rely on the assumptions modeled in the Baseline scenario. This scenario reflects expected premiums, enrollment, and federal subsidies, assuming no PO is offered. We do not show the explicit projections under the Baseline scenario in this report, but the Baseline scenario projections for enrollment, premiums, and subsidies are implicitly reflected in the waiver scenario projections of the "Surplus (Deficit) financial measure.

Enrollment

All scenarios, including the Baseline, reflect the following enrollment assumptions:

- *General population growth:* We assume all markets grow by 0.2% annually due to general population growth.[28] This growth is assumed to apply uniformly across the individual market (e.g., across income levels, age groups, metallic levels, etc.).
- *Individual market enrollment increase due to the expiration of the PHE:* We assume approximately 171,000 Medicaid enrollees are disenrolled between 2023 and 2025 following eligibility redeterminations due to the expiration of the PHE. We assume some of the disenrolled Medicaid enrollees have other coverage and some are uninsured.
- *Individual market enrollment decrease due to the expiration of enhanced premium subsidies:* We assume individual market enrollment decreases by approximately 10,000 enrollees between 2025 and 2026 due to the expiration of enhanced premium subsidies. The number of uninsured individuals increases by 8,000 due to the expiration of enhanced premium subsidies.
- *Individual market enrollment decrease due to the expiration of the 1332 waiver reinsurance program:* We assume individual market enrollment decreases by approximately 10,000 enrollees between 2025 and 2026 due to the expiration of the 1332 waiver reinsurance program. The number of uninsured individuals increases by 10,000 due to the expiration of the 1332 waiver reinsurance program.

Premiums

All scenarios, including the Baseline, reflect the following premium assumptions:

- *Premium trend:* Gross premiums for the individual market and MinnesotaCare are projected with a 4% annual increase.
- *Morbidity of individual market due to expiration of the PHE:* Individual market morbidity is not assumed to change due to additional enrollment transitioning from MA after the expiration of the PHE.
- *Morbidity of individual market due to expiration of enhanced premium subsidies:* Individual market morbidity is not assumed to change due to the exit of enrollees who lose enhanced premium subsidies.
- *Expiration of the 1332 waiver reinsurance program:* We assume gross premiums in the individual market increase by 25% due to the expiration of the 1332 waiver reinsurance program.

Subsidies

All scenarios, including the Baseline, reflect the following subsidy assumptions:

- *FPL increases:* The 100% federal poverty level (FPL), used to calculate a PTC-eligible person's subsidy, is increased in 2023 by 7.3% and by 2.5% annually thereafter.[29]

[28] https://www.census.gov/quickfacts/fact/table/MN
[29] We assume a larger increase in 2023 to reflect the actual increase. See Federal Poverty Level (FPL) - Glossary | HealthCare.gov.

- *Expiration of enhanced premium subsidies*: We assume eligibility for federal subsidies and federal subsidy amounts by income level revert to pre-ARPA levels after 2025, i.e., when the enhanced premium subsidies expire. The federal subsidies modeled in the analysis are illustrated in columns 1 and 2 of Table 4.

B. MODEL 1: MINNESOTACARE PUBLIC OPTION ADMINISTERED BY DHS

The State's cost of a PO under Model 1 is the unfunded portion of the cost of PO coverage remaining after federal funding and PO enrollee premiums.

The key driver of the results shown below under the Model 1 framework is the percentage of Minnesotans who enroll in the PO. Our assumption regarding migration to the PO depends on predictions about consumer behavior, which are subject to significant uncertainty and variability. Note, these results do not reflect any margin on PTF; however, we apply a 10% margin to projected required state funding to account for unknown contingencies, such as changes in federal or state law, significant healthcare innovations, or variances in PO take-up patterns.

Note, PMPM values shown in this section represent averages. Actual PMPM values for individual enrollees will vary significantly by enrollee age, income, and metal level prior to the PO. We illustrate this variance by age and income in Section III.E.

Scenario 1A

Table 8 shows the projected annual impact of the PO under Scenario 1A in 2027 for enrollees who migrate to the PO from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered under the MinnesotaCare framework with the same coverage and provider reimbursement as the BHP. The state enrollee premium scale for PO enrollees at or below 200% FPL in Scenario 1A is the same as the BHP enrollee premium scale, and the state enrollee premium scale for PO enrollees over 200% FPL is equivalent to the enrollee premium scale based on ARPA subsidies (i.e., 8.5% cap with no subsidy limit).

We estimate approximately $193 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 8
State of Minnesota Department of Human Services
Public Option Study: Overview and Preliminary Analysis
Projected 2027 Public Option Enrollment, Revenue, and Cost by Enrollment Source
Scenario 1A

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population – Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	75%	49%	12%	31%
(c)	Projected PO enrollees = (a) * (b)	83,000	25,000	36,000	144,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$759	$717	$482	$682
(e)	PO enrollee premium PMPM	$352	$593	$298	$380
(f)	Federal subsidies for PO enrollees PMPM	n/a	n/a	n/a	n/a
(g)	Federal PTF from PO enrollees PMPM	$330	$0	$0	$190
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$77	$124	$184	$112
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$755,000	$212,000	$210,000	$1,177,000
(j)	PO enrollee premium	$350,000	$176,000	$130,000	$656,000
(k)	Federal subsidies for PO enrollees	n/a	n/a	n/a	n/a
(l)	Federal PTF from PO enrollees	$328,000	$0	$0	$328,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$77,000	$36,000	$80,000	$193,000

The cost of PO coverage under the Model 1 framework is equal to the aggregate gross PO premiums and is based on BHP calendar year (CY) 2022 paid claims experience and CY 2024 rate development non-benefit expense load assumptions, both trended to 2027.

The differences in the cost of PO coverage on a PMPM basis (i.e., gross premium) across PO enrollment sources is attributable to differences in the assumed age mix within each group of enrollees. The average age of the population increases from the uninsured population to off-exchange enrollees to MNsure enrollees, and the average projected PO gross premium increases accordingly.

The PO enrollee premium PMPM is higher for enrollees from off-exchange than from MNsure or the uninsured population because we assume most enrollees from off-exchange have incomes above 600% FPL.[30] Based on the premium scale in Scenario 1A, most PO enrollees from off-exchange will pay their full premium.

Note, the underlying cost of PO coverage is based on medical and prescription drug costs in MinnesotaCare according to age. We assume, and model accordingly, the application of an age rating factor similar to QHPs offered through MNsure (i.e., the federal 3:1 age rating curve). The age rating factor results in some costs for older PO enrollees being subsidized by younger PO enrollees, and it creates a difference between the cost of PO coverage and the PO enrollee premium for some enrollees.

As shown in Table 8, enrollees who migrate from the off-exchange and uninsured populations do not generate federal pass-through savings, but enrollee premiums will cover a significant portion of their costs. For enrollees who migrate from MNsure, federal pass-through savings and enrollee premiums will collectively cover roughly 90% of the cost of PO coverage. Across the entire program, enrollee premiums will cover more than half of the cost of PO coverage and PTF will cover more than a quarter, so state-based sources will be required to fund less than 20% of the cost.

Enrollment assumptions

Scenario 1A reflects the same enrollment assumptions as the Baseline scenario plus the following assumptions:

- *PO migration:* We assume migration to the PO will be primarily driven by the following considerations:
  - Enrollee premiums in Scenario 1A are lower than MNsure enrollee premiums for most people eligible for the PO
  - The actuarial value of the PO is 94%, which is higher than all MNsure offerings
  - The PO covers more benefits than the essential health benefits covered by QHPs on MNsure (i.e., the supplemental benefits)

We apply different PO migration percentage assumptions for MNsure enrollees, off-exchange enrollees, and the uninsured population assumed to migrate to the PO, as each enrollee type has differing circumstances and trade-offs to consider.

MNsure: We project that a significant percentage of MNsure enrollees will enroll in the PO based on the take-up modeling described in Section III.E. However, we do not assume 100% migration due to other factors that may influence consumer behavior, including but not limited to provider network preferences or a tendency toward inaction.

Additionally, there are circumstances where PO enrollee premiums for unsubsidized and lightly subsidized MNsure enrollees could be higher than enrollee premiums for their current MNsure plans. This is more likely for enrollees with higher incomes in bronze plans and some younger enrollees in silver plans. We assume MNsure enrollees whose enrollee premium is higher for the PO than their current plan will be less likely to select the PO, despite the enhanced coverage and lower cost-sharing.

Off-Exchange: We assume a significant percentage of off-exchange enrollees will migrate to the PO because of the same considerations described for MNsure enrollees. We assume a lower percentage of migration from off-exchange than from MNsure because none of the off-exchange enrollees receive federal premium subsidies, so they realize the full impact of a change in the gross premium. The gross premium for some off-exchange enrollees will increase due to the higher AV and supplemental benefits available on the PO. Similar to MNsure enrollees, we assume some off-exchange enrollees whose enrollee premiums would actually decrease under the PO will not enroll in the PO due

[30] We assume less than 5% of off-exchange enrollees are enrolled in catastrophic plans. Of these catastrophic plan enrollees, approximately one-quarter (or roughly 1% of all off-exchange enrollees) have incomes below 400% FPL.

to other factors that may influence consumer behavior, including but not limited to provider network preferences or a tendency toward inaction.

Uninsured: We assume approximately two-thirds of people who are uninsured are ineligible for the PO due to immigration status or eligibility for other coverage (e.g., employer or Medicaid). Furthermore, we assume many uninsured people who are eligible for the PO, who currently pay no premium, will not enroll in the PO because they do not want to pay any premium, regardless of the amount. However, we assume the lower premium level and improved coverage over plans available on the individual market will draw some enrollees from the uninsured, particularly people who transitioned to uninsured status after the expiration of enhanced federal subsidies and the end of reinsurance. Therefore, we assume the percentage of individuals who migrate to the PO will be lower for the uninsured than for both MNsure and off-exchange enrollees.

Premium assumptions

Scenario 1A reflects the same premium assumptions as the Baseline scenario for non-PO plans plus the following assumptions:

- *PO provider reimbursement:* We assume provider reimbursement for the PO plan is the same as provider reimbursement for the BHP plan (approximately 83% of Medicare). Managed care contracting results in provider reimbursement in the BHP that is higher than the Medicaid fee schedule, in aggregate, but lower than Medicare.

- *Morbidity of individual market due to PO migration:* Individual market morbidity is not assumed to change as a result of the PO. Based on the PO migration assumption for Scenario 1A, it is possible the morbidity of enrollees remaining in the individual market will change; however, we have no reliable basis to evaluate the direction or magnitude of the morbidity impact. Therefore, we assume no change, but we evaluate the sensitivity of key metrics to a 10% increase or decrease in morbidity below.

- *Pharmacy costs reflect BHP formulary and contracting:* Consistent with the MinnesotaCare program, we assume the PO will reflect the state preferred drug list (PDL) and drug costs.

- *Administrative expenses are the same as BHP administrative expense load assumptions:* We assume PO administrative costs included in gross premiums are the same as the administrative expense load reflected in the BHP capitation rates. Since the same health plans are expected to operate both BHP plans and PO plans, we assume administrative expenses will be similar to the BHP, which is lower than the administrative expenses assumed to be reflected in QHPs.

- *Covered benefits are the same as the BHP:* We assume the PO will cover the same benefits covered under the BHP, including the supplemental benefits of dental, vision, hearing, and non-emergency transportation.

For consistency with the individual market, we scale public option premiums based on the Minnesota age rating scale which meets ACA requirements (i.e., the 3:1 limitation between oldest and youngest adults).

Subsidy assumptions

Subsidies under Scenario 1A reflect the same key assumptions as the Baseline scenario plus the following assumptions:

- *Enrollee premiums are based on the 8.5% enrollee premium scale with no subsidy cliff:* The enrollee premium scale assumptions are shown in columns 3 and 4 of Table 4 in Section III.C.

As described in Section III.E, the state PO enrollee premium scale is applied directly to the gross premium for all PO enrollees under Model 1. The state premium subsidy is the amount of the gross premium in excess of the enrollee premium, if any. There are no federal subsidies under Model 1, but the PTF is based on federal subsidies calculated under the Baseline scenario, as described in Section III.B.

Sensitivity analyses

Table 9 illustrates how the state funding requirement under Scenario 1A is impacted by changes in key program design elements. Each of these sensitivity analyses is described in more detail below.

Table 9
State of Minnesota
Minnesota Public Option Study
Projected PO Sensitivity to Assumption Changes in 2027 for Model 1

	Scenario 1A	Change Maximum Enrollee Premium from 8.5% to 10.0%	Change Actuarial Value of the PO from 94% to 80%	Assume 10% Increase to MNsure Morbidity and SLCS	Assume 10% Decrease to MNsure Morbidity and SLCS
Projected PO enrollees	144,000	125,000	143,000	144,000	144,000
Annual Cost by Funding Source (in thousands)					
Cost of PO coverage	$1,177,000	$1,007,000	$908,000	$1,177,000	$1,177,000
PO enrollee premium	$656,000	$628,000	$588,000	$656,000	$656,000
Federal subsidies for PO enrollees	N/A	N/A	N/A	N/A	N/A
Federal PTF from PO enrollees	$328,000	$297,000	$289,000	$328,000	$328,000
Required state funding	$193,000	$82,000	$31,000	$193,000	$193,000
PTF impact due to change in federal subsidies for enrollees who remain in MNsure	$0	$0	$0	($19,000)	$19,000
Change in BHP funding due to change in SLCS, assuming no adjustment by CMS	$0	$0	$0	$53,000	($53,000)
Potential Required State Funding	$193,000	$82,000	$31,000	$227,000	$159,000

Sensitivity to maximum enrollee premium

Table 9 shows the projected annual impact of the PO under Scenario 1A in 2027 if the maximum enrollee premium is 10.0% instead of 8.5%. We assume the enrollee premium is 150 basis points higher than the enrollee premium in Scenario 1A at all income levels above 200% FPL, as illustrated in columns 7 and 8 of Table 4. The federal PTF and premiums (gross premiums and enrollee premiums) are estimated based on the Scenario 1A assumptions described in this report, except that we assume lower PO migration due to the higher enrollee premium requirement. We assume the decrease in PO enrollment due to the change in enrollee premium will be skewed toward individuals with higher incomes. Since these individuals have lower or no federal subsidies in the Baseline scenario, the impact on federal funding is small compared to the impact on the cost of PO coverage. The total PO enrollee premiums decrease due to fewer PO enrollees, but this decrease is partially offset by higher enrollee premiums PMPM from those who do enroll in a PO.

Sensitivity to actuarial value

Table 9 shows the projected annual impact of the PO under Scenario 1A in 2027 if the actuarial value is 80% instead of 94%. We assume the gross premium is approximately 20% lower than the gross premium in Scenario 1A to account for the lower AV and expected lower utilization in a plan with higher enrollee cost-sharing. The federal PTF and premiums (gross premiums and enrollee premiums) are estimated based on the Scenario 1A assumptions described in this report, except that we assume lower PO migration due to the higher enrollee cost-sharing requirements, particularly among MNsure and off-exchange enrollees. However, we assume some unsubsidized MNsure enrollees and uninsured people who are younger with higher incomes are more likely to enroll in the PO due to the decrease in gross premiums. The lower AV and utilization combined with lower enrollment and a younger average age of PO enrollees results in a cost of PO coverage that is roughly 23% lower than Scenario 1A and total required state funding that is roughly 84% lower.

Sensitivity to morbidity impact on remaining MNsure enrollees

Table 9 shows the projected annual impact of the PO under Scenario 1A in 2027 if the morbidity of enrollees who remain on MNsure increases by 10% or decreases by 10% due to migration to the PO. The federal PTF and PO premiums PMPM (gross premiums and enrollee premiums) are the same as Scenario 1A, but we assume the MNsure SLCS increases by 10% or decreases by 10% due to changes in the morbidity for the remaining MNsure enrollees after the introduction of the PO. We expect morbidity changes will be priced into QHPs sold through MNsure over time, which will likely influence PO take-up and have a downstream impact on PO program costs and revenues. To mitigate the circular impact of MNsure morbidity in our modeling, the sensitivity test assumes the same PO take-up as in Scenario 1A.

A change in the SLCS will result in a change in subsidies available to enrollees who remain on MNsure. Any increase (or decrease) in subsidies for enrollees who remain enrolled on MNsure will decrease (or increase) the PTF dollar for dollar.[31]

Similarly, the BHP federal funding formula is based on the SLCS, and any increase (or decrease) in the SLCS will result in an increase (or decrease) in BHP federal funding. Depending on CMS' response to a morbidity impact on the SLCS due to the implementation of the PO, MinnesotaCare federal funding may or may not be at risk.

Scenario 1B

Table 10 shows the projected annual impact of the PO under Scenario 1B in 2027 for enrollees who migrate to the PO from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered under the MinnesotaCare framework with the same coverage and provider reimbursement as the BHP. The state enrollee premium scale for PO enrollees in Scenario 1B is the same as Scenario 1A, except enrollees over 400% FPL do not receive subsidies and pay the full gross premium.

We estimate approximately $103 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 10
State of Minnesota Department of Human Services
Public Option Study: Overview and Preliminary Analysis
Projected 2027 Public Option Enrollment, Revenue, and Cost by Enrollment Source
Scenario 1B

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population – Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	69%	37%	12%	28%
(c)	Projected PO enrollees = (a) * (b)	76,000	19,000	36,000	131,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$741	$616	$480	$652
(e)	PO enrollee premium PMPM	$353	$615	$297	$377
(f)	Federal subsidies for PO enrollees PMPM	N/A	N/A	N/A	N/A
(g)	Federal PTF from PO enrollees PMPM	$361	$0	$0	$210
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$27	$1	$183	$65
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$674,000	$142,000	$205,000	$1,021,000
(j)	PO enrollee premium	$321,000	$142,000	$127,000	$590,000
(k)	Federal subsidies for PO enrollees	N/A	N/A	N/A	N/A
(l)	Federal PTF from PO enrollees	$328,000	$0	$0	$328,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$25,000	$0	$78,000	$103,000

The cost of PO coverage varies from Scenario 1A due to different PO migration assumptions and an associated difference in PO enrollee age mix. Similar to Scenario 1A, the average age of the population increases from the uninsured population to off-exchange enrollees to MNsure enrollees, and the cost of PO coverage PMPM in row (d) increases accordingly. As shown in Table 10, none of the cost of PO coverage for enrollees who migrate from off-exchange or the uninsured population is covered by federal pass-through savings. We project more than three-quarters of the required state funding is attributable to migration from the uninsured population, although the uninsured population is only slightly less than one-third of the projected PO enrollees.

[31] Under a 1332 waiver, if the waiver reduces subsidies, this is recoverable in PTF. However, if the waiver increases federal subsidies (e.g., by increasing the morbidity on the exchange) and thereby increases the SLCS and federal spending on subsidies, this counts against the State when calculating PTF.

We assume off-exchange enrollees generally have incomes above 600% FPL.[32] Therefore, we assume the cost of PO coverage for off-exchange enrollees will be almost entirely funded through enrollee premiums. As explained for Scenario 1A, the age rating factor results in some costs for older PO enrollees being subsidized by younger PO enrollees, and it creates a difference between the cost of PO coverage and the PO enrollee premium for some enrollees. The small amount of required state funding for PO enrollees from off-exchange ($1 PMPM) is attributable to catastrophic plan enrollees with incomes below 400% FPL.

Enrollment assumptions

Scenario 1B reflects the same enrollment assumptions as Scenario 1A, except as follows:

- *PO migration:* Enrollment in the PO is assumed to be lower than in Scenario 1A due to fewer enrollees over 400% FPL enrolling due to the premium subsidy limit. Enrollment for individuals below 400% FPL is assumed to be the same as in Scenario 1A. Since we assume nearly all off-exchange enrollees are above 400% FPL, the projected PO enrollment from off-exchange decreases by a greater percentage than projected PO enrollment from the other markets versus Scenario 1A.

Premium assumptions

Scenario 1B reflects the same premium assumptions as Scenario 1A.

Subsidy assumptions

Subsidies under Scenario 1B reflect the same key assumptions as Scenario 1A, except as follows:

- *Enrollee premiums are based on the 8.5% enrollee premium scale with a 400% FPL subsidy limit:* The premium scale is the same as in Scenario 1A, except the enrollee premium for enrollees above 400% FPL is equal to the gross premium. The enrollee premium scale assumptions are shown in columns 5 and 6 of Table 4 in Section III.C.

Scenario 1C

Table 11 shows the projected annual impact of the PO under Scenario 1C in 2027 for enrollees who migrate to the PO from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered under the MinnesotaCare framework with the same coverage as the BHP, but provider reimbursement is 100% of Medicare. The state enrollee premium scale for PO enrollees in Scenario 1C is the same as Scenario 1A.

We estimate approximately $331 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

[32] We assume less than 5% of off-exchange enrollees are enrolled in catastrophic plans. Of these catastrophic plan enrollees, approximately one-quarter (or roughly 1% of all off-exchange enrollees) have incomes below 400% FPL.

Table 11
State of Minnesota Department of Human Services
Public Option Study: Overview and Preliminary Analysis
Projected 2027 Public Option Enrollment, Revenue, and Cost by Enrollment Source
Scenario 1C

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population - Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	72%	37%	11%	28%
(c)	Projected PO enrollees = (a) * (b)	79,000	19,000	33,000	131,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$883	$917	$553	$805
(e)	PO enrollee premium PMPM	$348	$664	$304	$382
(f)	Federal subsidies for PO enrollees PMPM	n/a	n/a	n/a	n/a
(g)	Federal PTF from PO enrollees PMPM	$348	$0	$0	$210
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$187	$253	$249	$213
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$833,000	$204,000	$218,000	$1,255,000
(j)	PO enrollee premium	$328,000	$148,000	$120,000	$596,000
(k)	Federal subsidies for PO enrollees	n/a	n/a	n/a	n/a
(l)	Federal PTF from PO enrollees	$328,000	$0	$0	$328,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$177,000	$56,000	$98,000	$331,000

The cost of PO coverage varies from Scenario 1A due to higher provider reimbursement, which increases gross premiums. Unsubsidized enrollees will realize the full impact of the higher gross premiums, so we assume lower PO enrollment than in Scenario 1A.

The PO enrollee premium PMPM for enrollees from MNsure is lower than in Scenario 1A because PO enrollment is more heavily weighted toward subsidized enrollees whose enrollee premiums are capped by the premium scale. This shift in weighting toward subsidized enrollees also results in higher federal PTF PMPM. PO enrollee premiums PMPM for enrollees from the off-exchange and uninsured populations increase due to higher gross premiums, but this increase is partially offset by a decrease in the average age of PO enrollees, as younger enrollees are less likely to be eligible for state premium subsidies due to their lower average premiums.

Enrollment assumptions

Scenario 1C reflects similar enrollment assumptions as Scenario 1A, except the PO take-up is lower for enrollees with higher incomes whose gross premiums are less than their maximum enrollee premiums (i.e., unsubsidized enrollees).

Premium assumptions

Scenario 1C reflects the same premium assumptions as Scenario 1A, except as follows:

- *PO provider reimbursement:* We assume provider reimbursement for PO plans is 100% of Medicare

Subsidy assumptions

Subsidies under Scenario 1C reflect the same key assumptions as Scenario 1A.

Scenario 1D

Table 12 shows the projected annual impact of the PO under Scenario 1D in 2027 for enrollees who migrate to the PO from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO

coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered under the MinnesotaCare framework with the same coverage as the BHP, but provider reimbursement is 100% of Medicare. The state enrollee premium scale for PO enrollees in Scenario 1D is the same as Scenario 1B.

We estimate approximately $194 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 12
State of Minnesota Department of Human Services
Public Option Study: Overview and Preliminary Analysis
Projected 2027 Public Option Enrollment, Revenue, and Cost by Enrollment Source
Scenario 1D

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population – Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	62%	14%	10%	23%
I	Projected PO enrollees = (a) * (b)	68,000	7,000	32,000	107,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$849	$492	$547	$734
(e)	PO enrollee premium PMPM	$322	$488	$303	$327
(f)	Federal subsidies for PO enrollees PMPM	n/a	n/a	n/a	n/a
(g)	Federal PTF from PO enrollees PMPM	$849	$492	$547	$734
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$322	$488	$303	$327
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$688,000	$43,000	$212,000	$943,000
(j)	PO enrollee premium	$261,000	$42,000	$118,000	$421,000
(k)	Federal subsidies for PO enrollees	n/a	n/a	n/a	n/a
(l)	Federal PTF from PO enrollees	$328,000	$0	$0	$328,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$99,000	$1,000	$94,000	$194,000

Similar to the difference between Scenario 1A and 1C, the cost of PO coverage in Scenario 1D varies from Scenario 1B due to higher provider reimbursement, which increases gross premiums. Unsubsidized enrollees will realize the full impact of the higher gross premiums, so we assume lower PO enrollment than in Scenario 1B.

The PO enrollee premium PMPM for enrollees from MNsure is lower than in Scenario 1B because PO enrollment is more heavily weighted toward subsidized enrollees whose enrollee premiums are capped by the premium scale. This shift in weighting toward subsidized enrollees also results in higher federal PTF PMPM. PO enrollee premiums PMPM for enrollees from the off-exchange and uninsured populations increase due to higher gross premiums, but this increase is offset to different degrees by a decrease in the average age of PO enrollees, as younger enrollees are less likely to be eligible for state premium subsidies due to their lower average premiums. The average age for enrollees from off-exchange decreases enough to outweigh the increase in gross premiums due to higher provider reimbursement.

Enrollment assumptions

Scenario 1D reflects similar enrollment assumptions as Scenario 1B, except the PO take-up is lower for enrollees with higher incomes whose gross premiums are less than their maximum enrollee premiums.

Premium assumptions

Scenario 1D reflects the same premium assumptions as Scenario 1C.

Subsidy assumptions

Subsidies under Scenario 1D reflect the same key assumptions as Scenario 1B.

C. MODEL 2: PUBLIC OPTION OFFERED AS A QUALIFIED HEALTH PLAN (QHP)

The State's cost of a PO under Model 2 is the unfunded portion of the following costs after federal 1332 waiver PTF:

- Supplemental benefits offered in addition to EHBs
- State premium wrap to ensure enrollee premiums do not exceed the PO premium scale

The key driver of the results shown below under the Model 2 framework is the decrease in the SLCS driven by the PO. Unlike Model 1, the PTF under Model 2 is not materially impacted by the number of Minnesotans who actually enroll in the PO. As with Model 1, these results do not reflect any margin on PTF; however, we apply a 10% margin to projected required state funding to account for unknown contingencies, such as changes in federal or state law, significant healthcare innovations, or variances in PO take-up patterns.

As previously noted, we conservatively assume all PO enrollees enroll in the MinnesotaCare Platinum plan. If some individuals enroll in PO plans at other metal levels and forfeit their state premium subsidies, required state funding will be lower than shown in these scenarios since state premium subsidies would decrease and we assume the State would not cover supplemental benefits for enrollees in other PO metal levels.

Note, PMPM values shown in this section represent averages. Actual PMPM values for individual enrollees will vary significantly by rating area, enrollee age, income, and metal level prior to the PO. We illustrate this variance by age and income in Section III.E.

Scenario 2A

Table 13 shows the projected annual impact of the PO under Scenario 2A in 2027 for PO enrollees from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered on the MNsure platform with the same coverage and provider reimbursement as the BHP. The state enrollee premium scale for PO enrollees in Scenario 2A is the same as the BHP enrollee premium scale for enrollees under 200% FPL and equivalent to the enrollee premium scale under the ARPA enhanced premium subsidies for enrollees over 200% FPL. The primary drivers of differences between the results in Scenarios 1A and 2A are the differences in key policies and pass-through savings mechanisms between the model frameworks, which are discussed in detail in Section III.B.

We estimate approximately $108 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 13
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option Enrollment, Revenue, and Cost by Enrollment Source
Scenario 2A

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population - Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	79%	53%	12%	32%
(c)	Projected PO enrollees = (a) * (b)	87,000	27,000	37,000	151,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$751	$702	$498	$681
(e)	PO enrollee premium PMPM	$407	$649	$303	$425
(f)	Federal subsidies for PO enrollees PMPM	$150	$0	$23	$92
(g)	Federal PTF from MNsure enrollees PMPM	$189	$0	($23)	$104
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$4	$53	$195	$60
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$784,000	$230,000	$220,000	$1,234,000
(j)	PO enrollee premium	$425,000	$213,000	$134,000	$771,000
(k)	Federal subsidies for PO enrollees	$157,000	$0	$10,000	$167,000
(l)	Federal PTF from MNsure enrollees	$198,000	$0	($10,000)	$188,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$4,000	$17,000	$86,000	$108,000

Under Model 2, the components of the required state funding can also be allocated between the cost of the state premium wrap and the cost of supplemental benefits, minus the federal PTF. Table 14 shows this allocation of the required state funding for each PO enrollment source.

Table 14
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option State Cost Components for Model 2
Scenario 2A

		PO Enrollment Source			
		MNsure	**Off-Exchange**	**Uninsured**	**Total**
PMPM State Cost Components					
(a)	Cost of state premium wrap PMPM	$162	$22	$141	$132
(b)	Cost of supplemental benefits PMPM	$32	$32	$32	$32
(c)	Federal PTF from MNsure enrollees PMPM	$189	$0	($23)	$104
(d)	Required state funding PMPM = (a) + (b) - (c)	$4	$53	$195	$60
Annual State Cost Components (in thousands)					
(e)	Cost of state premium wrap	$169,000	$7,000	$62,000	$238,000
(f)	Cost of supplemental benefits	$33,000	$10,000	$14,000	$57,000
(g)	Federal PTF from MNsure enrollees	$198,000	$0	($10,000)	$188,000
(h)	Required state funding = (e) + (f) - (g)	$4,000	$17,000	$86,000	$108,000

The cost of PO coverage under the Model 2 framework is equal to the aggregate cost of gross premiums for a 94% AV plan that covers EHBs on MNsure plus the cost of supplemental benefits (i.e., dental, vision, hearing, and non-emergency medical transportation). We assume PO enrollees who previously had coverage off-exchange are higher income and are not eligible for federal subsidies, and many will also not be eligible for state premium subsidies. We assume all enrollees have the same PMPM cost for supplemental benefits.

We project very little of the required state funding is attributable to PO enrollees who were previously enrolled in MNsure. Uninsured individuals who enroll in the PO and are subsidy-eligible decrease PTF because they have no federal subsidies in the Baseline scenario, but they do have federal subsidies under the waiver. Therefore, the federal funding in rows (k) and (l) in Table 13 must sum to zero to match their baseline federal funding.

Enrollment assumptions

Scenario 2A reflects the same enrollment assumptions as the Baseline scenario plus the following assumptions:

- *PO migration*: We assume migration to the PO will be primarily driven by the following considerations:
  - Maximum enrollee premiums in Scenario 2A are lower than MNsure maximum enrollee premiums at all income levels.
  - The actuarial value of the MinnesotaCare Platinum plan is 94%, which is higher than all other MNsure offerings.
  - The MinnesotaCare Platinum plan covers more benefits than the essential health benefits covered on QHPs sold through MNsure.

We apply different PO migration percentage assumptions for MNsure enrollees, off-exchange enrollees, and the uninsured population assumed to migrate to the PO, as each enrollee type has differing circumstances and trade-offs.

MNsure: The Model 2 framework assumes the SLCS will decrease due to the entrance of lower priced PO silver plans in all counties, which will lower the benchmark plan and decrease the federal subsidies available to MNsure enrollees. Therefore, unlike Model 1, many individuals enrolled in MNsure prior to the PO will experience an increase in their enrollee premiums if they do not enroll in a PO plan. We assume 79% of MNsure enrollees will enroll in the PO. We do not assume 100% take-up due to other factors that may influence consumer behavior, including but not limited to provider network preferences or a tendency toward inaction.

Off-Exchange: We assume slightly more than half of the off-exchange enrollees will enroll in the PO because of lower premiums, lower cost-sharing, and the inclusion of supplemental benefits. Again, we do not assume 100% migration due to other factors that may influence consumer behavior, including but not limited to provider network or a tendency toward inaction. We assume a lower percentage of migration from off-exchange than from MNsure since enrollee premiums for unsubsidized enrollees will not be impacted by decreases in federal subsidies due to the lower SLCS.

Uninsured: We assume approximately two-thirds of people who are uninsured are ineligible for the PO due to immigration status or eligibility for other coverage (e.g., employer or Medicaid). Furthermore, we assume many of the uninsured people who are eligible for the PO, who currently pay no premium, will not enroll in the PO because they do not want to pay any premium, regardless of the amount. However, we assume the lower premium level and improved coverage over plans available on the individual market before the waiver will draw some enrollees from the uninsured, particularly people who transitioned to uninsured status after the expiration of enhanced federal subsidies and the end of reinsurance. Therefore, we assume the percentage of individuals who migrate to the PO will be lower for the uninsured population than for both MNsure and off-exchange enrollees.

Premium assumptions

Scenario 2A reflects the same premium assumptions as the Baseline scenario for non-PO plans plus the following assumptions:

- *PO provider reimbursement:* We assume provider reimbursement for PO plans is the same as provider reimbursement for BHP plans. Managed care contracting results in provider reimbursement in the BHP that is higher than the Medicaid fee schedule, in aggregate, but lower than Medicare.
- *Actuarial value adjustment:* Since no platinum plans currently exist on MNsure, we assume the MinnesotaCare Platinum plan will be priced using theoretical relativities for AV and IU compared to the PO silver SLCS.
- *Morbidity of individual market due to PO migration:* Individual market morbidity is not assumed to change as a result of the PO. We do not expect the additional enrollment in the individual market to be material enough, or have significantly different morbidity, to materially change the overall morbidity of the individual market. Therefore, we assume no change.

- *Pharmacy costs reflect MNsure formulary and contracting:* Consistent with the individual market, we assume the PO are based on health plan formularies and drug costs reflected in QHPs.
- *Administrative expenses are the same as administrative expense load assumptions in QHPs:* We assume PO administrative costs are the same as the administrative expense load reflected in premiums for QHPs.
- *Covered benefits are the same as the BHP:* We assume the MinnesotaCare Platinum plan will cover the same benefits covered under the BHP, including dental, vision, hearing, and non-emergency transportation.

We assume the State will fund a state premium wrap to cover the difference between the PO enrollee premium scale and the federal premium scale. We also assume the State will fund the cost of supplemental benefits.

Subsidy assumptions

Subsidies under Scenario 2A reflect the same key assumptions as the Baseline scenario plus the following assumptions:

- *Enrollee premiums are based on the 8.5% enrollee premium scale with no subsidy limit:* The enrollee premium scale assumptions are shown in columns 3 and 4 of Table 4 in Section III.C.

As described in Section III.E, the state PO enrollee premium scale is applied to the gross premium net of supplemental benefits for all MinnesotaCare Platinum enrollees under Model 2. The state premium subsidy is the amount of the gross premium net of supplemental benefits in excess of the enrollee premium, if any. Federal subsidies are calculated using the same methodology as the Baseline scenario, but the assumed SLCS benchmark is lower than in the Baseline scenario due to the PO.

Sensitivity analyses

Table 15 illustrates how the state funding requirement under Scenario 2A is impacted by changes in key program design elements. Each of these sensitivity analyses is described in more detail below.

Table 15
State of Minnesota
Minnesota Public Option Study
Projected PO Sensitivity to Assumption Changes in 2027 for Model 2

	Scenario 2A	Change Maximum Enrollee Premium from 8.5% to 10.0%	Change Actuarial Value of the PO from 94% to 80%
Projected PO Enrollees	151,000	138,000	131,000
Total Cost by Funding Source (in thousands)			
Cost of PO coverage	$1,234,000	$1,124,000	$1,068,000
PO enrollee premium	$771,000	$755,000	$634,000
Federal subsidies for PO enrollees	$167,000	$159,000	$154,000
Federal PTF from MNsure enrollees	$188,000	$190,000	$188,000
Required state funding	$108,000	$19,000	$93,000

Sensitivity to maximum enrollee premium

Table 15 shows the projected annual impact of the PO under Scenario 2A in 2027 if the maximum enrollee premium is 10.0% instead of 8.5%. We assume the enrollee premium is 150 basis points higher than the enrollee premium in Scenario 2A at all income levels above 200% FPL. The federal PTF and cost of PO coverage are estimated based on the Scenario 2A assumptions described in this report, except that we project lower PO migration due to the higher enrollee premium scale.

Under Model 2, enrollee premiums for MNsure enrollees who do not enroll in the PO will increase due to the decrease in the SLCS and resulting lower federal premium subsidies; therefore, we assume the enrollee premium scale increase has a very minimal impact on PO take-up for those already on MNsure. Most of the enrollment impact versus Scenario 1A is due to lower enrollment in the PO from people with an uninsured status. The cost of the state premium wrap decreases due to both the decrease in enrollment and the shifting of more premium costs to enrollees for those selecting the PO.

Sensitivity to actuarial value

Table 15 shows the projected annual impact of the PO under Scenario 2A in 2027 if the actuarial value is 80% instead of 94%. We assume the gross premium is approximately 20% lower than the gross premium in Scenario 2A to account for the lower AV and expected lower utilization in a plan with higher cost-sharing. The federal PTF and cost of PO coverage are estimated based on the Scenario 2A assumptions described in this report, except that we assume lower PO migration due to the less generous benefits. We assume PO take-up from uninsured people is driven by enrollee premium; therefore, we assume the change in AV does not have any impact on PO take-up from the uninsured population. However, we assume PO take-up from MNsure and off-exchange enrollees is partially influenced by both enrollee premium and plan AV, so PO enrollment decreases for both of these populations due to the lower AV.

Scenario 2B

Table 16 shows the projected annual impact of the PO under Scenario 2B in 2027 for PO enrollees from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered on the MNsure platform with the same coverage and provider reimbursement as the BHP. The state enrollee premium scale for PO enrollees in Scenario 2B is the same as Scenario 2A, except enrollees over 400% FPL do not receive subsidies and pay the full gross premium.

We estimate approximately $78 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 16
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option Cost and Funding for Scenario 2B
Scenario 2B

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population – Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	78%	45%	12%	31%
(c)	Projected PO enrollees = (a) * (b)	86,000	23,000	36,000	145,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$745	$641	$494	$665
(e)	PO enrollee premium PMPM	$413	$608	$304	$417
(f)	Federal subsidies for PO enrollees PMPM	$152	$0	$23	$96
(g)	Federal PTF from MNsure enrollees PMPM	$192	$0	($23)	$108
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	($13)	$33	$191	$45
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$765,000	$178,000	$216,000	$1,159,000
(j)	PO enrollee premium	$424,000	$169,000	$133,000	$726,000
(k)	Federal subsidies for PO enrollees	$157,000	$0	$10,000	$167,000
(l)	Federal PTF from MNsure enrollees	$198,000	$0	($10,000)	$188,000
(m)	Required state funding = (i) - (j) - (k) - (l)	($14,000)	$9,000	$83,000	$78,000

Under Model 2, the components of the required state funding can also be allocated between the cost of the state premium wrap and the cost of supplemental benefits, minus the federal PTF. Table 17 shows this allocation of the required state funding for each PO enrollment source.

Table 17
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option State Cost Components for Model 2
Scenario 2B

		PO Enrollment Source			
		MNsure	Off-Exchange	Uninsured	Total
PMPM State Cost Components					
(a)	Cost of state premium wrap PMPM	$148	$1	$136	$122
(b)	Cost of supplemental benefits PMPM	$32	$32	$32	$32
(c)	Federal PTF from MNsure enrollees PMPM	$192	$0	($23)	$108
(d)	Required state funding PMPM = (a) + (b) - (c)	($13)	$33	$191	$45
Annual State Cost Components (in thousands)					
(e)	Cost of state premium wrap	$152,000	$0	$60,000	$212,000
(f)	Cost of supplemental benefits	$32,000	$9,000	$14,000	$55,000
(g)	Federal PTF from MNsure enrollees	$198,000	$0	($10,000)	$188,000
(h)	Required state funding = (e) + (f) - (g)	($14,000)	$9,000	$83,000	$78,000

The impact of the enrollee premium subsidy limit is much smaller under Model 2 than under Model 1. The change in the PO cost is driven by the premium wrap, which decreases from $238 million (based on $132 PMPM) in Scenario 2A to $212 million (based on $122 PMPM) in Scenario 2B due to slightly lower enrollment in the PO from individuals who were already enrolled in MNsure plans.

Enrollment assumptions

Scenario 2B reflects the same enrollment assumptions as Scenario 2A, except as follows:

- *PO migration*: We assume migration to the PO for enrollees over 400% FPL will be slightly lower than in Scenario 2A due to the premium subsidy limit. However, the impact is small because the MinnesotaCare Platinum plan premium is below the maximum state premium scale for most individuals above 400% FPL.

We assume the same drivers as in Scenario 2A, except that the enrollee premium subsidy limit may slightly reduce the percentage take-up in the PO from MNsure enrollees.

Premium assumptions

Scenario 2B reflects the same premium assumptions as Scenario 2A.

Subsidy assumptions

Subsidies under Scenario 2B reflect the same key assumptions as Scenario 2A, except as follows:

- *Enrollee premiums are based on the 8.5% enrollee premium scale with a 400% FPL subsidy limit:* The premium scale is the same as in Scenario 2A, except the enrollee premium for enrollees above 400% FPL is equal to the gross premium. The enrollee premium scale assumptions are shown in columns 5 and 6 of Table 4 in Section III.C.

Scenario 2C

Table 18 shows the projected annual impact of the PO under Scenario 2C in 2027 for PO enrollees from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered on the MNsure platform with the same coverage as the BHP, but provider reimbursement is 100% of Medicare. The state enrollee premium scale for PO enrollees in Scenario 2C is the same as Scenario 2A.

We estimate approximately $170 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 18
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option Cost and Funding for Scenario 2C
Scenario 2C

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population – Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	76%	47%	11%	30%
(c)	Projected PO enrollees = (a) * (b)	84,000	24,000	35,000	143,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$810	$774	$536	$737
(e)	PO enrollee premium PMPM	$412	$695	$310	$435
(f)	Federal subsidies for PO enrollees PMPM	$179	$0	$31	$112
(g)	Federal PTF from MNsure enrollees PMPM	$168	$0	($31)	$91
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$51	$79	$226	$99
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$819,000	$228,000	$226,000	$1,272,000
(j)	PO enrollee premium	$416,000	$204,000	$131,000	$751,000
(k)	Federal subsidies for PO enrollees	$181,000	$0	$13,000	$194,000
(l)	Federal PTF from MNsure enrollees	$170,000	$0	($13,000)	$157,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$52,000	$24,000	$95,000	$170,000

Under Model 2, the components of the required state funding can also be allocated between the cost of the state premium wrap and the cost of supplemental benefits, minus the federal PTF. Table 19 shows this allocation of the required state funding for each PO enrollment source.

Table 19
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option State Cost Components for Model 2
Scenario 2C

		PO Enrollment Source			
		MNsure	**Off-Exchange**	**Uninsured**	**Total**
PMPM State Cost Components					
(a)	Cost of state premium wrap PMPM	$188	$47	$164	$158
(b)	Cost of supplemental benefits PMPM	$32	$32	$32	$32
(c)	Federal PTF from MNsure enrollees PMPM	$168	$0	($31)	$91
(d)	Required state funding PMPM = (a) + (b) - (c)	$51	$79	$226	$99
Annual State Cost Components (in thousands)					
(e)	Cost of state premium wrap	$190,000	$14,000	$69,000	$273,000
(f)	Cost of supplemental benefits	$32,000	$9,000	$13,000	$54,000
(g)	Federal PTF from MNsure enrollees	$170,000	$0	($13,000)	$157,000
(h)	Required state funding = (e) + (f) - (g)	$52,000	$24,000	$95,000	$170,000

The impact of the higher provider reimbursement on enrollment is relatively small and is driven by enrollee sensitivity to the enrollee premium. The maximum enrollee premium is not impacted by the change in provider reimbursement; however, some enrollees at higher income levels whose gross premium is less than the maximum enrollee premium may be less likely to enroll in the PO under Scenario 2C. Federal funding is lower than in Scenario 2A because the SLCS does not decrease as much as in Scenario 2A. Since the enrollee premium is the same as in Scenario 2A for many enrollees, the higher gross premium also increases the cost of the state premium wrap.

Enrollment assumptions

Scenario 2C reflects similar enrollment assumptions as Scenario 2A, except the PO take-up is slightly lower for enrollees with higher incomes whose gross premiums are less than their maximum enrollee premiums.

Premium assumptions

Scenario 2C reflects the same premium assumptions as Scenario 2A, except as follows:

- *PO provider reimbursement:* We assume provider reimbursement for PO plans is 100% of Medicare.

Subsidy assumptions

Subsidies under Scenario 2C reflect the same key assumptions as Scenario 2A.

Scenario 2D

Table 20 shows the projected annual impact of the PO under Scenario 2D in 2027 for PO enrollees from MNsure, from off-exchange, and from uninsured status. This scenario reflects expected PO enrollees, cost of PO coverage, PO enrollee premiums, federal funding, and required State funding in CY 2027, assuming a PO is offered on the MNsure platform with the same coverage as the BHP, but provider reimbursement is 100% of Medicare. The state enrollee premium scale for PO enrollees in Scenario 2D is the same as Scenario 2B.

We estimate approximately $126 million of the cost of PO coverage in 2027 would need to be funded by state-based sources, such as a premium tax or general tax.

Table 20
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option Cost and Funding for Scenario 2D
Scenario 2D

		PO Enrollment Source			
Enrollment		**MNsure**	**Off-Exchange**	**Uninsured**	**Total**
(a)	Projected 2027 population – Baseline	110,000	51,000	310,000	471,000
(b)	% selecting PO	74%	37%	11%	29%
(c)	Projected PO enrollees = (a) * (b)	81,000	19,000	35,000	135,000
PMPM Cost by Funding Source					
(d)	Cost of PO coverage PMPM	$799	$672	$530	$712
(e)	PO enrollee premium PMPM	$412	$639	$310	$417
(f)	Federal subsidies for PO enrollees PMPM	$186	$0	$31	$120
(g)	Federal PTF from PO enrollees PMPM	$175	$0	($31)	$97
(h)	Required state funding PMPM = (d) - (e) - (f) - (g)	$27	$33	$220	$77
Annual Cost by Funding Source (in thousands)					
(i)	Cost of PO coverage	$778,000	$152,000	$222,000	$1,152,000
(j)	PO enrollee premium	$401,000	$144,000	$130,000	$675,000
(k)	Federal subsidies for PO enrollees	$181,000	$0	$13,000	$194,000
(l)	Federal PTF from PO enrollees	$170,000	$0	($13,000)	$157,000
(m)	Required state funding = (i) - (j) - (k) - (l)	$26,000	$8,000	$92,000	$126,000

Under Model 2, the components of the required state funding can also be allocated between the cost of the state premium wrap and the cost of supplemental benefits, minus the federal PTF. Table 21 shows this allocation of the required state funding for each PO enrollment source.

Table 21
State of Minnesota Department of Human Services
Public Option Study
Projected 2027 Public Option State Cost Components for Model 2
Scenario 2D

		PO Enrollment Source			
		MNsure	**Off-Exchange**	**Uninsured**	**Total**
PMPM State Cost Components					
(a)	Cost of state premium wrap PMPM	$170	$1	$157	$143
(b)	Cost of supplemental benefits PMPM	$32	$32	$32	$32
(c)	Federal PTF from MNsure enrollees PMPM	$175	$0	($31)	$97
(d)	Required state funding PMPM = (a) + (b) - (c)	$27	$33	$220	$77
Annual State Cost Components (in thousands)					
(e)	Cost of state premium wrap	$166,000	$0	$66,000	$232,000
(f)	Cost of supplemental benefits	$31,000	$7,000	$13,000	$51,000
(g)	Federal PTF from MNsure enrollees	$170,000	$0	($13,000)	$157,000
(h)	Required state funding = (e) + (f) - (g)	$26,000	$8,000	$92,000	$126,000

The impact of the enrollee premium subsidy limit from Scenario 2C to Scenario 2D is similar to the impact between Scenarios 2A and 2B. The change in the PO cost is driven by the premium wrap, which decreases from $273 million (based on $158 PMPM) in Scenario 2C to $232 million (based on $143 PMPM) in Scenario 2D due to slightly lower enrollment in the PO from individuals who were already enrolled in MNsure plans.

Enrollment assumptions

Scenario 2D reflects similar enrollment assumptions as Scenario 2B; however, we assume slightly lower migration from unsubsidized enrollees than in Scenario 2B because gross PO premiums under Scenario 2D are higher than gross PO premiums under Scenario 2B.

We assume the same drivers as in Scenario 2C, except that the enrollee premium subsidy limit may slightly reduce the percentage take-up in the PO from MNsure enrollees.

Premium assumptions

Scenario 2D reflects the same premium assumptions as Scenario 2C.

Subsidy assumptions

Subsidies under Scenario 2D reflect the same key assumptions as Scenario 2B.

V. CONCLUSION

The public options modeled in this analysis measure the incremental costs to the State of Minnesota (the State) relative to a baseline scenario that represents the current state of Minnesota healthcare coverage, except as otherwise noted. These costs are driven primarily by:

- Increased volume of people being insured (reducing the number of uninsured Minnesotans)
- Generally increasing the generosity of coverage for those who enroll, including generosity in covered benefits and enrollee cost-sharing
- Generally decreasing the amounts paid by enrollees relative to what they might pay under a federal premium scale

The scenarios and other sensitivity analyses we performed show that some program parameters can be adjusted to reduce costs, but overall program costs remain at a similar magnitude across various models and scenarios.

Based on our analysis, we believe the 1332 waiver scenarios modeled in this report would satisfy the federal 1332 guardrails. If the State decides to apply for a 1332 public option (PO) waiver amendment, actuarial and economic analyses will be required over a five-year waiver window and ten-year deficit neutrality window to demonstrate compliance with the federal 1332 guardrails. We did not provide these five and ten-year analyses in this report due to the volume of other scenarios provided; however, the general framework and characteristics of these models would, in our opinion, provide the level of federal PTF shown herein.

We summarize the analyses that would need to be included in a 1332 waiver amendment application below.

A. ACTUARIAL ANALYSIS

This section describes the actuarial analysis that will be required for a Section 1332 Waiver application. A description of the actuarial analysis meeting the requirements under 45 CFR 155.1308(f)(4)(i) and other applicable information as requested in the Checklist for Section 1332 Waiver Applications will need to be produced for a 1332 waiver application.

Affordability of premiums and cost-sharing

As required under 45 CFR 155.1308(f)(3)(iv)(B), a state's proposed 1332 waiver must provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable under Title I of the ACA. As described in CMS-9936-N, increasing the number of state residents with large health care spending burdens relative to their incomes would result in a waiver proposal failing to meet the affordability requirement of the 1332 waiver application..[33] Additionally, regulations state an evaluation of the affordability requirement will take into account the impact of the waiver proposal to "vulnerable residents, including low-income individuals, elderly individuals, and those with serious health issues or who have a greater risk of developing serious health issues."

Each of the scenarios modeled in this report assume the PO implements an enrollee premium scale with enrollee premiums that are less than or equal to enrollee premiums without the waiver. Each scenario also assumes cost-sharing under the PO will be comparable to the BHP, which is less costly to enrollees than a silver plan on MNsure. Therefore, the premiums and cost-sharing under each scenario modeled in this report would satisfy this guardrail.

The following exhibits will need to be produced for a 1332 waiver actuarial analysis to demonstrate the waiver provides coverage that is at least as affordable as the coverage available without the waiver, as required by the guardrail:

- Statewide 10-year premium projection and change from the Baseline scenario
- Ten-year SLCS projection and change from the Baseline scenario

Comparable number of state residents covered

As required under 45 CFR 155.1308(f)(3)(iv)(C), a proposed waiver of the State must provide coverage to at least a comparable number of its residents as the provisions of Title I of the ACA. Under each scenario modeled in this report, we estimate the number of Minnesotans with health insurance coverage will increase relative to without the waiver.

[33] See https://www.gpo.gov/fdsys/pkg/FR-2015-12-16/pdf/2015-31563.pdf for more information.

Each of the scenarios modeled in this report assume some migration to the PO by people who were uninsured, with no losses in coverage due to the PO. Therefore, the projected number of state residents covered under each of these scenarios would satisfy this guardrail.

The following exhibits will need to be produced with comparisons to the Baseline scenario for a 1332 waiver actuarial analysis to demonstrate the waiver provides coverage to at least as many residents as without the waiver, as required by the guardrail:

- Ten-year projected enrollment by income level
- Ten-year projected enrollment by metallic level
- Ten-year projected enrollment by age group
- Ten-year projected enrollment by subsidy eligibility

Comparable coverage

Section 31 CFR 33.108(f)(3)(iv)(A) requires that coverage provided under the waiver must be at least as comprehensive overall as coverage available without the waiver. The waiver does not make any changes to the requirements for QHPs, network adequacy, metallic level requirements (including de minimis amounts), essential health benefits, or other coverage requirements; therefore, the modeled Minnesota 1332 waiver amendments comply with this guardrail under all scenarios.

B. ECONOMIC ANALYSIS

Section 31 CFR 33.108(f)(3)(iv)(D) states that the waiver will not increase the federal deficit, either over the five-year waiver period or the 10-year federal deficit neutrality window. CMS requires various costs to be considered when determining the impact on the federal deficit. We list those costs below and address how the modeling handled each cost and the rationale for inclusion or exclusion.

a. **Income, payroll, and excise taxes:** The excise tax to fund the Patient-Centered Outcomes Research Initiative (PCORI) for plan years that end on or after October 1, 2023 and before October 1, 2024 is $3.22 per enrolled member per year. Relative to the premium tax credit (PTC) reductions, which are in the hundreds of millions, the PCORI fee change is immaterial to the economic analysis and was not modeled explicitly.

b. **User fees:** MNsure has been a state-based exchange since 2013 and does not utilize the federal platform at all.

c. **Changes in PTCs and other tax credits:** Our modeling includes the changes to the premium tax credits for those exchange enrollees qualifying for subsidies. We estimate premium tax credits by modeling advanced premium tax credits (APTCs).[34] and then applying an adjustment to account for the tax reconciliation process. This adjustment is 0%..[35]

d. **Changes in CSRs and Medicaid spending:** Cost-sharing reductions (CSRs) are not a federal obligation and are not modeled. It is assumed that the Public Option (PO) does not impact Medicaid spending in the waiver scenarios relative to the Baseline scenario.

e. **Changes in employer mandate penalties:** Because the PO is not expected to affect the employer group markets, the employer mandate revenue impact is zero. If the PO were to cause an increase in the migration of employees of small group employers utilizing ICHRAs, the employer mandate does not apply to this market.

f. **Changes in individual mandate penalties:** The impact to individual mandate penalty revenue is zero because the penalty is set to $0.

g. **Tax deductions for employer premiums and medical expenses:** Because the PO is not expected to affect the employer group markets, the federal costs from the tax deductibility of employer premiums and other medical expenses are expected to be zero.

[30] ATPCs are based on estimated household income and household size, as opposed to PTCs that are determined after the end of the year based on actual income and household size.
[35] IRS. Table 2: Individual Income and Tax Data, by State and Size of Adjusted Gross Income, Tax Year 2019. Retrieved November 9, 2022, from https://www.irs.gov/pub/irs-soi/19in29nv.xlsx (Excel download).

h. **Changes in IRS administrative costs, healthcare.gov administrative costs, and any other federal administrative costs that may be affected by the waiver:** We are not aware of, nor do we anticipate, any impact from Minnesota's waiver to IRS administrative costs.

In summary, the economic analysis of deficit neutrality over the 10-year deficit neutrality window for a 1332 waiver will be calculated using estimates of federal savings driven exclusively by changes in premium tax credits and enrollment.

At a high level, changes in PTCs related to the implementation of the PO under both Model frameworks will be driven by overall enrollment of PTC-eligible individuals and families. Under Model 2, changes in PTCs will also be impacted by the percentage savings the PO will drive relative to non-PO plans as it becomes the second lowest cost silver plan in each of the rating areas in Minnesota.

Model 1 will satisfy the deficit neutrality guardrail by design because the federal funding under the waiver will decrease by the total amount of PTCs for all PO enrollees. Based on the assumptions in all four Model 2 scenarios included in this report, Model 2 will also satisfy the deficit neutrality guardrail because the lower provider reimbursement in the PO will generate a reduction in the SLCS. Under Model 2, new PTCs for uninsured people who enroll in the individual market as a result of the PO will reduce PTF. Based on the Model 2 scenarios we modeled, the PTCs for uninsured people who migrate to the individual market will be significantly low enough relative to the PTC savings from the PO impact on the SLCS that the deficit neutrality guardrail will still be satisfied under each of these models.

A 1332 PO waiver application will include an illustration of PTC savings and PTF by using a series of four exhibits:

- Projected enrollment of PTC-eligible enrollees in the individual market.
- Projected gross premiums, split by PO and non-PO plan enrollment and then a composite market-wide premium, based on the assumed take-up of PO plans.
- Composite gross premiums split by PTC eligibility, with the APTC and net premium portions of a PTC eligible enrollee's premium shown separately.
- Calculation of total APTCs and final estimated PTCs after tax reconciliation.

VI. DATA AND METHODOLOGY

GLOSSARY

We use terminology to describe costs, funding sources, and other key terms used throughout this report as follows:

- *Actuarial value (AV)* is the percentage of health care expenses expected to be covered by the plan (i.e., not the financial responsibility of the member). Enrollee premiums are not included as part of the member's financial responsibility when calculating the AV.
- *Cost-sharing* is the portion of health care claims paid by the enrollee including copays, coinsurance, or deductibles, but not including enrollee premiums.
- *Essential health benefits (EHBs)* are the benefits required by the ACA to be covered by qualified health plans on the exchange.
- *Qualified health plans (QHPs)* are health plans offered on the individual market through MNsure. QHPs are required to provide coverage for all EHBs.
- *Gross premium* is the monthly revenue paid to an insurer to cover health care costs on behalf of an enrollee, inclusive of medical costs and non-benefit expenses (e.g., administrative costs, margin). The gross premium may be paid by any combination of sources including the enrollee, federal premium subsidies, or state funds. The gross premium is comparable to the capitation payment in managed care.
- *Enrollee premium* is the portion of the gross premium paid by the enrollee (e.g., net of federal or state premium subsidies, if applicable).
- *Federal premium subsidy* is the portion of the gross premium paid by the federal government on behalf of subsidy eligible enrollees obtaining coverage through an exchange.
- *Enhanced premium subsidy* is the federal premium subsidy available through the American Rescue Plan Act (ARPA) and extended by the Inflation Reduction Act (IRA) that is set to expire after 2025.

DATA SOURCES AND ADJUSTMENTS

Health care coverage and enrollment

We use estimates of population and sources of coverage taken from the American Community Survey for 2022. This data includes distributions of key variables, such as household income. We calibrate these estimates to other public sources and data provided by the State of Minnesota for Medicaid, MNsure, off-exchange, and MinnesotaCare enrollment to derive a view of the characteristics of the uninsured population within Minnesota. We used summarized results from the 2021 Minnesota Health Access Survey to check for reasonableness.

MNsure provided CY2022 enrollment data. The exchange data included the following elements:

- Segment Start Date
- Segment End Date
- Household Identifier
- Subscriber member ID
- Policy ID
- Plan ID (14-digit)
- Metal Level
- Subscriber Indicator
- Member Age
- Rating Area
- Span Gross Premium Amount
- Last Eligible SLCS Premium
- Last Eligible Household Max APTC
- Last Eligible FPL percentage

We also received summarized off-exchange data as of June 2022. The off-exchange data included the following data elements:

- Issuer
- Metal Level
- Age Range
- Enrollment Count

We reviewed both the exchange data and off-exchange data for reasonableness and compared it against publicly available sources. We summarized the key fields by various cuts to gauge feasibility of the data.

In our review, we noticed irregularities in the SLCS plan premium amount by enrollee for contracts with more than one member. We accounted for this by mapping in each member's and contract's total SLCS plan premium amount from the publicly available 1332 Public Use Files (PUFs) based on their rating area. We also excluded a minimal amount of membership with invalid or missing entries for key fields such as county, age, and premium.

MinnesotaCare detailed claims data

We received detailed CY2022 claims data for the MinnesotaCare BHP plan. We used this data to estimate the relative morbidity (as measured by the risk score produced by the HHS-HCC risk adjustment model used under the ACA) of this population, as well as relative aggregate provider reimbursement (as a percentage of Medicare).

Publicly available data

- Individual market Federal Risk Adjustment Reports
- Open enrollment PUFs
- 1332 waiver PUFs
- Benefits and cost-sharing PUFs
- American Community Survey (ACS)
- National Health Expenditures (NHE) projections
- Commercial medical loss ratio form data submitted to CMS
- Statutory statement insurer financial data
- Minnesota Health Access Survey

Other

- 2022 MNsure Annual Report

METHODOLOGY

We summarize the 2022 exchange enrollment and premium information to create a baseline, grouped by metal level, rating area, age band, FPL, and contract size to produce approximately 6,000 model cells. In 2022, we calculate federal subsidies based on the enrollee's selected premium, premium of SLCS plan available, household FPL, and current premium limits (based on the enhanced subsidy levels). For 2023 through 2027, we project enrollment and premium increases for each scenario, and calculate the corresponding subsidies for each model cell. The following sections provide further detail on the assumptions for enrollment and premium changes.

We calculate revised subsidies for each model cell and year. The difference between the total subsidies in each PO scenario is compared to the corresponding baseline scenario to calculate the estimated PTF.

Enrollment assumptions

We project these enrollment totals for population growth and the effects of Medicaid redetermination, as well as the expiration of enhanced premium subsidies after 2025. Estimates for Medicaid disenrollment due to redetermination were provided by DHS. We estimate the effects of the expiration of enhanced premium subsidies based on historical enrollment in MNsure.

Population-driven enrollment growth

We assume the exchange and other markets will grow by the population growth rate, absent other factors. The population of the State of Minnesota is assumed to grow 0.2% annually after 2022.[36]

Enrollment growth due to expiration of the PHE

We assume individual market enrollment will increase in each income level between 2022 and 2026 due to the expiration of the PHE, as shown in Table A-1. First, we estimated the total membership at each income level that we expect to lose Medicaid coverage upon expiration of the PHE by reviewing Minnesota's Medicaid enrollment forecast. We expect higher-income individuals will be more likely to have commercial group insurance available, and less likely to enter the individual market.

Table A-1
State of Minnesota Department of Human Services
Public Option Study
Modeling Assumptions
Individual Market Enrollment Increase Due to Expiration of the PHE

Income (% FPL)	Enrollee Increase
Under 100%	0
100 to 133%	0
133 to 150%	0
150 to 200%	0
200 to 250%	5,398
250 to 300%	3,874
300 to 400%	4,600
400 to 500%	1,134
500 to 600%	182
Over 600%	1,980
Total	**17,168**

Enrollment decrease due to the expiration of ARPA

We assume exchange enrollment will decrease in each income level between 2022 and 2026 due to the expiration of ARPA, as shown in Table A-2. To develop these assumptions, we estimated the increase in enrollees due to ARPA by measuring the 2021 and 2022 increases in enrollment. We assume that a relatively comparable number of enrollees will disenroll due to the expiration of ARPA.

[36] United States Census (December 10, 2023). Retrieved December 10, 2023, fromhttps://www.census.gov/quickfacts/fact/table/MN.

Table A-2 State of Minnesota Department of Human Services Public Option Study Modeling Assumptions Enrollment Decrease Due to Expiration of ARPA	
Income (% FPL)	**Enrollee Decrease**
Under 100%	0
100 to 133%	0
133 to 150%	0
150 to 200%	0
200 to 250%	1,440
250 to 300%	1,156
300 to 400%	2,111
400 to 500%	693
500 to 600%	386
Over 600%	4,215
Total	**10,000**

Incremental enrollment growth due to the public option

We assume the reductions in gross premium, state premium wrap, state cost-sharing reductions, and the supplemental benefits are offered only to enrollees choosing a PO plan. This will result in individual market enrollment growth and a substantial portion of the individual market joining the PO Plan. The total growth from new enrollees for each scenario can be seen in the new membership from uninsured status coming on-exchange in each scenario. The total take-up from each enrollment source in each segment is also included in the summary table. We model varying take-up from each population based on the relative value of the additional benefits compared to each enrollee's current selection.

Premium assumptions

PO premiums under Model 1

We estimate PO gross premiums under Model 1 based on actual calendar year (CY) 2022 claims costs and non-benefit load assumptions from the MinnesotaCare CY 2024 capitation rate development, trended to CY 2027. We assume PO claims costs under Model 1 are comparable to MinnesotaCare claims costs for enrollees of the same age. The total costs have been distributed along the Minnesota Age Rating curve[37] to produce premiums for each rate cell. Differences between average PO premiums and average MinnesotaCare premiums are driven by differences in projected enrollment mix by age.

As mentioned, the CY2027 non-benefit load assumptions assumed in the Model 1 PO Premiums are based on the MinnesotaCare CY2024 capitation rate development as follows. The administrative expenses are increased with trend to CY 2027.

- Administrative expenses: $37.50 PMPM
- Margin: 1.0% of Gross Premium
- Taxes: 1.6% of Gross Premium

For the BHP provider reimbursement scenarios, we use the costs described above.

For the 100% of Medicare reimbursement scenarios, we estimate that approximately two-thirds of benefit costs (e.g., inpatient, outpatient, professional) will increase by approximately 20% due to a change in provider reimbursement from 83% of Medicare to 100% of Medicare. Other benefit costs are not assumed to be impacted. Based on these assumptions, we assume benefit costs will increase by 14%. The benefit costs are increased by the non-benefit load assumptions shown above to estimate the gross premium.

[37] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/Downloads/StateSpecAgeCrv053117.pdf

PO premiums under Model 2

We estimate PO gross premiums under Model 2 based on CY 2022 MNsure gross premiums trended to CY 2027. We apply reductions from the baseline SLCS due to reimbursement savings as a percent of premium evenly across all areas. We assume approximately 60% of MNsure gross premiums are attributable to benefit costs that will be impacted due to changes in provider reimbursement, which results in a 35% decrease for BHP provider reimbursement scenarios and a 30% decrease in 100% of Medicare provider reimbursement scenarios. We estimate the MinnesotaCare Platinum premium by increasing the projected MNsure PO silver premiums by approximately 50.0% to account for the difference in benefits and estimated induced utilization.

Trend

We examined the trend in premium for the second lowest cost silver plan for the most recent years and in 2024 we expect a premium trend of 4.5%. For 2025-2027, we assume 4.0% annual trend for gross premiums in MinnesotaCare and MNsure baseline premiums from 2025-2027 based on a review of recent trends and general industry expectations.

Morbidity changes due to the expiration of the PHE

We assume the new enrollees who join the exchange due to the expiration of the PHE do not impact total individual market morbidity.

Morbidity changes due to the expiration of ARPA

We assume the enrollees who leave MNsure due to the expiration of ARPA do not impact total individual market morbidity.

Morbidity changes due to expiration of 1332 reinsurance

We assume the enrollees who leave MNsure due to the expiration of reinsurance do not impact total individual market morbidity.

Federal premium subsidies

We estimate federal premium subsidies using actual MNsure enrollment, adjusted for population growth, Medicaid redeterminations, and the expiration of enhanced premium subsidies. We calculate federal premium subsidies at the member or contract level and adjust for the HHS / Department of Treasury methodology for determining PTF.

Demographic and distribution assumptions

Enrollees under 200% FPL

Based on the Minnesota Health Care Programs eligibility hierarchy, we assume all current MNsure enrollees under 200% FPL (approximately 0.63% of the individual exchange market in CY 2022) are not eligible for MinnesotaCare and are eligible for the PO. We assume the percentage of uninsured people under 200% FPL who are not eligible for MinnesotaCare is immaterial, as we assume all or most would be eligible for the Basic Health Program under MinnesotaCare.

Income levels

The FPL in 2022 is $13,590.[38] For modeling purposes, we vary the average income level by FPL bucket and age band in order to more closely match the 2022 subsidies with publicly available information and the MNsure exchange data. Enrollees within each FPL bucket and age band have the same FPL percentage, based on the approximate distribution of 2022 exchange enrollment within each bucket. We assume individuals remain at the same percent of FPL from 2022 to 2027, or that any shifts will offset (other than for explicit market events such as Medicaid redeterminations and expiration of enhanced premium subsidies).

[38] Office of the Assistant Secretary for Planning and Evaluation (ASPE). Prior HHS Poverty Guidelines and Federal Register References. Retrieved December 10, 2023, from https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines/prior-hhs-poverty-guidelines-federal-register-references.

For off-exchange enrollees, FPL level was not available. Since off-exchange enrollees cannot receive federal premium subsidies, we assume all are over 600%, since otherwise they may move on exchange, especially with the current enhanced premium subsidies.

FPL increases

We assume the FPL will increase each year with trend. The 2023 published FPL levels show an increase of 7.3%[20] over the 2022 FPL levels. We assume this increase will moderate and will average 2.5% every year after, based on CMS projections.

ACA affordability limits

The maximum amount of premium for which an ACA enrollee is responsible as a percentage of their income is indexed based on National Health Expenditure data and projections done by CMS. We analyzed the changes in these values year over year prior to ARPA subsidies becoming available in 2021. Based on the historical change and current income and premium estimates, we projected out-of-pocket premium limits (as a percentage of income) through 2027. Our estimates are higher than current expected 2027 values to be conservative on PTF and state cost calculations.

Enrollee premium scales

Enrollee premium scales are based on the percentages in Table A-3.

Table A-3
State of Minnesota Department of Human Services
Public Option Study
Enrollee Premium Scales

	Federal Only	State PO Enrollee Premium Scales		
	After Expiration of Enhanced Premium Subsidies (Baseline)	8.5% of Income / No Subsidy Limit (Scenarios 1A, 1C, 2A, 2C)	8.5% of Income / 400% FPL Subsidy Limit (Scenarios 1B, 1D, 2B, 2D)	10.0% of Income / No Subsidy Limit (Sensitivity for Scenarios 1A, 2A)
	(1)	(2)	(3)	(4)
Member Income as % of FPL	Max Member Premium as % of Income	Max Member Premium as % of Income	Max Member Premium as % of Income	Max Member Premium as % of Income
201% to 250%	6.52% to 8.32%	2.00% to 3.99%	2.00% to 3.99%	3.50% to 5.49%
251% to 300%	8.33% to 9.82%	4.00% to 5.99%	4.00% to 5.99%	5.50% to 7.49%
301% to 400%	9.83%	6.00% to 8.49%	6.00% to 8.49%	7.50% to 9.99%
401% to No Limit	NA	8.50%	NA	10.00%

Note: The federal-only percentages reflect the maximum member premium percentage for CY 2021. These percentages are indexed each year. For example, the percentage for 301% FPL will decrease from 9.83% to 9.12% in CY 2023. For modeling purposes, the CY 2021 percentages were used for 2026 and 2027 as a conservative estimate.

Take-Up assumption calculations

The take-up rate used to determine final PO enrollment varies by population and consumer elasticity. The On-Exchange and Off-Exchange populations use the same elasticity function based on the total change in value (as a percentage of current premiums) whereas the uninsured population uses an elasticity function based on affordability as a percentage of assumed income.

Change in Value Calculation

For the on-exchange and off-exchange populations, we projected 2027 PO "Net" Premiums and 2027 Non-PO "Net" Premiums. The difference in these net premiums in addition to the value of the change in benefit richness (including cost-sharing differences and additional supplemental benefits) equals the total change in value calculated for each rate cell.

The 2027 Non-PO "Net" Premium was calculated based on the projected on-exchange gross premiums. We assume off-exchange premiums are 7.1% lower than on-exchange premiums at the same rate cell, based on a review of CY2022 premiums reported in the MNsure data and the total individual market average Premium reported in the 2022

Final RA Report. Since there are no Platinum plans on-exchange, we used a theoretical pricing gold to platinum ratio of 1.225 to account for the difference in AV plus an adjustment for induced utilization. For Catastrophic plans, we trended the average catastrophic gross premium PMPM from the 2022 Final RA Report to 2027.

Take-Up Rate & Elasticity Function

We assume PO take-up is a function of two key financial factors: the difference in enrollee premium between the PO and the enrollee's current plan, and the difference in the value of benefits (estimated based on AV) between the PO and the enrollee's current plan. We dampen the value of the change in benefits by 30% to simulate general consumer biases that favor of definitive savings in out-of-pocket expenses over the potential value of lower cost-sharing. The weighted value is the sum of the change in enrollee premium and the dampened change in benefits. We then compare the overall weighted change in value to their net premium on their current non-PO plan.

The take-up rate for the MNsure and off-exchange cohorts is based on the following logic:

- For individuals with a negative change in total weighted value, we assume a 0% take-up rate
- For individuals with a positive change in total weighted value, we assume the following take-up rate curve:

Table A-4
State of Minnesota Department of Human Services
Public Option Study
On & Off Exchange Elasticity Curve

Change in Value	Take-up Rate
0%	20%
10%	30%
20%	40%
30%	55%
40%	70%
50%	80%
60%	90%
70%	95%
80%	98%
90%+	99%

Since the uninsured population has no current plan, nor current premium, we estimate take-up for the uninsured population by determining PO affordability as a percentage of assumed income. To account for uninsured people who are ineligible for the PO (e.g., due to an employer offered alternative or immigration status), we estimate only 36% of the total uninsured population is eligible for the PO based on a review of publicly available data.

We apply the table below to the uninsured population eligible for the PO to determine final PO enrollment from the uninsured population:

Table A-5 State of Minnesota Department of Human Services Public Option Study Uninsured Elasticity Curve	
Premium as a % of income	**Expected Take-up**
0.0%	95.0%
0.5%	90.0%
1.0%	85.0%
1.5%	80.0%
2.0%	75.0%
2.5%	70.0%
3.0%	65.0%
3.5%	60.0%
4.0%	55.0%
4.5%	50.0%
5.0%	45.0%
5.5%	40.0%
6.0%	35.0%
6.5%	30.0%
7.0%	25.0%
7.5%	20.0%
8.0%	15.0%
8.5%	10.0%
9.0%	5.0%
9.5%	2.5%
10.0%	2.5%
15.0%	1.0%
20.0%	1.0%
25.0%	0.0%

EXHIBITS

Exhibit 1
State of Minnesota Department of Human Services
Public Option Study
Sample Calculation for Age 53 member in Rating Area 8 at 399% FPL

		(a) Gross Premium	(b) Federal Subsidy	(c) State Subsidy Wrap	(d) Enrollee Premium	(e) Actuarial Value
Scenario 1A						
(1)	2027 Bronze Plan (non-PO)	$662.06	$179.57	N/A	$482.50	60%
(2)	2027 PO Plan as MinnesotaCare	$785.33	N/A	$330.49	$454.85	94%
(3)	Premium Savings by Moving to PO				$27.65	
(4)	Improvement in Benefits				$331.21	
(5)	Total Value Improvement				$358.86	
Scenario 2A						
(6)	2027 Bronze Plan (non-PO)	$662.06	$0.00	N/A	$662.06	60%
(7)	2027 MNsure Platinum Plan	$687.63	$0.00	$232.78	$454.85	94%
(8)	Premium Savings by Moving to PO				$207.22	
(9)	Improvement in Benefits				$331.21	
(10)	Total Value Improvement				$538.43	

Exhibit 2
State of Minnesota Department of Human Services
Public Option Study
Sample Calculation for Age 43 member in Rating Area 8 at 600% FPL

		(a) Gross Premium	(b) Federal Subsidy	(c) State Subsidy Wrap	(d) Enrollee Premium	(e) Actuarial Value
Scenario 1A						
(1)	2027 Bronze Plan (non-PO)	$440.99	$0.00	N/A	$440.99	60%
(2)	2027 PO Plan as MinnesotaCare	$524.35	N/A	$0.00	$524.35	94%
(3)	Premium Savings by Moving to PO				-$83.36	
(4)	Improvement in Benefits				$220.51	
(5)	Total Value Improvement				$137.15	
Scenario 2A						
(6)	2027 Bronze Plan (non-PO)	$440.99	$0.00	N/A	$440.99	60%
(7)	2027 MNsure Platinum Plan	$457.80	$0.00	$0.00	$457.80	94%
(8)	Premium Savings by Moving to PO				-$16.81	
(9)	Improvement in Benefits				$220.51	
(10)	Total Value Improvement				$203.69	

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